Refining the Role of Social Support in First-time Mothers' Development of Parental Self-efficacy

Permalink
https://escholarship.org/uc/item/3n49f1mc

Author
Kerrick, Madeleine R.

Publication Date
2017

Peer reviewed|Thesis/dissertation
UNIVERSITY OF CALIFORNIA
SANTA CRUZ

REFINING THE ROLE OF SOCIAL SUPPORT IN THE DEVELOPMENT
OF FIRST-TIME MOTHERS’ PARENTAL SELF-EFFICACY

A dissertation submitted in partial satisfaction
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

PSYCHOLOGY

by

Madeleine R. Kerrick

June 2017

The Dissertation of Madeleine R. Kerrick
is approved:

Professor Emerita Avril Thorne, Chair

Professor Margarita Azmitia

Professor Bettina Aptheker

_________________________________________________________________

Tyrus Miller
Vice Provost and Dean of Graduate Studies
# TABLE OF CONTENTS

ABSTRACT ........................................................................................................ iv
ACKNOWLEDGEMENTS ................................................................................ vi
LIST OF TABLES ............................................................................................... viii
INTRODUCTION ................................................................................................. 1
METHOD ............................................................................................................. 15
QUANTITATIVE ANALYSES AND RESULTS ................................................. 28
QUALITATIVE ANALYSES AND RESULTS ....................................................... 41
DISCUSSION ....................................................................................................... 64
APPENDICES ..................................................................................................... 77
REFERENCES .................................................................................................... 135
Abstract

Refining the Role of Social Support in First-time Mothers’ Development of Parental Self-efficacy

Madeleine R. Kerrick

Research has established that a mother’s beliefs about her ability to plan and carry out the activities of parenting, or parental self-efficacy (Porter & Hsu, 2003), has important implications both for herself and for her child (for a review see Jones & Prinz, 2005). Less clear, however, is how parental self-efficacy is constructed during the prenatal period, and how mothers themselves experience and understand these developments. The present longitudinal survey and interview study was conducted with a sample of 82 U.S. first-time expectant mothers who were predominantly European American, well-educated, and partnered to men. It examined a) the development of parental self-efficacy from the 2nd trimester to early postpartum, b) whether the quality of prenatal care provider interactions predicted parental self-efficacy, when controlling for known predictors such as social support and depression, and c) postpartum interviews with two mothers to understand their lived experiences of social support and developing efficacy beliefs. Quantitative findings indicated a non-significant increase in parental self-efficacy across time. Second trimester parental self-efficacy was associated with social support and later parental self-efficacy, but not with depression. Further, provider empowerment, an aspect of the quality of prenatal provider interactions, significantly predicted 3rd trimester parental self-efficacy, but not postpartum parental self-efficacy. Findings from the
qualitative analysis highlighted the importance of friends and family for social support during pregnancy and early parenthood, and how such interactions served to support the development of parental self-efficacy. Further, the mothers identified a variety of other contributors to their feelings of efficacy in reading and responding to their babies’ cues. Implications for future research, policy, and practice are discussed.
Acknowledgements

This dissertation would not have been possible without the support and encouragement of a number of individuals. I am especially grateful to Professor Emerita Avril Thorne, my advisor and committee chair, for her consistently brilliant mentorship. She has always fostered an ideal balance between free-reign and guidance, and her modeling of work-life balance is inspiring. Thanks also go to my dissertation committee members, Professors Margarita Azmitia and Bettina Aptheker, who pushed me to more deeply consider the larger sociocultural, historical, and political influences in women’s lives. Professor Shelly Grabe helped me to develop the original idea for this project in my first year and has been a trusted mentor ever since. Professor Lynda Stone first awakened my love for research and launched me on my path to completing a doctoral degree. I am forever grateful. The UCSC Narrative Identity Research Group has provided amazing feedback on my qualitative analyses and has taught me so much about qualitative methods. Thanks to the National Science Foundation for funding this work.

I am deeply indebted to the mothers who have participated in this research and those whose stories first sparked my interest in women’s transitions to motherhood 14 years ago. This work would also not have been possible without my amazing team of research assistants: Rachel Henry, Jose Mariscal, Lisa Nunez, Wendi Pacheco-Lopez, Karen Piñon, Diana Rivas, Kylie Sloan, Itzel Soto-Liu, and Catherine Spurrell.

The members of my Reading Group, you know who you are, have provided wonderful support (in all its many forms) throughout my time in graduate school.
Finally, especially in a dissertation on social support, I would be remiss not to acknowledge the role of my family. This dissertation would have been simply impossible without their unwavering support, especially that of Steven Kerrick.
List of Tables

Table 1: Descriptive Statistics for Reliable Continuous Variables.................................32
Table 2: Mean Parental Self-efficacy (PSE) across Time for Mothers Enrolled in the 2nd Trimester ........................................................................................................................................34
Table 3: Bivariate Correlations of Key Variables for Hypothesis 3 .................................37
Table 4: Summary of Hierarchical Regression Analysis for Concurrent Prediction of T2 Parental Self-efficacy ................................................................................................................................38
Table 5: Summary of Hierarchical Regression Analysis for Prediction of Postpartum Parental Self-efficacy (PSE) ............................................................................................................40
Table 6: Shannon and Carol’s Scores on Key Variables .....................................................44
Refining the Role of Social Support in First-time Mothers’ Development of Parental Self-efficacy

The transition to motherhood represents a unique developmental period, involving physical, psychological, and relational changes. Among the challenges faced by expectant and new mothers is that of constructing beliefs about their ability to plan and carry out the activities of parenting, or parental self-efficacy (PSE; Porter & Hsu, 2003). While maternal development is posited to begin in pregnancy (Smith, 1999), PSE has predominantly been studied in the postpartum period. Past research has established that a mother’s PSE has important implications both for herself and for her child (for a review see Jones & Prinz, 2005). However, how PSE is constructed during the prenatal period and how mothers themselves experience and understand the development of their efficacy beliefs is less clear.

While social support has been found to relate to PSE (Cutrona & Troutman, 1986; Haslam, Pakenham, & Smith, 2006; Leahy-Warren, McCarthy, & Corcoran, 2012; Leerkes & Crockenberg, 2002; Reece & Harkless, 1998; Shorey, Chan, Chong, & He, 2015), less well understood is how social support facilitates the development of PSE, and who provides this social support. The present study extends social support to include interactions with the prenatal care provider and examines women’s lived experiences of social support and developing efficacy beliefs.

Unique to the prenatal period, an expectant mother’s interactions with her primary prenatal care provider are not only a chance to monitor the physical progress of a pregnancy, but can also afford an opportunity to support the mother’s
psychological development. With regard to the latter, it is known that these visits provide an occasion for the prenatal care provider to convey information about motherhood (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011), but prior research has not examined whether and how interactions with the prenatal provider serve as a context in which the expectant mother begins exploring her perceived ability to parent. To that end, the present quantitative analysis assessed the developmental trajectory of PSE from the 2nd trimester to early postpartum for first-time mothers and examined whether the quality of prenatal care provider interactions predicted PSE in the 3rd trimester of pregnancy and postpartum. Further, the present qualitative analysis drew from postpartum interviews with two mothers to explicate their experiences of developing efficacy beliefs and their understanding of the role of social support in this development. This study builds on self-efficacy theory, postpartum research on the implications of PSE for mother and child, and on studies of maternal depression and social support as predictors of PSE.

**Parental Self-efficacy**

Self-efficacy is defined as an individual’s beliefs about her/his ability to plan and execute tasks within a given domain, such as studying or parenting. These domain-specific efficacy beliefs “vary in level, strength, and generality” (Bandura, 1997, p. 22). Efficacy beliefs are theorized to derive from four sources: one’s own experiences of success or failure, one’s physical and emotional reactions, vicarious experiences, and verbal persuasion (Bandura, 1982; 1997). As perceived efficacy
develops, it plays an important role in the individual’s performance.\footnote{It is important to note that self-efficacy is not a trait that remains stable once developed. Instead, efficacy beliefs emerge and evolve through experiences within the domain they concern (Bandura, 1997). The four sources of efficacy beliefs are not only the means for the development of efficacy but potential avenues for change in efficacy beliefs over time (Bandura, 1997).} With greater persistence and better coping found in those with high self-efficacy (Bandura, 1982; 1997), individuals with high PSE are likely best prepared to overcome the difficulties of parenting.

**Measurement**

As PSE is constituted by an individual’s beliefs about his/her ability to plan and carry out parenting tasks, the construct has usually been measured with a self-report scale that assesses the level, strength, and generality of these beliefs. There are four approaches to measuring PSE (Barnes & Adamson-Macedo, 2007; Coleman & Karraker, 2003; Jones & Prinz, 2005; Leahy-Warren & McCarthy, 2011). First, *task-specific* measures ask parents to evaluate their skill level regarding a specific task within the general domain of parenting (e.g., breastfeeding; “I can always ensure that my baby is properly latched on for the whole feeding,” “I can always recognize when my baby is finished breastfeeding;” Dennis & Faux, 1999). Second, *domain-specific* measures ask parents to evaluate their skill level regarding a variety of tasks within the general domain of parenting (e.g., “I am able to soothe my baby easily when he or she is crying or fussing,” “I am able to recognize teething”). Third, *domain-general* measures ask parents to evaluate their skill level within the general domain of parenting, without reference to specific tasks (e.g., “I honestly believe I have all the
skills necessary to be a good mother”). Domain-specific and domain-general measures have been found to correlate moderately (e.g., Coleman & Karraker, 2003; Teti & Gelfand, 1991; information on correlations between task-specific measures and other types of PSE measures is not available). Fourth, general self-efficacy scales assess self-efficacy as a stable personality trait across diverse domains, a method not supported by Bandura’s theory (Leahy-Warren & McCarthy, 2011; information on correlations between general self-efficacy measures and other types of PSE measures is not available). As domain-specific measures are considered more precise in assessing self-efficacy within the given domain than are other approaches (see Coleman & Karraker, 2003), the present study utilized a domain-specific measure particular to parenting a newborn, with both prenatal and postpartum versions (Pedersen, Bryan, Huffman, & Del Carmen, 1989; Porter & Hsu, 2003). In addition, to address the possibility that some mothers may simply have more confidence in their ability to accomplish tasks or to interact with others across domains (i.e., greater personal or interpersonal control; Paulhus, 1983), a measure of locus of control was included in the present study (Paulhus & Van Selst, 1990).

**Past Findings**

PSE, measured as task- and domain-specific and domain-general, has been found to be strongly associated with parenting competence and behaviors (Jones & Prinz, 2005; Leerkes & Crockenberg, 2002; Sanders & Woolley, 2005; Teti & Gelfand, 1991). Overall, self-report and observational studies of ethnically and socioeconomically diverse mothers have found that higher levels of domain-specific
and domain-general PSE were associated with more competent parenting (Jones & Prinz, 2005). For instance, a study of White mothers of 3- to 13-month old infants found that domain-specific PSE was the strongest predictor of maternal competence, above depression, social support, and demographics (Teti & Gelfand, 1991).

Similarly, research with mostly White, first-time mothers from diverse socioeconomic backgrounds found a curvilinear relationship between domain-specific PSE and sensitive behavior toward highly distressed infants (Leerkes & Crockenberg, 2002). Mothers with moderately high PSE exhibited more sensitive behaviors, while those with low and those with extremely high PSE exhibited less sensitive behaviors. Together these findings indicate that women with higher PSE are especially likely to exhibit competent and sensitive parenting behaviors with their infants.

The relationship between PSE and maternal behavior appears to persist beyond infancy. For example, in a study of socioeconomically diverse Australian mothers of older children (2- to 8-year olds), PSE in the task of dealing with “difficult” child behavior predicted maternal discipline style even when controlling for the child’s behavior, the other parent, and sociodemographic risk factors, including socioeconomic status (Sanders & Woolley, 2005). Specifically, higher PSE predicted less reported laxness and less harsh discipline. Further, in a review of research with samples of socioeconomically diverse African American and White families, PSE (measured using domain-specific and domain-general scales) was

---

Past research on mothers’ PSE has been conducted with samples who were predominantly married or partnered to men; thus marital status/sexual orientation is not described for individual studies.
found to relate to children’s socio-emotional functioning (e.g., peer social skill) both directly and indirectly through PSE’s influence on parental functioning (Jones & Prinz, 2005). It is important to note that the authors suggested that cultural factors may influence the relationship between PSE and socio-emotional functioning (Jones & Prinz, 2005). Although further research is needed to adequately assess this possibility, a study of first-generation Mexican immigrant mothers and their oldest children (3-9 y.o.) found that domain-general PSE predicted parental warmth and control, which in turn predicted the children’s socio-emotional functioning (Izzo, Weiss, Shanahan, & Rodriguez-Brown, 2000). Thus, the salutary associations between PSE and parenting behavior and between PSE and children’s development have been found to persist throughout childhood.

Not only has PSE been found to be positively associated with children’s development, it has also been found to relate to mothers’ experiences of parenting. In a sample of middle-class women in an urban area of Boston, domain-specific PSE was found to positively correlate with aspects of the adaptation to parenthood (Reece & Harkless, 1998). Specifically, higher PSE was associated with better quality partner relationships, higher confidence in parenting, greater satisfaction with the infant and with parenting, and greater sense of well-being (Reece & Harkless, 1998). These strongly supported connections to aspects of the transition to parenthood and early parenting suggest that PSE plays an important role in women’s development as parents.
**Developmental Trajectory**

While maternal development purportedly begins in pregnancy (Smith, 1999), most past research on PSE has focused on the postpartum period. However, a few studies have assessed the development of PSE in pregnancy and from the prenatal to postpartum periods. For example, a study examining the prenatal development of PSE in predominantly well-educated, partnered, Dutch first-time-expecting women found that PSE increased a small but significant amount from the 1st to the 3rd trimesters (Wernand, Kunseler, Oosterman, Beekman, & Schuengel, 2014). While this study is the only to confine itself to PSE measured during pregnancy, several studies have explored the developmental trajectory from pregnancy to postpartum.

Several studies found that prenatal PSE, measured in the late 2nd or 3rd trimesters, increased across time and strongly predicted PSE between one- and three-months postpartum for predominantly well-educated, middle-class, first-time mothers (predominantly White living in the Midwestern U.S., and Dutch, respectively; Porter & Hsu, 2003; Verhage, Oosterman, & Schuengel, 2013). These findings align with the theorized role of personal experience in the development of PSE; the more successful experiences a mother has with her infant over time, the greater her PSE. The present study will further the literature on developmental trajectories of PSE by assessing it early in the 2nd trimester, in the 3rd trimester, and in the 2nd month postpartum.
**Known Predictors**

Past research on predictors of PSE largely has focused on three theorized sources of efficacy beliefs: one’s *emotional reactions*, which have been measured primarily through the proxy of depression, and *vicarious experience* and *verbal persuasion*, which have been measured primarily through the proxy of social support.

**Emotional reactions.** Research has consistently found a negative association between depression and PSE, but is divided on the direction of this effect. In support of depression predicting PSE, Porter and Hsu (2003) found that for a sample of first-time mothers in the Midwestern U.S., depression measured in the 3rd trimester was significantly negatively correlated with both concurrent PSE and PSE at 1-month postpartum, but not with PSE at 3-months postpartum. Though correlational, these findings suggest that depression influences the development of PSE. In contrast, two studies support PSE as a predictor of depression. Cutrona and colleagues (1986) surveyed a U.S. sample of both mothers having their first child (primips) and those having subsequent children (multips) in the 2nd or 3rd trimester of pregnancy and again at 3-months postpartum. Haslam and colleagues (2006) surveyed an Australian sample of primips in the 3rd trimester of pregnancy and at 4-weeks postpartum. Both studies found that depressive symptoms in pregnancy were not related to postpartum PSE and that postpartum PSE mediated the relationship between social support and postpartum depression (Cutrona & Troutman, 1986; Haslam et al., 2006). In other words, PSE was found to influence postpartum depression. Taken together, the
research on PSE and depression clearly indicates a negative relationship between the two and suggests the possibility that this relationship is bidirectional.

However, because different measures of depression have often been employed, it is difficult to compare findings across studies of depression and PSE. The research reported above employed the Edinburgh Postnatal Depression Scale (EDPS) and/or the Beck Depression Inventory (BDI; or a few items thereof). These two measures have been found to be only moderately correlated in postpartum samples (Boyd, Le, & Somberg, 2005). Further, use of the BDI with postpartum populations is questionable, due in part to its development for non-postpartum assessment. Specifically, the BDI’s assessment of somatic symptoms (e.g., regarding weight loss and fatigue) is inappropriate in a postpartum sample for whom these changes are typical (Boyd et al., 2005; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Ove Samuelsen, 2001). The present study will help to clarify how PSE and depression relate by using the EPDS, the measure of depressive symptoms most extensively researched with postpartum samples. The EPDS is reliable, validated, and specifically intended to assess postpartum depression (Boyd et al., 2005), and has been validated for identifying prenatal depression as well (Murray & Cox, 1990).

**Vicarious experience and verbal persuasion.** Vicarious experience and verbal persuasion typically occur in the context of a mother’s interpersonal relationships and have been most often operationalized as social support. Social support usually has been assessed as the perceived availability of some combination of emotional, informational, and tangible/instrumental support, and of positive social
interaction, affection, and the provision of comments related to self-evaluation (cf., Sherbourne & Stewart, 1991). While these facets can be measured with separate subscales, the subscales tend to be highly correlated and have often been combined into an overall measure of perceived social support (e.g., Campos et al., 2008; Gjesfjeld, Greeno, Kim, & Anderson, 2010; Leahy-Warren et al., 2012).

Among predominantly well-educated, White mothers of infants, research examining various types of social support and PSE, using domain-specific and domain-general measures, supports a strong relationship between these variables (Cutrona & Troutman, 1986; Haslam, Pakenham, & Smith, 2006; Leahy-Warren et al., 2012; Leerkes & Crockenberg, 2002; Reece & Harkless, 1998; Shorey, Chan, Chong, & He, 2015). For example, for White, predominantly well-educated, first-time mothers in Ireland, social support from family and friends (measured using a self-designed scale that included assessment of informational, emotional, and instrumental forms of support) was found to be significantly and positively correlated with domain-specific PSE scores at 6-weeks postpartum (Leahy-Warren et al., 2012), as was partner support (self-designed measure) at 5-months postpartum for mostly White mothers of diverse socioeconomic backgrounds (Leerkes & Crockenberg, 2002). Further, overall social support measured in the 2nd or 3rd trimester was found to predict PSE at 3-months postpartum in a combined sample of mothers having their first or subsequent child (Cutrona & Troutman, 1986). This suggests that not only are social support and PSE concurrently related, but that social support influences the development of PSE.
Several issues are of note in research on PSE and social support. First, the prevalent use of self-designed measures of social support makes it difficult to compare findings from multiple studies. Second, whether measures of social support actually assess the vicarious experiences and verbal persuasion related to parenting that a mother experiences is questionable (cf. Kerrick, 2016). Third, social support scales do not necessarily identify sources of social support, which would be useful in understanding from whom mothers receive verbal persuasion and vicarious experience. The present study used a common, validated, and reliable measure of overall social support (Sherbourne & Stewart, 1991) in the early 2nd trimester, in the 3rd trimester, and in the 2nd month postpartum. Further, the present study explored new mothers’ descriptions of what types of social support they received and from whom, and examined interactions with the prenatal care provider as a possible source of verbal persuasion and vicarious experiences.

The vicarious experience of watching another parent and of being cared for herself may impact the PSE of an expectant mother prior to her own child’s birth. Indeed, as part of their maternal development, expectant mothers have been found to seek out and watch parents and other pregnant women, in order to observe how these role models “do” pregnancy and parenting (Nelson, 2003; Rubin, 1967). Though research has not examined how such observations might impact the development of PSE, research does exist on expectant mothers’ PSE and another type of vicarious experience—memories of her own experiences of being cared for. In a study of mostly White, socioeconomically diverse, first-time mothers, those with higher
reported levels of warmth and acceptance from their own mothers in childhood had higher global self-esteem, which predicted higher PSE (Leerkes & Crockenberg, 2002).

I posit that as a more recent care-receiving experience than remembered maternal care, and one that could serve as a point of intervention to support the development of PSE, interactions with the prenatal care provider may function as a vicarious experience, in that the provider is caring for the mother, with implications for an expectant mother’s PSE. Additionally, providers may support or constrain prenatal efficacy beliefs through verbal persuasion. For example in postpartum research, many mothers reported feeling that providers were “monitoring their incompetence” (Nelson, 2003, p. 473) and that they felt unable to ask questions due to feeling inhibited by the competence of the providers (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997). Affirmation (or disaffirmation) of the mother’s capabilities in pregnancy may thereby contribute to her PSE (Leahy-Warren & McCarthy, 2011). However, little emphasis has been placed on prenatal predictors of PSE in the literature (for exceptions see Leerkes & Crockenberg, 2002; Wernand et al., 2014) and notably, there exists no research on quality of interactions with the prenatal care provider as a predictor of mothers’ PSE. The present study seeks to address these gaps in the literature by assessing prenatal social support, depression, self-esteem, locus of control, and quality of the prenatal provider interactions as possible predictors of PSE.
Aspects of *prenatal provider interactions* include communication (e.g., how frequently the provider makes the mother feel empowered to care for herself and her pregnancy, or explains care processes), interpersonal style (e.g., friendliness/courteousness, respectfulness/emotional support) and shared decision making (Wong, Korenbrot, & Stewart, 2004). In particular, the frequency with which a provider constructs a mother as capable in caring for herself and her pregnancy may be related to a mother’s own beliefs in her ability to care for her baby after the birth.

**The Lived Experience of Developing PSE**

While much work has focused on the quantitative measurement of PSE—on understanding its development, antecedents, and consequences—there is scant qualitative research on how women actually experience the development of efficacy beliefs and on how they themselves understand this development. One exception is a qualitative focus group study on the challenges of parenting conducted with mothers of children under age 6, health visitors, and family support workers in the UK (Bloomfield et al., 2005). Among the findings were that the mothers felt that understanding the child’s needs and responding appropriately could be challenging, but that it was important to effective parenting. Further, some mothers identified a “willingness to change,” or to try out different strategies when one tactic was not working, as a necessary element of effective parenting. While this past research sheds some light on mothers’ understandings of efficacy beliefs, it was quite broad—involving not just the accounts of mothers of children under age 6, but also of health and family professionals. Further, Bloomfield and colleagues’ (2005) focus group
approach, while enabling participants to talk with each other, did not allow space for individual participants to share long, detailed accounts. Presently, the literature lacks an in-depth look at how new mothers describe the experience of developing efficacy beliefs from pregnancy through the early postpartum period. In examining such accounts, the present study sought to fill this gap and to provide a more nuanced and personal explanation of the development of PSE than is possible through survey measures or focus groups.

**The Present Study**

Given gaps in the literature on the prenatal development of PSE, including the paucity of research on PSE in early pregnancy and prenatal predictors of PSE, the quantitative portion of this study had two aims: 1) to examine the developmental trajectory of PSE from the 2nd trimester to early postpartum and explore the correlates of 2nd trimester PSE for first-time mothers, and 2) to examine whether the quality of prenatal care provider interactions predicted first-time mothers’ PSE in the 3rd trimester and the 2nd month postpartum, when controlling for depression and social support. To do this I surveyed PSE, social support, and depression in the 2nd and 3rd trimesters and around 6-weeks postpartum, and assessed the quality of prenatal provider interactions in the 3rd trimester.

Based on past findings, I formulated the following hypotheses to be tested with the survey data:

**H1:** PSE would increase from the 2nd to 3rd trimesters and from the 3rd trimester to postpartum.
H2: 2\textsuperscript{nd} trimester PSE would be positively correlated with concurrent social support and negatively with depression, as well as positively with 3\textsuperscript{rd} trimester and postpartum PSE and social support.

H3: Aspects of prenatal provider interactions, assessed in the 3\textsuperscript{rd} trimester, would predict both concurrent and postpartum PSE, when controlling for social support and depression.

In addition to the survey data, a subsample of participants was interviewed around 12-weeks postpartum about their experiences in pregnancy, prenatal care, birth, and early parenting. This qualitative portion of the study aimed to clarify how, in the mother’s own words, social support can facilitate the development of PSE. Using Interpretive Phenomenological Analysis (Smith, 1996; Smith & Osborn, 2003), I conducted two in-depth case studies of mothers with complete data (i.e., three surveys and an interview) to inductively explore these mothers’ experiences of social support and developing PSE.

**Method**

**Participants**

Women pregnant with their first baby were recruited to participate in a 3-wave survey and 1-time interview study via Facebook, word-of-mouth, flyers/postcards, mailings to Central California Alliance for Health members of childbearing age, and in-person recruitment at local events/classes targeting pregnant women ($N = 82$). At the time of recruitment, participants had to speak/read English or Spanish, be at least 18-years-old, be pregnant, be receiving or plan to receive routine prenatal care, and
not have any children (participants could have had previous pregnancies that ended in abortion or miscarriage, and/or be a step-parent). Mothers ranged from 19 to 41 years of age ($M = 30.79; SD = 4.29$).

Of the 82 participants, 20 were enrolled in the 2$^{nd}$ trimester (T1), all of whom completed surveys at all three time points, and 62 were enrolled in the 3$^{rd}$ trimester (T2), 59 of whom completed the postpartum (T3) survey. Of the three participants who did not submit a T3 survey, one withdrew from the study after her newborn passed away, and two participants did not respond to requests to complete the survey. A fourth participant only completed part of the T3 survey due to technical difficulties. Thus, 20 participants completed all three surveys, and 58 participants fully completed the last two surveys.

Most participants identified as European American (86.6%), with few identifying as Latina (8.5%), American Indian (3.7%), Asian (3.7%), African American (1.2%), or other (2.4%; totals exceed 100% because participants could select all ethnicities that applied). The sample was predominantly employed when enrolled (81.7%) and well educated, with many participants having some college or a Bachelor’s degree (45.12%) and most having education beyond a Bachelor’s (52.4%). All participants were either married/co-habitating (98.78%) or dating but not living with the partner. All participants who responded to a question about partner gender ($n = 80$) reported that their partner was male. One participant reported having two partners. One participant was pregnant with twins.
A subsample of 47 English-speaking participants was asked to participate in individual, semi-structured interviews about their experiences in pregnancy, prenatal care, labor and birth, and early parenting. While initially all participants were asked to participate, once a large enough survey sample was obtained to determine the T2 mean for PSE, mothers who scored one standard deviation above or below this mean were asked to participate. Eleven of the mothers invited to participate in an interview declined, with most explaining that they did not have time. Of the 36 mothers who were interviewed, 8 had complete data (i.e., three surveys and an interview). From these 8 participants, 2 were selected to be analyzed as in-depth case studies using Interpretive Phenomenological Analysis. A description of this analysis and a detailed description of each participant introduce the qualitative findings below.

**Procedure**

**Surveys.** Participants took surveys at two or three time points, depending on gestational age at enrollment. Surveys could be completed by mail or online, per participant preference. Only one participant elected to take the surveys in Spanish. The T1 Survey had 80 items and was taken at 12 to 16 weeks of pregnancy or before the fourth prenatal visit ($M = 15.45$, $SD = 2.56$, range = 12-22). The T2 Survey had 115 to 143 items (depending on whether the participant took the T1 Survey) and was taken between 32 and 40 weeks of pregnancy ($M = 34.43$, $SD = 2.27$). The T3 Survey had 128 to 152 items (depending on ethnicity; women who identified as Latina/Hispanic took an acculturation scale) and was taken between 4 and 17 weeks postpartum ($M = 6.28$, $SD = 2.39$).
The surveys consisted of items from existing, validated measures and those supported by an extensive literature review. Measures were presented serially, rather than intermixing items across measures, and in a fixed order. Domains surveyed included demographics (including obstetric history), parental self-efficacy, social support, depression, locus of control, self-esteem, and childbirth experience. The surveys took 15-30 minutes to complete. When they reached the appropriate gestational age, participants electing the online surveys were emailed with instructions for completing the survey. Participants could stop the online surveys and resume taking them later. Mail surveys were sent with instructions and a stamped, pre-addressed return envelope. In order to send the postpartum survey at the correct time, with their permission, I followed up with each participant two weeks after her estimated due date to determine her baby’s date of birth. Participants were reminded up to two times to complete each survey.

Interviews. The two participants selected for the qualitative analysis, Shannon and Carol, were interviewed at 11 and 9 weeks postpartum, respectively. These participants were selected based on the developmental trajectory of their PSE—one was low on PSE in pregnancy, relative to the rest of the sample, while the other was high, and both were at least average by the time of the interview. This enabled an exploration of both similarities and differences across the two cases.

Participants chose the location/method of the interview, between their home

---

3 While additional domains were surveyed, they are beyond the scope of the present study. For a full list of domains/measures, please see Appendix A.
4 All case names are pseudonyms.
or a local family education center for those living locally, and between phone or Skype for those living outside the region. Both Shannon and Carol elected to be interviewed in their homes. Shannon’s interview was 49 minutes long and Carol’s was 78 minutes long. With consent, both interviews were audio-recorded using a digital recording device.

The interviews were semi-structured (see Appendix B for the interview protocol) and were designed to elicit the mother’s story of her experience in pregnancy, prenatal care, labor and birth, and early parenthood. Not all questions were asked of all mothers, and when asked, the questions did not always occur in the same order. Audio-recordings of the interviews were transcribed by trained undergraduate research assistants (URAs) in Transana (a computer program facilitating the transcription of audio or video data; Woods & Fassnacht, 2007). Each interview was subsequently checked by a different research assistant for accuracy. All names were replaced with pseudonyms and other proper nouns were replaced with common nouns.

Measures

Descriptions of the survey measures used in the present study follow. When an existing Spanish-language version was available, it was reviewed by two to four native Spanish-speaking, bicultural URAs for comprehensibility; each existing measure was changed to the female gender and all other changes made to existing versions are noted below. When an existing translation was unavailable, translation of the survey measure was conducted through a process of translation and back-
translation by two native Spanish-speaking URAs. This was followed by a review for comprehensibility by two native speaking Graduate students and two additional native speaking, bicultural URAs.

**Demographics.** Along with taking the surveys, participants responded to a range of demographic questions including age, ethnicity, education level, employment status, relationship status, and partner gender. In addition, they were asked questions regarding their obstetric history, place of birth, location of schooling, and time in the United States (if born outside the U.S.). See Appendix C for a full list of demographic questions.

**Parental self-efficacy.** The Self-Efficacy in the Nurturing Role (SENR) questionnaire was developed by Pedersen, Bryan, Huffman, and Del Carmen (1989), based in part on an earlier measure developed by Gibaud-Wallston and Wandersman (1978). As no Spanish-language version of this scale could be located, we translated this measure. This 16-item scale measures mothers’ perceptions of their competence in basic infant care skills (see Appendix D; e.g., “I feel confident in my role as a parent,” “I can soothe my baby easily when he or she is crying or fussing,” “Touching, holding, and being affectionate with my baby is comfortable and pleasurable for me”). Participants responded to these items on 7-point Likert scales (1 = not at all representative of me to 7 = strongly representative of me). Item scores for the measure were summed for a total parental self-efficacy score that could range from 16 to 112, with higher scores representing greater efficacy. Internal reliability
for the scale was excellent with our sample ($\alpha = .87$ at T1, $\alpha = .80$ at T2, $\alpha = .82$ at T3).

The prenatal version of the Self-Efficacy in the Nurturing Role questionnaire was used for the T1 and T2 surveys, while the postpartum version was used for the T3 survey. These scales are identical, except that items are worded in future tense for the prenatal version (e.g., “I look forward to becoming a parent with confidence in my role as a parent,” “I expect to be able to soothe my baby easily when he or she is crying or fussing,” “Touching, holding, and being affectionate with my baby will be comfortable and pleasurable for me.”).

**Social support.** The Medical Outcomes Study Social Support Survey measured women’s perceived social support (see Appendix E; Spanish version; Seacord, 1998; English version; Sherbourne & Stewart, 1991). This 19-item scale measures the frequency of availability ($1 = \text{none of the time}$ to $5 = \text{all of the time}$) of four dimensions of support: *emotional/informational* support (8 items, e.g., “Someone you can count on to listen to you when you need to talk,” “Someone to give you information to help you understand a situation”), *tangible* support (4 items, e.g., “Someone to help you if you were confined to bed,” “Someone to take you to the doctor if you needed it”), *positive social interaction* (4 items, e.g., “Someone to have a good time with”), and *affection* (3 items, e.g., “Someone who hugs you”).

For the present study, the overall measure of social support was used. This overall measure is calculated by averaging scores and transforming them to a 0 to 100

---

5 In item 2 of the Spanish version, we changed ‘encamada’ (bedridden) to ‘restringida a la cama’ (restricted to bed) for comprehensibility.
scale, with higher scores representing greater perceived access to support. The overall measure had excellent internal reliability with the present sample ($\alpha = .97$ at T1, $\alpha = .96$ at T2, $\alpha = .97$ at T3).

**Depression.** The Edinburgh Postnatal Depression Scale was included in the surveys at all three time periods, since this scale has been validated for identifying major depression in prenatal samples as well (Murray & Cox, 1990; see Appendix F; Mexican version; Alvarado-Esquivel, Sifuentes-Alvarez, Salas-Martinez, & Martínez-García, 2006; English version; Cox, Holden, & Sagovsky, 1987). This 10-item self-report scale was designed specifically to assess depression in postpartum populations by asking mothers to respond to statements about their feelings in the past week (e.g. “I have been able to laugh and see the funny side of things” - reverse scored, “I have been anxious or worried for no good reason”). Non-postpartum depression scales may result in false-positive results due to questions about sleep and appetite (disruption of which is normal in prenatal and postpartum populations; Eberhard-Gran et al., 2001). However, the EPDS has been found to have concurrent validity with other depression scales; for example, correlations between the EPDS and BDI have been found to range from .59-.78 (Boyd et al., 2005). Items are rated on 4-point scales (0 to 3) with possible scores ranging from 0-30. Major postpartum depression is indicated by a score of 12/13 or above in the English version (Cox, Chapman, Murray, & Jones, 1996; Cox et al., 1987) and a score of 11/12 or above at 0-4 weeks postpartum and 7/8 or above at 4-13 weeks postpartum in the Mexican version (Alvarado-Esquivel et al., 2006). The English version has been found to have
acceptable sensitivity and specificity when compared to the Research Diagnostic Criteria for depression (Cox et al., 1996), as did the Mexican version when compared to the DSM-IV criteria (Alvarado-Esquivel et al., 2006). The measure had excellent internal reliability with our sample (α = .92 at T1, α = .83 at T2 and T3).

Given that the English version of the scale was originally created in the United Kingdom, pre-testing with American English speakers was conducted. Based on this pre-testing, two items were slightly altered in the English version. For item 5, “I have felt scared or panicky for no very good reason”, “very” was removed. Item 6 was altered for comprehensibility to read “Thing have been piling up on me,” since the original statement, “Things have been getting on top of me,” was not well understood by American pre-testers. Based on review by native Spanish speakers, one item was slightly altered in the Mexican version; for item 8, “Me he sentido triste y desgraciada,” “desgraciada” was replaced with “miserable” to avoid the negative/insulting connotation of the original word (c.f. Wojcicki & Geissler, 2013).

**Prenatal care.** Participants were asked several questions about their prenatal care (see Appendix G). They were asked how many routine prenatal checkups they had had so far, what type of prenatal provider they saw most often for their routine prenatal visits, and for what percentage of their visits they had seen this provider. In addition, they were asked how many providers they had seen, how long their visits typically lasted and where they occurred, and whether they had officially changed providers.
**Quality of prenatal provider interactions.** The Prenatal Interpersonal Processes of Care scale assesses the quality of three dimensions of the prenatal provider relationship: communication, decision making, and interpersonal style (Wong, Korenbrot, & Stewart, 2004). As the existing Spanish version of the scale was not available from the study authors, this measure was translated. This measure has seven scales that use a 4-point Likert scale (1 = *none of the time* to 4 = *all of the time*) to assess the frequency of certain care processes. Six of the original 7 subscales were used (see Appendix H). References to prenatal care providers were altered to a single provider, in order to focus questions on the primary prenatal provider, and verbs were changed to the present tense to reflect the ongoing nature of the care being received.

All three communication scales were used: *empowerment* measures the frequency with which the provider supports a woman’s ability to care for her body and pregnancy (4 items, e.g., “How often does your provider make you feel that your everyday activities such as diet and lifestyle will make a difference in your pregnancy?”); *elicitation/responsiveness* of patient’s problems assesses how often the provider asks about and addresses a woman’s concerns or problems (4 items, e.g., “How often does your provider take your concerns seriously?”); *explanation* of care measures how frequently the provider explains what and/or why he or she is doing particular exams and tests (2 items, e.g. “How often does your provider tell you what they are doing as they give you a physical examination?”).
The patient-centered decision making scale is used to assess how frequently the provider engages the woman in discussing the provider’s advice (4 items, e.g. “How often does your provider ask if you feel comfortable following advice that they give you?”).

Two of the three subscales for interpersonal style were used: respect measured respectfulness and emotional support (6 items, e.g. “How often does your provider help you feel less worried about your pregnancy?”) and friendliness measured affability and courteousness (3 items, e.g. “How often does your provider make you feel as if you aren’t welcome?” – reverse scored).

The mean subscale scores were each converted to a range of 0 to 100, with higher scores indicating better care processes (Wong et al., 2004). Internal reliability for most of the subscale ranged from acceptable to excellent (α = .66 - .92). The exception to this was the friendliness subscale, α = .58, which was thus omitted from analyses.

Childbirth experience. The childbirth experience questionnaire (CEQ) is a 22-item scale designed to measure four aspects of satisfaction with the childbirth experience (see Appendix I; Dencker, Taft, Bergqvist, Lilja, & Berg, 2010). The mother’s perception of her own capacity is assessed with eight items (e.g. “I felt strong during labor and birth”, “I was tired during labor and birth”– reverse scored). Perception of professional support was measured with five items (e.g. “My

---

6 The perceived discrimination subscale within the interpersonal style dimension was omitted because most of the questions asked about discrimination due to MediCal insurance, which was not appropriate for most of the study sample.
provider(s) devoted enough time to me”, “My provider(s) kept me informed about what was happening during labor and birth”). The original items in this scale referred to “my midwife”, which for the present study was replaced with “my provider(s)” in order to apply to women who birthed with non-midwife care providers. “Provider(s)” was defined in the instruction set for this measure as “any doctors, midwives, or nurse-midwives who attended you during labor and birth.” Perceived safety was assessed with six items (e.g. “I felt scared during labor and birth” – reverse scored, “I have many positive memories from childbirth”). For use with an American sample, in the English-language version ‘labour’ was changed to ‘labor’. Women’s feelings about their own participation in labor and birth were assessed with three items (e.g. “I felt I could have a say whether I could be up and about or lie down”, “I felt I could have a say in deciding my birthing position”).

All but three items in the CEQ asked women to respond to statements about their experience on 4-point likert scales (1 = totally disagree to 4 = totally agree). Three items asking about labor pain, sense of security, and control (items 20-22) were assessed with visual analogue scales (VAS). The scores from the VAS-scales were transformed to categorical values (0-40 = 1, 41-60 = 2, 61-80 = 3, 81-100 = 4). Scale scores were calculated by taking the mean item score for each scale. Scale scores could range from 1 to 4, with higher ratings representing more positive experience. All CEQ scales had good to excellent internal reliability in the present sample (α = .72-.90).
**Locus of control.** The Personal Control and Interpersonal Control subscales of the Spheres of Control Scale-3 were used (see Appendix J; Paulhus & Van Selst, 1990). As no Spanish-language version was found, we translated these subscales. The subscales assess two components of perceived control using 7-point Likert scales (1 = *totally inaccurate* to 7 = *totally accurate*). The Personal Control subscale has 10 items, which measured participants’ perceived efficacy in nonsocial environments (e.g., “I can usually achieve what I want when I work hard for it,” “Almost anything is possible for me if I really want it”). The Interpersonal Control subscale has 10 items, which measured participants’ perceived efficacy in controlling other people in interpersonal interactions (e.g., “I have no trouble making and keeping friends,” “When I need assistance with something, I often find it difficult to get others to help” – reverse scored). Items for each subscale were intermixed in the survey and subscales were separately scored by totaling responses for the 10 items from each subscale. Scores could range from 10-70, with higher scores reflecting greater perceived control. While the Personal Control subscale had good internal reliability in this sample (α = .81 at T2, α = .83 at T3), the Interpersonal Control subscale had poor internal reliability (α = .59 at T2, α = .60 at T3). Thus Interpersonal Control was omitted from further analyses.

**Self-esteem.** The Rosenberg Self-esteem scale was used to measure global self-esteem (see Appendix K; Spanish version; Martin-Albo, Núñez, Navarro, & Grijalvo, 2007; English version; Rosenberg, 1965). This 10-item scale measures responses on a 4-point Likert (1 = *strongly disagree* to 4 = *strongly agree*) to
questions assessing how the participant felt about herself (e.g., “I feel that I’m a person of worth at least on an equal basis with others,” “I take a positive attitude toward myself”). Scores were calculated by totaling the responses. Scores could range from 10-40, with higher scores reflecting greater self-esteem. Internal reliability for this sample was very good ($\alpha = .89$).

**Quantitative Analyses and Results**

**Characteristics of Obstetric History, Prenatal Care, and Birth**

Of the 82 participants, the majority (79%) were trying to conceive when they became pregnant and either wanted to be pregnant at the time that they conceived (61%) or earlier in life (24.4%), with very few using artificial reproductive technologies to conceive (7.3% of $n = 80$). Few participants wanted to be pregnant later in life (12.2%) or never (2.4%). Most participants (72%) were pregnant for the first time, though 22% had experienced one or more miscarriages and 14.6% had experienced one or more abortions.

Most participants (47.6%) had been to 8-12 prenatal visits at T2, while 26.8% had been to 4-7 and 25.6% had been to more than 12. Participants’ primary prenatal providers were most commonly obstetricians (OBs; 39%), certified nurse midwives (CNMs; 32.9%), or certified professional midwives/licensed midwives (CPMs/LMs; 20.7%), and were most commonly female (85.4%). Nearly half of participants (40.2%) had officially switched providers, with 32.9% of the total sample choosing to make the switch. Almost all participants had seen their primary provider for at least half of their routine prenatal visits (92.7%), with many (42.7%) having seen them for
all of their visits. However, time spent with the provider during routine prenatal visits varied, with nearly half of participants (45.1%) reporting 6-15 minutes spent with the provider as typical, and less than a quarter each reporting 16-30 minutes (24.4%), 31-60 minutes (13.4%), or more than 60 minutes (17.1%) spent with the provider as typical. When asked in pregnancy, most participants (76.8%) reported that they would prefer to have their primary prenatal care provider attend their birth. Almost all participants attended childbirth education, with a fairly even split between attendance at a hospital-based class (46.3%) and an out-of-hospital class (42.7%). Of those who responded to questions about common prenatal complications \( n = 78 \), it was most frequent for participants to not report any complications (57.7%), followed by one (25.6%) or two (14.1%) complications. Two participants reported experiencing more complications, with one reporting three and one reporting four. Of the 11 common prenatal complications asked about, the most frequently reported were vaginal bleeding \( n = 9 \), severe nausea, vomiting, or dehydration \( n = 7 \), gestational diabetes \( n = 7 \), and high blood pressure, hypertension, preeclampsia, or toxemia \( n = 6 \).

Participants who responded to questions about their birth experience \( n = 78 \) gave birth between 36 and 42 full weeks of pregnancy \( M = 39.6, SD = 1.36 \). Only half of participants (50%) had their primary prenatal care provider as their primary birth provider, and more than a quarter (26.8%) had a primary birth provider that they met for the first time during labor or birth. Participants were fairly evenly split between having an OB (35.4%), a CNM (32.9%), and a CPM/LM (23.2%) as their primary birth provider, with few having another type of provider (3.7%). More than a
third of mothers (39%) had a doula or trained labor support person with them during labor and birth. Labors ranged from 1.75 to 65 hours (n = 73, M = 17.34, SD = 13.29). Most participants (68.3%) gave birth vaginally, without assistance from vacuum or forceps, 14.6% had an assisted vaginal birth, and 12.2% gave birth by cesarean (evenly split between planned, non-elective cesareans and cesareans decided on in labor). Whereas most participants (82.05%) had planned hospital births, 12.82% had planned home births, 2.56% had planned out-of-hospital birth center births, and 2.56% transferred to the hospital from a planned home birth.

Of participants who responded to questions about medical problems and infant feeding (n = 73), more than a quarter of their babies (27.4%) and more than a third of the mothers (41.09%) experienced medical problems during or following the birth. On average, both babies’ medical problems and mothers’ medical problems were rated as slightly serious (M = 2.37, SD = 1.8, range = 1-7 and M = 4.05, SD = 1.9, range = 1-7, respectively; 1 = not serious to 7 = life threatening) and moderately stressful for the mother (M = 4.05, SD = 1.9, range = 1-7 and M = 3.57, SD = 1.68, range = 1-7, respectively; 1 = not at all stressful to 7 = extremely stressful). Nearly all mothers (93.15%) were mainly breastfeeding at T3, with few mainly formula feeding (4.1%) or breastfeeding and formula feeding equally (2.74%).

**Preliminary Analyses**

Participants who enrolled in the study at T1 and those who enrolled at T2 were compared on demographic and obstetric variables, as well as important study variables. There were no associations between time of enrollment and provider type,
desire to be pregnant, whether the participant was trying to conceive, use of artificial reproductive technologies, employment, education, whether the participant had experienced abortion, or whether they had experienced miscarriage. Those who enrolled at T1 had significantly lower mean T2 PSE than those who enrolled at T2 ($M = 84.20, SD = 13.29, N = 20$ and $M = 90.31, SD = 10.22, N = 61$, respectively); $t(79) = 2.15, p = .04$, 95% CI of the difference [.45, 11.77]. Those who enrolled at T1 also had significantly lower mean provider empowerment than those who enrolled at T2 ($M = 60.83, SD = 26.78, N = 20$ and $M = 76.34, SD = 23.72, N = 62$, respectively); $t(80) = 2.46, p = .02$, 95% CI of the difference [2.98, 28.04]. These groups did not significantly differ on social support, depression, or personal control at T2 or T3, on T3 PSE, or on other quality of prenatal provider interaction variables.

Table 1 presents descriptive statistics for reliable continuous variables. While a number of variables were skewed and/or kurtotic, they were retained for use in the hierarchical regressions as the residuals were normally distributed. To identify whether any demographic or obstetric variables should be included in regressions predicting T2 and T3 PSE, a series of ANOVAs was conducted. No significant differences were found in mean PSE at T2 or T3 based on education, employment, trying to conceive, desire to be pregnant, and whether or not participants had a prior miscarriage. Ethnic differences and differences between those who had and had not had an abortion were not tested due to the low representation of women of color (13%) and women who had had abortions (15%).
Table 1

*Descriptive Statistics for Reliable Continuous Variables*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>M (SD)</th>
<th>Range</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSE T1</strong></td>
<td>20</td>
<td>82.5 (14.20)</td>
<td>55-105</td>
<td>-.18</td>
<td>-77</td>
</tr>
<tr>
<td><strong>PSE T2</strong></td>
<td>81</td>
<td>88.80 (11.28)</td>
<td>61-111</td>
<td>-.16</td>
<td>-49</td>
</tr>
<tr>
<td><strong>PSE T3</strong></td>
<td>79</td>
<td>88.43 (11.73)</td>
<td>56-110</td>
<td>-.60</td>
<td>.16</td>
</tr>
<tr>
<td><strong>Social Support T1</strong></td>
<td>20</td>
<td>79.33 (16.88)</td>
<td>55-105</td>
<td>-.18</td>
<td>1.15</td>
</tr>
<tr>
<td><strong>Social Support T2</strong></td>
<td>82</td>
<td>81.55 (17.15)</td>
<td>61-111</td>
<td>-.16</td>
<td>.81</td>
</tr>
<tr>
<td><strong>Social Support T3</strong></td>
<td>78</td>
<td>78.95 (16.81)</td>
<td>56-110</td>
<td>-.60</td>
<td>-.36</td>
</tr>
<tr>
<td><strong>Depression T1</strong></td>
<td>20</td>
<td>7.45 (5.98)</td>
<td>1-22</td>
<td>.83</td>
<td>.18</td>
</tr>
<tr>
<td><strong>Depression T2</strong></td>
<td>82</td>
<td>6.39 (4.67)</td>
<td>0-22</td>
<td>.83</td>
<td>.51</td>
</tr>
<tr>
<td><strong>Depression T3</strong></td>
<td>79</td>
<td>6.43 (4.23)</td>
<td>0-18</td>
<td>.56</td>
<td>-.38</td>
</tr>
<tr>
<td><strong>Quality of Prenatal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Interactions T2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>82</td>
<td>72.56 (25.24)</td>
<td>0-100</td>
<td>-.84</td>
<td>.05</td>
</tr>
<tr>
<td>Elicitation</td>
<td>82</td>
<td>89.43 (14.23)</td>
<td>42-100</td>
<td>-1.32</td>
<td>1.06</td>
</tr>
<tr>
<td>Explanation</td>
<td>82</td>
<td>85.37 (18.41)</td>
<td>33-100</td>
<td>-1.49</td>
<td>1.82</td>
</tr>
<tr>
<td>Decision Making</td>
<td>82</td>
<td>56.10 (31.86)</td>
<td>0-100</td>
<td>-.02</td>
<td>-1.34</td>
</tr>
<tr>
<td>Respect</td>
<td>82</td>
<td>74.46 (23.28)</td>
<td>5.56-100</td>
<td>-.78</td>
<td>.05</td>
</tr>
<tr>
<td><strong>Childbirth Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Capacity</td>
<td>76</td>
<td>2.68 (.51)</td>
<td>1.5-3.75</td>
<td>-.25</td>
<td>-.17</td>
</tr>
<tr>
<td>Professional Support</td>
<td>77</td>
<td>3.51 (.54)</td>
<td>2-4</td>
<td>-.75</td>
<td>-.60</td>
</tr>
<tr>
<td>Perceived Safety</td>
<td>77</td>
<td>3.24 (.54)</td>
<td>1.5-4</td>
<td>-1.10</td>
<td>.86</td>
</tr>
<tr>
<td>Participation</td>
<td>77</td>
<td>3.35 (.78)</td>
<td>1-4</td>
<td>-1.34</td>
<td>1.20</td>
</tr>
<tr>
<td>Personal Control T2</td>
<td>82</td>
<td>52.16 (5.62)</td>
<td>29-63</td>
<td>-1.05</td>
<td>2.72</td>
</tr>
<tr>
<td>Personal Control T3</td>
<td>75</td>
<td>52.47 (5.79)</td>
<td>39-63</td>
<td>-.56</td>
<td>.05</td>
</tr>
<tr>
<td>Self-esteem T2</td>
<td>60</td>
<td>33.33 (5.06)</td>
<td>20-40</td>
<td>-.60</td>
<td>-.07</td>
</tr>
</tbody>
</table>

*Note.* T1 = 2nd trimester. T2 = 3rd trimester. T3 = postpartum. PSE = parental self-efficacy

To identify which prenatal characteristics should be included in a regression predicting T2 PSE, I tested for group differences in T2 PSE based on type of prenatal provider (comparing those with OBs, CNMs, CPMs/LMs, and other providers), length of prenatal visits, whether or not prenatal complications were reported, and
location of childbirth education (non-attenders were excluded due to low sample size). Of these, only the ANOVA comparing mothers based on type of prenatal provider was significant; \( F(3, 77) = 3.33, p = .02 \). Post-hoc comparisons revealed that mothers who had a CPM/LM as their primary prenatal care provider had significantly higher PSE at T2 than those who had an OB as their primary prenatal care provider (\( M = 95.41, SD = 11.31 \) and \( M = 85.34, SD = 10.59 \), respectively; \( p = .01, 95\% CI \) of the difference [1.54, 18.59]).

To try to understand what might make mothers who had a CPM/LM as their primary prenatal care provider different from those who had an OB, I compared the two groups on mean age, T2 personal control, and self-esteem. The difference in personal control trended toward significance, such that those with a CPM/LM trended toward having higher T2 personal control than those with an OB (\( n = 17, M = 53.65, SD = 7.91 \) and \( n = 32, M = 50.06, SD = 4.96 \), respectively; \( t(47) = 1.95, p = .057, 95\% CI \) of the difference [-.12, 7.29]). The groups did not significantly differ on age or self-esteem (\( t(47) = -1.34, p = .19, 95\% CI \) of the difference [-4.05, .82] and \( t(31) = 1.66, p = .11, 95\% CI \) of the difference [-.72, 6.98], respectively). Further, there were no significant associations between having a CPM/LM versus an OB and desire to be pregnant, whether the participant was trying to conceive, use of artificial reproductive technologies, employment, education, whether the participant had experienced abortion, or whether they had experienced miscarriage.

To identify whether prenatal and birth characteristics should be included in a regression predicting T3 PSE, I conducted an additional series of ANOVAs. T3 PSE
did not significantly differ based on type of prenatal provider, type of birth provider, whether a doula was present, mode or location of birth, or whether mother or baby had medical problems during or after birth.

**Hypothesis 1: Longitudinal Development of PSE**

To test the first hypothesis, that PSE would increase across time, I used the, albeit small, subsample of participants who completed surveys at all three time points (n = 20). Paired samples t-tests revealed that while PSE increased across time, the mean increases between T1 and T2 PSE, between T2 and T3 PSE, and between T1 and T3 PSE were not significant (see Table 2, M diff = 1.7, 95% CI [-2.03, 5.43], t(19) = .96, ns; M diff = .5, 95% CI [-4.40, 5.40], t(19) = .21, ns; M diff = 2.2, 95% CI [-3.39, 7.79], t(19) = .82, ns; respectively).

Table 2

<table>
<thead>
<tr>
<th>PSE T1</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSE T1</td>
<td>82.50</td>
<td>14.20</td>
</tr>
<tr>
<td>PSE T2</td>
<td>84.20</td>
<td>13.29</td>
</tr>
<tr>
<td>PSE T3</td>
<td>84.70</td>
<td>11.98</td>
</tr>
</tbody>
</table>


**Hypothesis 2: Social Support, Depression, and PSE**

To better understand PSE in the 2nd trimester and to test the second hypothesis—that T1 PSE would be correlated with concurrent social support and depression, and with T2 and T3 PSE and social support—bivariate correlations were conducted. T1 PSE was significantly positively correlated with both T2 and T3 PSE (r = .83, p < .001, and r = .6, p < .01, respectively). T1 PSE was also significantly
positively related to social support at all three time points ($r = .51, .46, \text{ and } .45$, respectively, $p \leq .05$), but was not related to depression at any time. Notably, T1 PSE was not related to the quality of interactions with the prenatal provider.

Given that a preliminary ANOVA indicated that T2 PSE was greater for mothers with CPMs/LMs than those with OBs as their primary prenatal care provider, I conducted a $t$-test for whether T1 PSE differed between these groups. Mothers with CPMs/LMs had higher T1 PSE ($n = 3, M = 97.33, SD = 12.42$) than mothers with OBs ($n = 9, M = 77.11, SD = 14.12$; $t(10) = 2.20, p = .05$, 2-tailed, 95% CI of the difference [-.27, 40.72])

**Hypothesis 3: Prenatal Provider Interactions and the Prediction of PSE**

**Third trimester PSE.** To test the third hypothesis, regarding the prediction of T2 PSE, a hierarchical regression was conducted using the full sample. Given that a preliminary ANOVA indicated that T2 PSE differed by provider type, this variable was dummy coded, with those having an OB as the contrast group, and entered in the first step of the regression. To identify which continuous variables should be entered into the regression, bivariate correlations were conducted (see Table 3). As expected, concurrent social support and depression were significantly correlated with T2 PSE, and thus were entered in the second step. Given that empowerment was the provider interaction variable most strongly correlated with T2 PSE, it was selected, along with T2 personal control, for entry in the third step of the model (see Table 4).

7 A regression was also tested in which self-esteem was entered along with empowerment and personal control. However, this resulted in a substantially lower sample size ($n = 58$) due to missing data, while the total model explained the same
Provider type independently explained 12% of the variance in T2 PSE, with mothers with CPMs/LMs having higher PSE than mothers with OBs. Social support and depression explained an additional 24% of the variance in T2 PSE. Together, empowerment and personal control explained an additional 9% of the variance in T2 PSE, with empowerment uniquely predicting 4% of the variance in T2 PSE. The addition of these two variables in Step 3 rendered provider type and social support no longer significant. In the final model, every 1 point decrease in depression was associated with a .61 point increase in T2 PSE; every 1 point increase in empowerment was associated with a .1 increase in T2 PSE, and every 1 point increase in T2 personal control was associated with a .43 increase in T2 PSE.

amount of variance in T2 PSE as the one reported here. These findings, combined with the moderately strong correlation between self-esteem and personal control, resulted in the decision to omit self-esteem.
Table 3

**Bivariate Correlations of Key Variables for Hypothesis 3**

<table>
<thead>
<tr>
<th>Variable</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
<th>10.</th>
<th>11.</th>
<th>12.</th>
<th>13.</th>
<th>14.</th>
<th>15.</th>
<th>16.</th>
<th>17.</th>
<th>18.</th>
<th>19.</th>
<th>20.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSE T2</td>
<td>r</td>
<td>n</td>
<td>.47&quot;</td>
<td>.78</td>
<td>.08</td>
<td>.24&quot;</td>
<td>n</td>
<td>81</td>
<td>79</td>
<td>78</td>
<td>75</td>
<td>74</td>
<td>76</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>2. PSE T3</td>
<td>r</td>
<td>n</td>
<td>.49**</td>
<td>.81</td>
<td>.09</td>
<td>.10</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.27</td>
<td>.29</td>
<td>.30</td>
<td>.31</td>
<td>.32</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
</tr>
<tr>
<td>3. Age</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>4. Hours of Work/Week</td>
<td>r</td>
<td>n</td>
<td>.49**</td>
<td>.81</td>
<td>.09</td>
<td>.10</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.27</td>
<td>.29</td>
<td>.30</td>
<td>.31</td>
<td>.32</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
</tr>
<tr>
<td>5. Social Support T2</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>6. Social Support T3</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>7. Depression T2</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>8. Depression T3</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>Quality of Prenatal Provider Interactions T2</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>9. Efficacy</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>10. Decision Making</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>11. Respect</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>12. Personal Control T2</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>13. Personal Control T3</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>14. Self-esteem T2</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>15. Childbirth Experience T3</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>17. Own Capacity</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>18. Professional Support</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>19. Perceived Safety</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
<tr>
<td>20. Participation</td>
<td>r</td>
<td>n</td>
<td>.44**</td>
<td>.46**</td>
<td>.76**</td>
<td>.09</td>
<td>.14</td>
<td>.20</td>
<td>.21</td>
<td>.22</td>
<td>.25</td>
<td>.28</td>
<td>.30</td>
<td>.33</td>
<td>.34</td>
<td>.35</td>
<td>.36</td>
<td>.37</td>
<td>.38</td>
<td>.39</td>
</tr>
</tbody>
</table>

*Note. T2 = 3rd trimester. T3 = postpartum. PSE = parental self-efficacy. **p ≤ 0.01 level. * p ≤ 0.05 level.*
Table 4

**Summary of Hierarchical Regression Analysis for Concurrent Prediction of T2 Parental Self-efficacy**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Step 1</th>
<th></th>
<th>Step 2</th>
<th></th>
<th>Step 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B [95% CI]</td>
<td>SE B</td>
<td>b</td>
<td>sr²</td>
<td>B [95% CI]</td>
<td>SE B</td>
</tr>
<tr>
<td>Provider Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certified Nurse Midwife (CNM)</td>
<td>3.96 [-1.72, 9.65]</td>
<td>2.86</td>
<td>.17</td>
<td>.02</td>
<td>-0.5 [-5.26, 5.16]</td>
<td>2.62</td>
</tr>
<tr>
<td>Certified Professional Midwife (CPM)</td>
<td>10.07** [3.60, 16.53]</td>
<td>3.25</td>
<td>.37</td>
<td>.11</td>
<td>6.09 [0.32, 11.87]</td>
<td>2.90</td>
</tr>
<tr>
<td>Other</td>
<td>.99 [-8.59, 10.57]</td>
<td>4.81</td>
<td>.02</td>
<td>&lt;.00</td>
<td>-6.34 [-15.04, 2.36]</td>
<td>4.37</td>
</tr>
<tr>
<td>Social Support T2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.23** [.09, .38]</td>
<td>.07</td>
<td>.35</td>
<td>.09</td>
<td>.12 [-.03, .27]</td>
<td>.08</td>
</tr>
<tr>
<td>Depression T2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-.64 [-1.17, -.10]</td>
<td>.27</td>
<td>-.27</td>
<td>.05</td>
<td>-.61 [-1.12, -.11]</td>
<td>.25</td>
</tr>
<tr>
<td>Empowerment T2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.10 [.01, .19]</td>
<td>.04</td>
<td>.22</td>
<td>.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Control T2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.43 [.03, .83]</td>
<td>.20</td>
<td>.21</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.12</td>
<td></td>
<td>.36</td>
<td></td>
<td>.45</td>
<td></td>
</tr>
<tr>
<td>F for change in R²</td>
<td>3.33</td>
<td></td>
<td>14.41</td>
<td></td>
<td>5.64</td>
<td></td>
</tr>
<tr>
<td>p value for F</td>
<td>.02</td>
<td></td>
<td>&lt;.001</td>
<td></td>
<td>.005</td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = 80. CI= Confidence interval. Reference group: Mothers with Obstetricians. T2 = 3rd trimester. **p ≤ 0.01. *p ≤ 0.05.*
Postpartum PSE. Based on the bivariate correlations and results from the regression predicting T2 PSE, I conducted a hierarchical regression predicting T3 PSE with T2 PSE and social support in Step 1, empowerment in Step 2, T3 social support, depression and personal control in Step 3, and childbirth experience variables (own capacity and perceived safety) in Step 4 (see Table 5). T2 Depression and T2 personal control were omitted from this model as they were not significantly correlated with T3 PSE, as was type of prenatal provider as there were no mean differences by group.

T2 PSE and T3 depression were the only significant predictors of T3 PSE. T2 PSE and social support explained 23% of the variance in T3 PSE, and T2 empowerment did not explain any additional variance. The addition of T3 social support, depression, and personal control explained an additional 21% of the variance in T3 PSE, with T2 PSE and T3 depression being the only significant predictors. The addition of childbirth experience variables in Step 4 did not significantly contribute to the amount of variance explained. In the final model, T2 PSE and T3 depression each uniquely explained 5% of the variance in T3 PSE. Every 1 point increase in T2 PSE was associated with a .34 point increase in T3 PSE, while every 1 point decrease in T3 depression was associated with a .78 point increase in T3 PSE.
Table 5

**Summary of Hierarchical Regression Analysis for Prediction of Postpartum Parental Self-efficacy (PSE)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Step 1</th>
<th></th>
<th></th>
<th></th>
<th>Step 2</th>
<th></th>
<th></th>
<th></th>
<th>Step 3</th>
<th></th>
<th></th>
<th></th>
<th>Step 4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B[95% CI]</td>
<td>SE</td>
<td>b</td>
<td>sr²</td>
<td>B[95% CI]</td>
<td>SE</td>
<td>b</td>
<td>sr²</td>
<td>B[95% CI]</td>
<td>SE</td>
<td>b</td>
<td>sr²</td>
<td>B[95% CI]</td>
<td>SE</td>
</tr>
<tr>
<td>PSE T2</td>
<td>.49** [.23, .74]</td>
<td>.13</td>
<td>.45</td>
<td>.16</td>
<td>.49** [.21, .76]</td>
<td>.14</td>
<td>.45</td>
<td>.14</td>
<td>.30† [.04, .57]</td>
<td>.13</td>
<td>.29</td>
<td>.04</td>
<td>.34† [.07, .61]</td>
<td>.14</td>
</tr>
<tr>
<td>Social Support T2</td>
<td>.03 [-.14, .21]</td>
<td>.09</td>
<td>.05</td>
<td>&lt;.00</td>
<td>.03 [-.15, .22]</td>
<td>.09</td>
<td>.05</td>
<td>&lt;.00</td>
<td>-.12 [-.34, .10]</td>
<td>.11</td>
<td>-.16</td>
<td>.01</td>
<td>-.13 [-.34, .09]</td>
<td>.11</td>
</tr>
<tr>
<td>Empowerment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.001 [-.12, .12]</td>
<td>.06</td>
<td>.002</td>
<td>&lt;.00</td>
<td>.02 [-.08, .13]</td>
<td>.05</td>
<td>.05</td>
<td>.001</td>
<td>.02 [-.09, .13]</td>
<td>.05</td>
</tr>
<tr>
<td>Social Support T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.20 [-.02, .42]</td>
<td>.11</td>
<td>.27</td>
<td>.03</td>
<td>.19 [-.03, .41]</td>
<td>.11</td>
<td>.26</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.96* [-1.56, -.36]</td>
<td>.30</td>
<td>-.34</td>
<td>.09</td>
<td>-.78† [-1.43, -.12]</td>
<td>.33</td>
<td>-.27</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Control T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.25 [-.23, .73]</td>
<td>.24</td>
<td>.12</td>
<td>.01</td>
<td>.13 [-.39, .64]</td>
<td>.26</td>
<td>.06</td>
<td>&lt;.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Capacity T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.26 [-2.94, 9.47]</td>
<td>3.11</td>
<td>.14</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Safety T3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.83 [-4.93, 6.59]</td>
<td>2.88</td>
<td>.04</td>
<td>&lt;.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td>.44</td>
<td></td>
<td></td>
<td></td>
<td>.46</td>
<td></td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>10.29</td>
<td></td>
<td></td>
<td></td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td>8.35</td>
<td></td>
<td></td>
<td></td>
<td>1.04</td>
<td></td>
</tr>
<tr>
<td>$p$ value for $F$</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td>.99</td>
<td></td>
<td></td>
<td></td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td>.36</td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = 71. CI= Confidence interval. T2 = 3rd trimester. T3 = postpartum. **p ≤ 0.001. *p < 0.01. †p < 0.05.*
Summary of Quantitative Findings

Findings from testing the first hypothesis—that PSE would increase across time—indicated that the mean increases in PSE between waves were not significant. Findings from testing the second hypothesis—that 2\textsuperscript{nd} trimester PSE would correlate with concurrent social support and depression, and with 3\textsuperscript{rd} trimester and postpartum PSE and social support—revealed that 2\textsuperscript{nd} trimester PSE correlated with social support and with PSE at all time points, but did not correlate with depression at any time point. Finally, findings from testing the third hypothesis—that aspects of the prenatal provider interaction would predict PSE in both the 3\textsuperscript{rd} trimester and postpartum—indicated that provider empowerment, personal control, and 3\textsuperscript{rd} trimester depression significantly predicted 3\textsuperscript{rd} trimester PSE. However, only 3\textsuperscript{rd} trimester PSE and postpartum depression significantly predicted postpartum PSE.

Qualitative Analyses and Results

Two cases were selected for an Interpretive Phenomenological Analysis (IPA; Smith, 1996; Smith & Osborn, 2003) of how the participants, Shannon and Carol, experienced and understood social support and the development of PSE. These cases were chosen based on the developmental trajectory of their PSE—Shannon’s was high throughout pregnancy and postpartum, relative to the sample, while Carol’s was low in pregnancy and average postpartum. This variation enabled an examination of similarities and differences across the two cases. In keeping with an IPA approach (Smith & Osborn, 2003), I began by repeatedly
reading Shannon’s transcript, making notes on her talk about social support and efficacy beliefs. I then reviewed the transcript and transformed my initial notes into concise themes. Next, I collected all of the themes and explored whether and how they related to one another, thus identifying superordinate themes. I repeated this process with Carol’s interview. I then looked across the two interviews to note similarities and differences, and to see where differences might be connected under superordinate themes. Below, I begin by presenting descriptive information about Shannon and Carol gained from their survey and interview data. This is followed by a presentation of and explication of the themes identified in the two interviews. The findings are organized by both topic (social support and PSE) and by superordinate themes, and are illustrated with excerpts from the interview transcripts.

**Shannon**

Shannon was 35 years old when she enrolled in the study. She identified as Latina and European American and had completed a Bachelor’s degree. At TI, she was employed 30 hours per week, but changed careers partway through her pregnancy to a job that enabled flexible self-scheduling. At the time of the interview Shannon was working part time, and childcare was being balanced between herself, her partner, her parents, and her aunt. Shannon’s PSE measured relatively stable and high throughout the study, coming in more than one standard deviation above the means for the present sample (see Table 6). In keeping with this, she scored high on social support throughout (see Table 6), though she did
experience a dip postpartum. She also scored very low on depression throughout (see Table 6).

Carol

Carol was 33 years old when she enrolled in the study. She identified as European American and had completed education beyond a Bachelor’s degree. At T1 she was employed 45 hours per week, and at the time of the interview she was preparing to return to work less than full time and to split that time between working from home and working outside the home. Carol’s PSE measured low in pregnancy, more than one standard deviation below the sample mean, and average postpartum (see Table 6). Given this, it was not surprising that Carol’s social support score was quite low in pregnancy. Her social support scores were more than two standard deviations below the sample mean at T1 and more than one standard deviation below the sample mean at T2, but came within one standard deviation of the mean by T3 (see Table 6). Carol’s depression scores were average in pregnancy and below average postpartum (see Table 6).
Table 6

Shannon and Carol’s Scores on Key Variables

<table>
<thead>
<tr>
<th></th>
<th>Shannon</th>
<th>Carol</th>
<th>Sample M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSE T1</td>
<td>97</td>
<td>61</td>
<td>82.5 (14.20)</td>
</tr>
<tr>
<td>PSE T2</td>
<td>105</td>
<td>61</td>
<td>88.80 (11.28)</td>
</tr>
<tr>
<td>PSE T3</td>
<td>102</td>
<td>81</td>
<td>88.43 (11.73)</td>
</tr>
<tr>
<td>Social Support T1</td>
<td>98.68</td>
<td>44.75</td>
<td>79.33 (16.88)</td>
</tr>
<tr>
<td>Social Support T2</td>
<td>98.68</td>
<td>50</td>
<td>81.55 (17.15)</td>
</tr>
<tr>
<td>Social Support T3</td>
<td>90.79</td>
<td>65.79</td>
<td>78.95 (16.81)</td>
</tr>
<tr>
<td>Depression T1</td>
<td>1</td>
<td>7</td>
<td>7.45 (5.98)</td>
</tr>
<tr>
<td>Depression T2</td>
<td>1</td>
<td>6</td>
<td>6.39 (4.67)</td>
</tr>
<tr>
<td>Depression T3</td>
<td>1</td>
<td>3</td>
<td>6.43 (4.23)</td>
</tr>
<tr>
<td>Personal Control T2</td>
<td>56</td>
<td>55</td>
<td>72.56 (25.24)</td>
</tr>
<tr>
<td>Personal Control T3</td>
<td>57</td>
<td>51</td>
<td>52.16 (5.62)</td>
</tr>
<tr>
<td>Empowerment T2</td>
<td>66.67</td>
<td>16.67</td>
<td>52.47 (5.79)</td>
</tr>
<tr>
<td>Self-esteem T2</td>
<td>-</td>
<td>29</td>
<td>33.33 (5.06)</td>
</tr>
</tbody>
</table>

Note. PSE = parental self-efficacy. T1 = 2nd trimester. T2 = 3rd trimester. T3 = postpartum. Shannon did not take the self-esteem scale at T2.

Social Support

In the interviews, the importance of having a community of friends and family to provide support arose as an especially salient theme. In regards to support from friends, the timing of transitioning to parenthood relative to one’s peers was noteworthy.

Timing relative to friends. Both Carol and Shannon remarked that they had a great many friends who were already parents at the time that they were expecting their babies and that their transition to parenthood brought them closer to these friends. At long last, they had joined the “cult” or “club.” Carol noted that “at this point probably at least (. ) like half my friends (. ) have had kids.” She went on to describe that her transition to parenthood gave her access to this group of friends in a new way (C= Carol; S= Shannon; I= Interviewer; see Appendix L for
a guide to the Jeffersonian transcription notations used; Atkinson & Heritage, 1984).

C: ... and yeah I mean all my friends were (1.2) the ones who have kids were [like=  
I: [yeah  
C: =super excited [it's like=  
I: [yeah  
C: =joining the cult you know they're like, “yes! we got another one hahahaha” ((deep breath)) ((laughs))

Shannon described a feeling of being drawn back into a group that she had not necessarily felt fully a part of since her friends began having children.

S: I think you know it was (. ) more like we-we're just sorta like the late joiners to the club [because=  
I: [((laughs))  
S: =all of our friends have already started having babies an-and um we were sort of late joiners to the marriage club too and um so we- we just kinda felt like we were catching up and all of our friends lives have already started shifting and we've s- like seen them you know start to be parents an- and that's been really fun and so (. ) now we're just kind of uh part of- part of that group again

This idea of the “cult” or “club” of motherhood ties in with Carol’s experience of finding it easy to make new friends and find community—something that had not seemed easy in the past. Having the shared experience of motherhood seemed to grease the wheels of community building.

C: =also I think (2.2) feeling the the community (. ) [part of things=  
I: [mmm
C: =and making (. ) new mom friends has been easier than I expected too [like it's kind of weird=
I: [interesting
C: =like dating
I: ((laugh))
C: you know like- making friends as you get older
I: yes
C: is really different than making friends when you were younger
I: that's very true ((laughs))
C: you know and like- (. ) almost all my friends were people I had met through work or [I've known=
I: [yeah
C: =since like elementary school [you know=
I: [yeah
C: =before and so meeting new people and then being like do you wanna hang out do you wanna have lunch like it kinda feels like- like you're dating but we're all in the exact same position [and so there's not like (. ) a judgey [or =
I: [mmmm] [yeah
C: =or cliquey feeling [and so that=
I: [mhm
C: =has been really nice at actually how kind of easy that has been
Not only did having friends who were already parents give Shannon and Carol a sense of community, but talking with these friends was a means of preparing for motherhood. Shannon and Carol described these interactions as
times when their friends gave advice and shared their experiences (i.e., informational support).

I: did you do anything to prepare to become a mother?

S: I think talking to friends [you know=

I: [yeah

S: =while pregnant and um was one of um the most informative you know [um things=

I: [mhm

S: =because um they have all [kind of just re- re- ....they have all just recently kind of gone through it [an- and=

I: [yeah

S: =um (.) and just advice on (0.5) um (2.0) just uh you know everything from you know different life changes to (.) what you need and what you don't need and

Interactions with friends were also described as opportunities for vicariously experiencing parenting and using the friends as role models.

C: I definitely checked in with my friends [that are parents=

I: [mmm mhm

C: =and I feel like not (.) systematically [not like=

I: [yeah

C: =sit down tell me about you know being a mom but- from (1.4) probably from the time that I was pregnant (.). through I made much more of an effort [to=

I: [mmm

C: =to watch their experience in parenthood more closely [like pay=
I: [mhm]

C: =more attention and talking to them about it more specifically

Similarly, Carol noted that her conversations with friends and with her partner were also occasions in which her friends and partner told her that she was going to be a successful parent (i.e., verbal persuasion).

C: ...and my husband is super supportive you know tells me all the time like- what a great (. ) mom I am [and=

I: [yeah]

C: =and it- and when I was pregnant like- (. ) would be and stuff like that so yeah

Overall, both mothers emphasized the important role community played in their experiences. They stressed that having friends and family to socialize with and to get social support from were pivotal to their experiences and acknowledged that not all mothers were so lucky.

I: has there been anything that we haven't (. ) kind of hit on that you feel like has been really (. ) important to your experience (0.9) from being pregnant through (. ) parenting Tommy?

S: um- (2.0) I think just (0.4) for me the um (1.5) one of the big takeaway is just like how important it is to have a family structure [and friend=

I: [mm]

S: =structure who are supportive (. ) and I just (. ) can't imagine (. ) (.hhh) um the people who do it alone I really have a lot of respect and and also just (. ) compassion for [you know=

I: [mmm]
S: =how hard (0.6) that is um because it's I mean (.) it's really hard to be (.) ya know (.) the caretaker of someone twenty four seven you know and [and an=]

I: [yeah]

S: =when (.hhh) you have um less support or y- you know financial necessities make- (0.8) you know it hard you have all these other life stresses (0.4) um I can see how easily it would be to affect your relationship with yur child

Family. In addition to support from friends, support from family was also a focus of both mothers’ interviews. They described how their families of origin were excited about the baby and present in their lives, signaling the provision of affective support, and how family (including partners) was essential in providing tangible support, such as childcare and meals, so that they could meet their own basic needs and take care of errands. Both Shannon and Carol remarked on the difficulty of caring for an infant alone (i.e., after their partners returned to work) and described how the involvement of extended family helped to ease this burden.

C: um- and it's great to have some help (.) you know have- (.) my mom comes over a couple times a week and (.) it can be challenging to not have a minute to yourself (.) [to like=

I: [mmm]

C: =take a shower

I: mhm

C: um (0.8) and you can leave them and stuff but I- you feel nervous (.) you know [like=

I: [yeah]

C: =the baby's out here alone and you're in the shower you couldn't hear kind of thing [so=
I: [yeah

C: =sometimes just having that time (.) alone to like take care of basic things and like (.) things are hard to do like going to the post office is harder

Further, both women stressed the role of tangible support in enabling them to get sleep.

S: =ye-an and the fact that Rich was here an- and (.) um (. ) what he had- has done for me um (. ) especially even more so when he was um (. ) here more often before going back to work full time (0.6) is um he- would take the baby (. ) um in very early in the morning when he woke up at like five or something like that [and= I: [mhm

S: =take him and go for a walk and so I could sleep a little bit longer [and=

I: [yes

S: =just the not having the baby in the house because i- if he's right next to you your ears are always like like little bats like you're attuned to it an- and so if your- not in the house he'll- you can actually get some sleep so [that's been really really good

I: [yeah

Not surprisingly, sleep was emphasized in both interviews. Both mothers described feeling grateful that their babies slept relatively well. This gratitude, as Shannon explicitly articulated, seemed to stem from the role of sleep in coping with challenging tasks.

S: ...after the hospital experience because I basically hadn't slept in like five or six days [like= I: [mmm

50
S: =you know I was- (0.4) mo- (.) really really exhausted an- and you
know and so I was (.) tired for- really tired for a number of weeks
but I was able to kinda (.) get back into it and as long as (.) you
know (those) sleeps okay you know you- you really feel like you
can kinda deal with anything you know

**PSE**

**Contributors to general PSE.** In addition to sleep being viewed as
supporting the ability to cope, or a general sense of efficacy, the mothers
identified several other contributors to general feelings of PSE. For both women,
relationships— with baby or with self— were viewed as facilitating a sense of
efficacy in their role as parents. Shannon described that her relationship with her
baby facilitated a sense of ease in taking on the tasks of parenthood, whatever
baby might throw at her.

S: I-I-I just think that we're just both like you know so in love with
him he could do whatever he wanted to do...

Whereas Shannon located her ability to cope with parenting challenges in her
relationship with her baby, Carol located a sense of ease in parenting within her
relationship with her self.

C: and um (1.5) yeah (.) I think (1.4) and feeling like kind of just hu-
like a human has been easier than I thought [I've talked to=

I: [mmm

C: =I had talked to a lot of moms who like didn't leave the house for
( .) [weeks=

I: [yeah

C: =you know after giving birth and like ( .) never you know took
showers and
I: yeah

C: just felt very (.) disconnected from like themselves as a person

I: yes

C: and I feel like I’ve done a pretty good job at like (1.2) maintaining a sense of self (.) in like-

I: mm

C: getting dressed leaving the house you know doing (0.8) communicating as a- as an adult like that [sort of stuff =

I: [yeah

C: =I think (.) um (.) has been (.) has made everything else easier

Carol had multiple, conflicting theories about what might have enabled her to maintain her sense of self. On the one hand, she felt that perhaps having an “easy and uncomplicated” experience of birth and early parenthood had permitted her to maintain her sense of self. On the other hand, she believed that she may have played a more active role in this maintenance of self. In the end, she described herself as “pretty good at like recognizing” her needs and “going (.) after” them, and said that in this case “[she] would imagine that (1) [maintaining a sense of self] just felt right to [her].”

The baby’s temperament was also identified as contributing to both mothers’ efficacy beliefs. Temperament came up in relation to sleep (as noted above, both felt their babies were relatively good sleepers), but also in regards to crying. Both Shannon and Carol remarked that their babies were not ones to cry
without cause and that this made them feel more efficacious in their parenting roles.

C: ...she doesn't (. ) she's not one of those ones that just cries for no reason

I: yeah yeah

C: so (((laughs)))

I: (((laughs)))

C: so (((laughs))) um- yet- you know

I: mhm

C: so um (. ) yeah I feel pretty confident in that- and I didn't necessarily expect that I thought I would [feel a lot more lost] as per like=

I: [mmm] [mhm]

C: =(. ) cause I never really spent time with kids or babies (. ) [much

I: [okay

C: before having one

I: yeah

Carol’s surprise in her own confidence may explain why her PSE was low in pregnancy, but rose to average postpartum. With the personal experience of parenting, she found that she felt confident in her role, despite her expectation that a lack of experience with babies would be a hindrance.  

---

8 Prior experience with infants was measured using a 5-point, self-designed scale. Though this variable was not used in the quantitative portion of the present study, it is interesting to note that Shannon scored half of a standard deviation below the
Capability in reading and responding to cues. It is likely that the mothers’ beliefs that their babies’ cries were not unwarranted were connected to their sense of efficacy in reading and responding to their babies cues. For both Shannon and Carol, this was an area in which they felt most efficacious and one which they identified as “not too complicated” and “not that (.) difficult.”

I: what areas of parenting do you feel most capable in?
(1.6)
S: (.hhh) ((tsk)) um (1.4) ((laughs)) (2.2) I think responding (0.8) to (1) what- what he needs [I think um=

I: [mm

S: =you know I think I’m (. ) pretty intuitive about (. ) you know what might be (. ) the problem an- and and um how I can (. ) go about (. ) you know fixing it so I mean I- I kinda (. ) can tell you know like (. ) which little (. ) cries you know mean (. ) what an and and um and what he needs and I mean (. ) i- it’s really not too complicated eh- like I said it’s only [one of those three things [((laughs))=

[((laughs))]

I: [((laughs))

S: =and so (. ) process of elimination most of the time (.hhh) um (. ) but (. ) but yeah I feel I think that

Shannon described intuition as contributing to her efficacy in the area of reading and responding to cues. In contrast, Carol identified having spent a lot of time with her baby as contributing to her ability to read and respond to her baby’s cues.

I: yeah so (. ) it sounds like you feel like you are able to kind of read (. ) what she needs in any given situation an-

sample mean (1.88, \( M = 2.65, SD = 1.5 \)), while Carol scored 1 ½ standard deviations below the sample mean (0.38).
Carol and Shannon’s differing views about what most contributed to their efficacy in reading and responding to cues could shed light on the differences in their PSE scores and in their developmental trajectories for PSE. For Shannon, intuition was the most important contributor and was something that she likely felt she had before her baby arrived. If intuition was not only an important contributor to her efficacy in this area of parenting, but to her efficacy in parenting generally, this may explain, in part, her high level of PSE throughout pregnancy and postpartum. In her mind, she already had the inner resources
necessary to be an efficacious parent. In contrast, for Carol, time spent with her baby was the most important contributor. Because this time could only occur after her baby was born, Carol’s sense that this was an important contributor could explain, in part, her low level of PSE in pregnancy as well as the rise in PSE she experienced from pregnancy to postpartum. It was not until Carol had spent time with her baby that she could feel efficacious as a parent.

In addition to intuition and time with baby as contributors to feeling efficacious in reading and responding to cues, both mothers’ efficacy in this area was supported by their sense that there is no single “right way” in parenting and by their ability to devote themselves to the task of caring for baby, without other demands on their time and attention. Carol’s belief that there was not a single right way in parenting came from talking with and observing friends with multiple children. She saw differences in the children’s temperaments and noted that this required and elicited different responses from the parents. Further, the realization that there is not a single right way bolstered Carol’s confidence in her ability to figure out for herself how to identify and meet her baby’s needs.

C: and so it was really interesting (.) talking to them about the difference between

I: mmm

C: their children

I: [mhmm

C: [like you know two kids from the same parents and that their kids are so different [in talking=
I:  [yeah

C:  =to them a lot about (.) how the kid's personality really shapes things

I:  mmm

C:  um (.) and I feel like what you think as like a pregnant person is like (1.3) this is how it's going to be and this is how I'll need to react to it [you know like=

I:  [mmm

C:  =my baby will sleep this much or- and what you- (.) it's hard to understand that like (.) they can be such individuals that there is no one (.) way and that's partly where a lot of the like books and the like "this is how you sleep train them" and "this is how you do this" (.) like aren't- just don't feel as relevant once you realize that like the kid- is (.) the kid kind of calls the shots in that way [like some=

I:  [yeah

C:  =kids- I have friends who like one kid is (.) a complete kind of angel and sleeps ten hours a night and the second kid- or the first kid y'know is a total (.) fussy pants and who never sleeps [and it's like=

I:  [yeah

C:  =the parents are the exact same parents

I:  right

C:  they're raised in the same house everything's the same and the kids are just totally different

I:  yeah

C:  that was really helpful I think [in- in=

I:  [mmm

57
C: kind of mitigating my expectations of like needing to find the right way
I: mmm
C: and then like oh- if I just read this book I'll- then I'll know what to do (.) and talking to them really helped me feel that (. ) um (1.5) you will learn from your kid what they need as [opposed to= I: [mmm
C: =learning from (.) a book or a movie or you know- an expert or something like that
I: yeah
C: you know and that (1.8) once you- have- get the basics down (.) like you know yes they need diapers and food [you know= I: [((laughs))
C: =feed them and change them and (1) like- you figure it out [they gave=
I: [yeah
C: =me a lot more confidence that like you'll just figure it out [and that=
I: [mmm
C: =was really helpful
I: mhm

For Shannon, her understanding of multiple ways of parenting came from her experience doing massage and learning about Chinese medicine. She described how this taught her that nothing is fixed and that trying something different will likely elicit a different response.
I: what helps you to feel capable in that?
(1.0)
S: um I think my work with um (. ) people [in general=  
I: [mm  
S: =an- and um (. ) and working um (. ) on the body (. ) and understanding [how=  
I: [mhm  
S: =the body works ... and just understanding you know um how energy works in the body and (. ) um (0.8) how- and (. ) you know I study Chinese medicine so oppositions [you=  
I: [mhm  
S: =know these (. ) you know um (1.1) when things start to shift an- an- an knowing that you know like crying necessarily bad it's just energy [you know=  
I: [mhm  
S: =and it's and it's energy manifesting in a certain way right now [you know  
I: [mhm  
S: ...I just know that it'll change and it'll most likely change and equal something different if we (. ) you know [try different=  
I: [mhm  
S: =different stimulus try you know or no stimulus or whatever it is [you know um=  
I: [yeah  
S: =but there's a way to counteract energy with usually it's opposite  

Both Carol and Shannon expressed gratitude for their ability to care for their babies without other demands on their time. They recognized that this was a
privilege—they had both the financial security and the social support necessary to focus their time and attention on baby. In turn, this ability to focus on baby supported their sense of capability in reading and responding to baby’s cues.

I: so you talked about um (.) feeling kind of able to read her cues and that breastfeeding has gone well- what areas of parenting would you say you felt most capable in?

C: most capable yeah um well certainly the (. ) the feeding part

I: yeah

C: is great (. ) the like (1.8) being (1) and right now not working [I feel like=

I: [mmm

C: =just being able to be responsive all the time

I: mhm

C: um (. ) goes pretty well like I don't- I don't feel like I'm ever like [“oh my god what is- like again?”] [you know= [((dramatically))]}

I: [mm mhm

C: =that (1.4) but I also have the luxury of not having a lot of other demands on my energy or my time right now

I: mhm

C: so I don't feel as like- I don't feel stretched (. ) thin

I: yeah

C: (like that)

I: yeah

C: um (. ) and I think she benefits from that [((laughs))]


Doubt about future parenting tasks. While Carol and Shannon both clearly felt efficacious in some areas, they both identified future tasks as the area in which they felt least capable. For each of them, their lack of past experience with the willfulness of toddlers and the need to set boundaries led them to feel that they might struggle in these parenting tasks.

I: what areas of parenting do you feel less capable in?
(1.3)
S: ((tsk)) um I think (0.6) that I've always wondered (.) ya know (.) what I would do in situations once they start becoming more willful (.) [you know

I: [mm

S: =an- and having that own little I'm my own little person with you know (.) and I want this and that and this and that [and=

I: [yeah

61
S: and so an- and that's of course when- where you see like in public and your like, “oh my god, I would never do that” or [“I would never do this”=

S: =you know it's easy to judge from the far away perspective

I: yeah

S: and and I think once we have the first grocery store meltdown we- we'll see we'll see where I ((laughs)) I'm able to (.) come in on that but I think um (.hhh) (0.5) uh you know (.) discipline and how to do [that and how ta (0.5) set boundaries [um=

I: [mhm] [mhm]

S: =an (0.8) you know just um (1.6) how to work with (.) you know (.) your little- your little being so that um (1.1) they're (0.3) happy an and content but also know (.) you know boundaries [and you=

I: [mhm]

S: =know you know so- yeah an- an- and you know just never done that before so I would (.) um imagine that that's gonna be (.) um (0.9) just more challenging

Notably, in talking about feeling less capable in future tasks, Carol reflected on her current experience. She described feeling she was doing well at parenting an infant despite her earlier concerns that her lack of experience would be a hindrance. Thus, the violation of her expectation that a lack of experience would keep her from succeeding had given her confidence in her future abilities.

C: and it's still hard for me like you still- I still sit here sometimes and I'm like holding this baby and I'm like, (.) “oh I'm like such a klutz”

I: ((laughs))

C: I'm like who- (1.3) like who gave me baby that's crazy ((laughs)) like how did- I'm like sixteen in my own head [you know=.
I: \[((laughs))\]

C: =it's like [you don't it's er- eh more like twenty two maybe=

I: [yeah

C: =[but I'm like, “oh my god” like- (1) “you sure?”]

I: [yeah ] \[((laughs))\]

C: “that was a smart (.) thing to- am I responsible enough?”
   [you know=

I: [yeah

C: =but (1.8) but at the same time I think like- (.I think we're great
   parents I think I'm a good mom and so

I: yeah

C: you know feels goo- and so that has given me more confidence about

I: mmm

C: dealing with like a toddler [and dealing with a teenager someday=

I: [mhm

C: =[so that is (1.8) feeling that- (1)=

I: [yeah

C: =I dunno feeling surprised by my ability to handle it now

I: mmm

C: pleasantly surprised

I: yeah

C: makes me hope that I will feel pleasantly surprised continually down the road
Discussion

This study examined the developmental trajectory of PSE from the 2nd trimester to early postpartum, with an unprecedented exploration of the relationship between PSE and the quality of prenatal care provider interactions. Further, the qualitative analysis explored two mothers’ lived experiences of developing PSE. Below, I review and discuss the main findings from both the quantitative and qualitative analyses.

Quantitative Findings

Scant research has examined PSE before the 3rd trimester. In exploring the developmental trajectory of PSE from the 2nd trimester through the early postpartum period, I found that while PSE increased from the 2nd trimester to the 3rd, and from the 3rd trimester to 6-weeks postpartum, as hypothesized, this increase was not significant. Given that the changes trended in the expected direction, the non-significant findings could be due to the inability to detect a small effect with the small sample who participated at all three time periods (n = 20). Suggestive of this, past studies found that significant increases in PSE across pregnancy were of small effect size (Wernand et al., 2014), while the increase in PSE from 32 weeks of pregnancy to 3 months postpartum was moderate (e.g., Verhage et al., 2013).

In examining 2nd trimester PSE and in partial support of the second hypothesis, I found that 2nd trimester PSE was significantly related to social support measured concurrently, in the 3rd trimester, and in early postpartum. This
is unsurprising given past research indicating a strong relationship between social
support and PSE later in pregnancy and in the postpartum period (Cutrona &
Troutman, 1986; Haslam et al., 2006; Leahy-Warren et al., 2012; Leerkes &
Crockenberg, 2002; Reece & Harkless, 1998; Shorey et al., 2015). It would have
been surprising had this relationship been unique to late pregnancy or the
postpartum period. However, similar to past quantitative research, what is not
elucidated by these quantitative results is whether and how social support
interactions serve as opportunities for vicarious experiences of parenting and
verbal persuasion. These mechanisms are discussed below in reviewing the
qualitative findings.

Past research has found PSE measured in the 3\textsuperscript{rd} trimester to be strongly
predictive of postpartum PSE (Porter & Hsu, 2003; Verhage, Oosterman, &
Schuengel, 2013). Thus, it follows that in the present study, 2\textsuperscript{nd} trimester PSE was
related to PSE measured later on. Mothers seemed to begin forming efficacy
beliefs early in pregnancy (or before), and these beliefs developed cumulatively
from there.

It is noteworthy that unlike PSE measured later, 2\textsuperscript{nd} trimester PSE was not
significantly related to depression measured at any time point. This is in contrast
to the second hypothesis and to Wernand and colleagues’ (2014) findings that
PSE was concurrently negatively related to depression at 12, 22, and 32 weeks of
pregnancy for a sample of predominantly Dutch first-time expectant mothers. One
possible explanation for this discrepancy between findings is that the present
study measured depression using the EPDS, while Wernand et al. used the BDI-II. Unlike the EPDS, the BDI-II is not designed for use with pregnant and postpartum samples and asks about changes that may be caused by pregnancy—such as changes in energy, fatigue, sleep, eating, irritability, concentration, and interest in sex. When the BDI-II is used with a pregnant sample, rather than measuring depression, it may instead be measuring experience of pregnancy, which would likely be related to prenatal PSE. If a mother feels she has not adjusted well to pregnancy, she may have doubts about her ability to adjust to and carry out the tasks of parenthood. Alternatively, it may be that the present study did not find a significant association between 2nd trimester PSE and depression due to the large standard deviation for 2nd trimester depression and the lack of power, as the effects sizes found by Wernand and colleagues (2014) were quite small.

When using the full sample I found that while depression concurrently negatively predicted PSE measured in the 3rd trimester and postpartum, 3rd trimester depression was not related to postpartum PSE. Past research has supported a negative association between depression and PSE (Cutrona & Troutman, 1986; Haslam et al., 2006; Porter & Hsu, 2003), but has been divided on whether PSE influences depression or vice versa. The present findings support the theory that PSE influences depression. This would mean that rather than depressive symptoms being an emotional reaction to parenting experiences, which influence the development of efficacy beliefs (Bandura, 1982), it is efficacy
beliefs which influence the development of depressive symptoms. In other words, mothers who believe that they have a poor ability to plan and execute parenting tasks feel depressed.

The present study was the first to examine the relationship between PSE and mothers’ prenatal provider type and the quality of provider interactions. Mothers with CPMs had higher PSE than those with OBs in the 2nd and 3rd trimesters. Given that in the 2nd trimester the mothers had been to fewer than 4 prenatal visits, it is likely that this group difference was driven by a third variable. Mothers who select a CPM as their care provider are choosing to give birth outside the hospital, a rare choice in the United States. It may be that these mothers share qualities or beliefs about pregnancy and parenting that not only support them in making an atypical choice about provider/birth location, but that also support their PSE. Indeed, mothers with CPMs trended toward having higher 3rd trimester personal control than mothers with OBs.

It bears noting that women’s ability to have choice in the type of provider they see in pregnancy is due to the second-wave feminist movement (Rooks, 1997). During this movement, women began actively seeking out and creating alternatives to the medical model of maternity care, access to hospital-based midwives increased, and a home birth movement emerged (Rooks, 1997). Indeed, it is possible that feminist ideology plays a role in mothers’ choice of provider. Future research examining the characteristics of mothers who choose OBs as
compared to those who choose CPMs could help elucidate the relationship between PSE and provider type.

In partial support of the third hypothesis, the quality of provider interactions, specifically the frequency with which mothers felt their providers empowered them, predicted 3rd trimester PSE. Taken together with the finding that 2nd trimester PSE was not related to the quality of provider interactions measured in the 3rd trimester, these findings are suggestive of a causal relationship, such that experiencing greater empowerment from one’s prenatal care provider leads to greater concurrent PSE. However, given the correlational nature of the data a definitive casual claim cannot be made. When providers empower mothers to feel that they can care for themselves and their pregnancies, mothers may interpret this as indicative of their ability to also care for their babies once born. As such, provider empowerment may serve as a form of verbal persuasion that supports mothers in feeling that they will be efficacious in parenting (Bandura, 1982; 1997). While, in contrast to the third hypothesis, provider empowerment did not predict postpartum PSE, 3rd trimester PSE was the strongest predictor of postpartum PSE. Possibly, the impact of provider empowerment on prenatal PSE may have an indirect, and lasting, effect on postpartum PSE. However, it is also possible that the power of the prenatal care provider fades postpartum, as other sources of social support continue and the mother’s PSE is impacted by her own personal experiences with her infant. Indeed, in their postpartum interviews Shannon and Carol did not make
connections between experiences with their prenatal care providers and developing efficacy beliefs. Future research with a larger sample could explore these possibilities.

**Qualitative Findings**

The findings from the qualitative analysis provide an in-depth view of Shannon and Carol’s experiences of and beliefs about social support and the development of PSE. Both mothers stressed the importance of having community to proffer social support—informational support and role modeling from friends and affective and tangible support from family. In keeping with past research (Nelson, 2003; Rubin, 1967), Shannon and Carol explicitly articulated how social support interactions with friends were an opportunity to vicariously experience parenting and use friends as role models.

While social support has long been used as a proxy for vicarious experience and verbal persuasion, little was known about whether and how these occurred in actual social support interactions (cf. Kerrick, 2016). Further, past research has not explored how observing and learning from role models might influence the development of PSE. Shannon and Carol made the explicit connection between their social support interactions and the development of their PSE. Carol, in particular, spoke of how talking with and watching friends with multiple children taught her that there was no one “right way” to parent, and that this, in turn, supported her own PSE. Knowing that there was not a single right way and picking up through observation that she would learn how to parent her
baby from her baby, at least in part, gave her a sense of confidence in her own abilities.

Both mothers spoke about how tangible support from family facilitated sleep, and how sleep contributed to general PSE. Infant temperament and relationship—with self or with baby—were also identified as contributing to general PSE. While infant temperament has been identified as a correlate of PSE in past research (e.g., Cutrona & Troutman, 1986), the role of relationship with self or with baby as a possible contributor to PSE is novel. It may be that the quality of such relationships has implications for a mother’s emotional reactions to challenging parenting situations. Given that such emotional reactions are theorized as a source of efficacy beliefs (Bandura, 1982; 1997), they may moderate an association between relationship with self or with baby and PSE. As Shannon described, her love for her baby made her more tolerant. Future research is needed to understand whether an association exists between relationships with self and with baby and PSE. And if so, investigation into the mechanism for such an association would be warranted.

Both mothers identified the ability to read and respond to baby’s cues as one of the areas in which they felt most efficacious. Past qualitative research with UK mothers found that while this task could be challenging, the ability to read and respond to a child’s needs was an important element of effective parenting (Bloomfield et al., 2005). Both Carol and Shannon felt their efficacy in reading and responding to cues was supported by the belief that there is no one right way
and by not having additional demands on their time. The belief that there was not a single right way to parent is similar to past findings that identified the willingness to try out different strategies as an essential component of effective parenting (Bloomfield et al., 2005). Such a philosophy runs counter to the messages of so-called parenting experts, who as Carol noted, aim to promote a single parenting method.

That both mothers identified not having additional demands on their time as supportive of PSE is an important finding. Shannon and Carol emphasized that they were privileged to be able to focus their attention and energy on baby and remarked on the relatively greater stress that less privileged mothers must experience. These findings point to new mothers’ needs for individual social support, and, more importantly, to the need for national family leave policy that enables all parents to have financial and job security during the postpartum period, so that they can focus their attention on baby. With past research indicating the lasting implications of PSE for both mother and baby (Jones & Prinz, 2005; Leerkes & Crockenberg, 2002; Reece & Harkless, 1998; Sanders & Woolley, 2005; Teti & Gelfand, 1991), should the connection between having undivided time and PSE be confirmed in future research, national family leave policy could support the development of parents and children well beyond infancy through its impact on PSE.

Whereas Shannon and Carol described common contributors to PSE, they differed in what they felt was the largest contributor to PSE in reading and
responding to cues. For Shannon the largest contributor was intuition, while for Carol it was spending extensive time with her baby. Shannon’s belief that her ability to read and respond to cues largely came from intuition, or instinct, may explain her high and stable PSE across time. For Shannon, her beliefs in her ability to plan and carry out the tasks of parenthood were, at least in part, already in place before her baby’s arrival. In contrast, Carol’s belief that time spent with baby was supportive of PSE aligns with self-efficacy theory—personal experiences of success or failure are theorized to be the most influential source of efficacy beliefs (Bandura, 1982; 1997). For Carol, spending lots of time with her baby allowed her to feel increasingly capable in her ability to read and respond to her baby’s cues. This may partially explain the increase in PSE that Carol experienced between pregnancy and postpartum.

Finally, both mothers felt doubt about their capability in future tasks, specifically parenting toddlers, and identified their lack of experience in this area as contributing to feeling less efficacious. Again this fits with the theory of self-efficacy. The mothers suggested that their lack of personal experience in this area led to lower feelings of efficacy. It was notable though that Carol was able to reflect on her prior experience of having felt low PSE before her daughter arrived, but of being pleasantly surprised by how efficacious she felt once she was engaged in parenting. This experience led her to believe that her lack of experience in tasks related to parenting a toddler may not hinder her efficacy in those areas as much as she had previously worried it would.
Limitation and Future Directions

The present study has several important limitations. The most notable among these is the homogeneity of the sample. Despite recruiting through agencies like WIC and the Central California Alliance for Health, the present sample was predominantly European American and well-educated. All participants had partners and of those who responded to a question about partner gender, all were partnered with men. Further, the majority (>85%) wanted to be pregnant when they conceived, or earlier in life. Thus, the present quantitative findings are not intended to be generalized beyond first-time mothers with characteristics similar to those of the present sample, and the qualitative results are not intended to generalize at all.

Future research is needed to help understand whether and how the present quantitative findings play out for mothers with different ethnic and educational backgrounds, partner statuses and sexual identities. For instance, past research suggests that low-income Latina mothers and well-educated European American mothers may experience different patterns in the relationships between depression and PSE (Le & Lambert, 2008; Porter & Hsu, 2003) and that the context and structure of social support differ between low-income Latino/a and European American caregivers (MacPhee, Fritz, & Miller-Heyl, 1996). Further, socioeconomic status (measured in the present study through the proxy of education) is posited to influence PSE, with socioeconomic disadvantage hindering the development of PSE (Jones & Prinz, 2005). Notably, the present
sample had fairly high social support, and with a high educational level, those without local support from friends and family were likely in a position to pay for help. Mothers with lower educational attainment would be less likely to be able to overcome a lack of social support in this way and more likely to have limited or non-existent family leave. Given the present findings, both quantitative and qualitative, regarding the importance of social support and the qualitative findings on the importance of being able to devote time exclusively to baby in the early postpartum period, educational differences may profoundly impact PSE. In all, it is likely that each of these sociodemographic differences would have important implications for the findings of the present study.

In addition, the sample size, especially for the 2nd trimester enrollees, was quite small \( n = 20 \), and prevented a definitive determination of whether the relationships between certain variables were truly non-significant or simply so due to a lack of statistical power. Future research examining PSE in the 2nd trimester is needed to verify the results of the present study. In addition, whereas provider empowerment did not significantly predict postpartum PSE, these variables did have a small but significant correlation. Future research with a larger sample should re-examine whether provider empowerment measured in the 3rd trimester predicts postpartum PSE, as the lack of a significant predictive relationship in the present study may have simply been due to lacking the statistical power necessary to find a small, but meaningful relationship.

To further explicate how the quality of provider interactions and PSE
connect, future research is needed to explore what precisely is happening in interactions with the prenatal provider to support or constrain maternal development of PSE. In other words, research directly examining the interactions between mothers and their prenatal providers is warranted. Such research would help identify the communicative and relational practices that providers employ to support maternal development, which may be of use in the training of prenatal care providers. As training for communication skills is “not generally emphasized” in the schooling of obstetricians (Lazarus, 1988, p. 49), evidence-based suggestions for improving provider relationship skills may be merited.

While the analysis of Shannon and Carol’s descriptions of the connection between social support and PSE has provided new and necessary insights, future research is needed to understand whether their experiences are shared by others and to explore precisely how PSE develops in social support interactions. To ascertain whether Shannon and Carol’s experiences were unique, future research should examine the prevalence of mothers’ beliefs that their interactions with friends in pregnancy are an opportunity for vicarious experience and verbal persuasion that support their PSE. In addition, research exploring the actual interactions between friends will help identify how self-efficacy beliefs are constructed in these everyday social situations.

**Practical Implications and Conclusions**

The present study examined the longitudinal development of PSE, with a focus on the role of prenatal provider interactions, social support, and women’s
own perceptions of developing PSE. Interactions in pregnancy, with prenatal care providers and friends, were found to play an important role in the development of PSE before the arrival of the first child. Given that PSE measured in pregnancy is strongly predictive of postpartum PSE, which in turn has implications for parenting behavior and children’s development, prenatal interactions present an important avenue for supporting the development of PSE in first-time mothers. In particular, prenatal care providers are uniquely positioned to support the development of PSE during routine prenatal visits. Thus, a greater emphasis in maternity care on the psychological development of new mothers may be needed. Further, interactions with friends were found to be an opportunity for social support, and occasions for vicarious experiences of parenting and verbal persuasion about the expectant mother’s abilities as a parent. Expectant mothers without friends who are parents should be encouraged to participate in contexts in which they can meet others who are further along in the parenting journey, while those with existing friendships with parents should be urged to draw on these resources during pregnancy and postpartum. The present research suggests that such interactions with friends may be at the heart of the association between PSE and social support. As such, the actual interactions between friends in pregnancy and early parenthood warrant further attention.
APPENDIX A

Complete List of Domains/Measures in the Transition to Motherhood Study

Self-Efficacy in Nurturing Role Questionnaire
MOS Social Support Scale
Edinburgh Postnatal Depression Scale
Previous Infant Experience Scale
Prenatal Interpersonal Processes of Care
Locus of Control
Childbirth Experience Questionnaire
Rosenberg Self-Esteem Scale
The Bidimensional Acculturation Scale
Demographics
Pregnancy intention questions
Extraordinary life events
Feeding & medical problems
Pregnancy experience questions
Prenatal care questions
Labor & birth experience questions
Semi-Structured Interview Protocol for The Transition to Motherhood Study

Questions proceeded by “*” will always be asked. Subordinate questions will be asked on a case-by-case basis to elicit a more in-depth description of participants’ experiences and to address areas of interest not spontaneously brought up by the participant.

I am interested in your experiences of prenatal care, labor & birth, and parenting.

*Would you tell me about your pregnancy and prenatal care starting with whether you planned your pregnancy?

Did you plan to get pregnant when you did?

How did you feel about being pregnant?

How did you choose your provider?

What did you like about them?

What didn’t you like about them?

How would you characterize your relationship with your provider?

How did you feel about your prenatal provider?

What do you think most contributed to your feeling that way?

Can you describe when you first thought of yourself as a mother?

During your pregnancy, did you think about motherhood? What did you think about it?

What were your thoughts about being/becoming a mother?

Did you feel supported in becoming a mother? How so?
Did you do anything to prepare for labor and birth? What?

Did you do anything to prepare for becoming a mother? What?

*What did it feel like to be pregnant?

*Would you tell me the story of your labor and birth?

Who attended your birth?

Did you feel supported?

Who most contributed to your feeling supported?

How did they do that?

Did you feel supported by [your birth provider]?

In what ways? In what ways did you not feel supported by them?

Did you feel respected?

Who most contributed to your feeling respected?

How did they do that?

Did you feel respected by [your birth provider]?

In what ways? In what ways did you not feel respected by them?

Did you feel prepared for labor and birth?

In what ways? What could have helped you to feel more prepared?

During your birth, did you think about becoming a mother? What did you think about?

What were your feelings just after you gave birth?

*What did it feel like to give birth?

*Would you tell me about your experiences as a parent?
What were your initial thoughts about being a mother?

Do you feel supported in being a new mother?

What about motherhood do you find most rewarding?

What is easiest? [can you tell me about a time you remember doing this?]

What is most challenging? [can you tell me about a time you remember doing this?]

Did you feel prepared to become a parent?

In what ways? What could have helped you to feel more prepared?

What areas of parenting do you feel most capable in?

What do you think helps you to feel capable in these areas?

What areas of parenting do you feel least capable in?

What do you think contributes to your feelings less capable in these areas?
APPENDIX C

Demographics

Source: Self-designed questions.

English

J1 I am ______ years old.

J2 What is your date of birth?______________________

(mm/dd/yyyy)

J3 How would you describe your race/ethnicity? Please CIRCLE ALL that apply.

American Indian……………………………. 1
Asian Indian……………………………….. ..2
Asian ……………………………………… .. 3
Black or African American ………………….4
Hispanic or Latina……………………………5
White or Caucasian or European American…..6
Pacific Islander ………………………….........7
Other, please specify_____________________.8

J4 What is the highest degree or level of school you have completed? CIRCLE ONE

Less than Middle School or Junior High...........0
Middle School or Junior High…………………...1
Some High School…………………………..2
High school diploma or GED………………….3
Some college…………………………………4
Bachelor’s degree…………………………...5
Beyond a Bachelor’s degree …………………...6
J5  I am currently: (CIRCLE ONE)

Married/partnered (see J5A).........................1
Dating but NOT living with a partner...............2
Single..................................................3
Divorced/separated..................................4

A. IF you are married/ partnered, what is your partner's gender?

Female..............................................1
Male..................................................2
Transgender........................................3
Other..................................................4

J6  Are you currently employed? CIRCLE ONE

Yes (see J6 A).................................1
No....................................................2

A. If YES, for how many hours do you work per week? _____

J7  Where do you currently live?

___________________________________________
(City/Town) (State)
(Country)

J8  How many times have you been pregnant?_____

J9  How many times have you given birth?_____

J10 How many times have you had a miscarriage (if you have never had a miscarriage, write “0”)?_____

J11 How many times have you had an abortion (if you have never had an abortion, write “0”)?_____

J12 How many weeks pregnant are you this week? ____
J12A Are you pregnant with multiples (i.e., twins, triplets, etc.)?

Yes……………1

No…………….2

I don’t know….3

J13 What is your baby’s due date? _____________

(mm/dd/yyyy)

J14 Since the last survey has anything happened that’s been unusually stressful? IF YES, please briefly describe what happened.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

A. If YES, please rate how stressful this event feels NOW.

<table>
<thead>
<tr>
<th>Not At All</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Extremely</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stressful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

J18 How are you mainly feeding your baby?

Breastfeeding…………………………………1

Formula feeding…………………………….2

Breastfeeding and formula feeding equally….3

A. How did you decide on this feeding arrangement?___________________________________
J19  Has your baby had any medical problems?
   Yes (see A & B below)........1
   No..................................2

   A. IF YES, how serious have your baby’s medical problems been?
      Not Serious Life Threatening
      1  2  3  4  5  6  7

   B. IF YES, how stressful have your baby’s medical problems been for you?
      Not At All Extremely Stressful
      1  2  3  4  5  6  7

J20  Did you have any medical problems during labor, birth, or since the birth?
   Yes (see A & B below).......1
   No..................................2

   A. IF YES, how serious have your medical problems been?
      Not Serious Life Threatening
      1  2  3  4  5  6  7

   B. IF YES, how stressful have your medical problems been for you?
      Not At All Extremely Stressful
      1  2  3  4  5  6  7

J21  Where were you born? _______________
     (Country)
J21A If you were NOT born in the United States, how long have you lived in the U.S? _______________

J23 In what country did you go to school? _______________
(Country)

Spanish

J15 Yo tengo ____ años

J16 Su fecha de nacimiento_______________________(mm/dd/aaaa)

J17 ¿Cómo describirías su raza/ etnicidad? Por favor CIRCULE TODAS las respuestas que aplique

Indígena de los Estados Unidos……………………………………1
India………………………………………………………………………2
Asiática……………………………………………………………………3
Negra o Africana Americana………………………………………4
Hispana o Latina…………………………………………………………5
Blanca o Caucasiana o Europea Americana…………………..6
Proveniente de las Islas Pacificas .................................7
Otra raza, por favor especifique ____________________…………8

J18 ¿Cuál fue la más alta cantidad de educación que usted ha completado? Por favor CIRCULE UNA respuesta

Menos de la secundaria.................................0
Secundaria....................................................1
Parte de la Preparatoria .................................2
Termino la Preparatoria o GED......................3
Parte del colegio universitario......................4
Licenciatura.....................................................5
Más allá del Licenciatura..............................6
(Profesional, medical, maestría, doctorado, etc.)

J19 En el momento estoy: (CIRCULE UNA RESPUESTA)

Casada/ viviendo con pareja (ver J5 A)……………………………..1
Con pareja pero viviendo aparte  ………………………………..2
Soltera ……………………………………………………3
Divorciada/Separada …………………………………………4

A. SI está casada/con pareja, ¿Cuál es el sexo de su pareja?

Mujer...............................1
Hombre..............................2
Transgénero............................3
Otro.................................4

J20 ¿Al momento usted tiene trabajo? (CIRCULE UNA RESPUESTA)

Si (ver J6 A)……………………………..1
No………………………………………..2

A. SI respondió SÍ, ¿cuántas horas a la semana trabaja? ______

J21 ¿Dónde vive al momento?

_______________________________________________
(Ciudad/Municipio)   (Estado)   (País)

J22 ¿Cuántas veces ha estado embarazada? ______

J23 ¿Cuántas veces ha dado a luz? ______

J24 ¿Cuántas veces ha aborto involuntario (si nunca ha tenido un aborto involuntario escriba 0)?  _____

J25 ¿Cuántas veces ha tenido usted un aborto planeado (si usted nunca ha tenido un aborto planeado escriba “0”)? _____

J12-2 ¿En cuál semana de embarazo está usted? _____

J12A ¿Está usted embarazada con múltiples (i.e. gemelos, mellizos, trillizos, etc.)?
Sí .............1
No...............2
No lo sé........3

J13-2  ¿Cuál es su fecha estimada del parto? ____________
        (mm/dd/aaaa)

J14  ¿Desde la última encuesta ha pasado algo que es inusualmente estresante?
     En caso que SÍ, por favor describa brevemente lo que sucedió.
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________
     ____________________________________________________________________

A. En caso que SÍ, por favor califique que tan estresante se siente el evento AHORA.

Para Nada  |  Estresante  |  Extremadamente Estresante
           |              |                          
           |  1  |  2  |  3  |  4  |  5  |  6  |  7  |

J18  ¿Cómo alimenta principalmente a su bebé?
     Lactancia .................................................................1
     Alimentación con fórmula .............................................2
     Lactancia y fórmula igualmente.................................3
A. ¿Cómo decidió en este arreglamiento de alimentación?

J19 ¿Su bebé ha tenido problemas médicos?

Sí (vea A y B debajo)...............................1

No.........................................................2

A. En caso que SÍ, ¿qué tan serio ha sido el problema médico de su bebé?

<table>
<thead>
<tr>
<th>No Es Grave</th>
<th>Vida o Muerte</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

B. En caso que SÍ, ¿qué tan estresante ha sido el problema médico de su bebé?

<table>
<thead>
<tr>
<th>Para Nada Estresante</th>
<th>Extremadamente Estresante</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

J20 ¿Tuvo algún problema médico durante su parto, nacimiento, y desde nacimiento?

Sí (vea A y B debajo)...............................1

No.........................................................2

A. En caso que SÍ, ¿qué tan serio ha sido su problema médico?

<table>
<thead>
<tr>
<th>No Es Grave</th>
<th>Vida o Muerte</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

B. En caso que SÍ, ¿qué tan estresante ha sido su problema médico?

<table>
<thead>
<tr>
<th>Para Nada Estresante</th>
<th>Extremadamente Estresante</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

J21 ¿Dónde nació usted? ______________________

(País)
A. ¿Si usted NO nació en los Estados Unidos, cuando te mudaste a los Estados Unidos?_______

J22  ¿En qué país fue usted a la escuela? ____________________________
     (País)
APPENDIX D

Parental Self-Efficacy

Scale Name: Self-Efficacy in the Nurturing Role Questionnaire


Prenatal Version

English. During pregnancy, many expectant parents begin to think about themselves in their new stage of life with a child. Accompanying such thoughts may be a range of feelings that include pleasure and satisfaction, as well as possibly some apprehension about one’s new role as a parent. Using the statements below, please tell us how you feel about becoming a parent. For each item, CIRCLE the number (1-7) that most accurately reflects your current feelings.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Not at all representative of me</th>
<th>Slightly representative of me</th>
<th>Moderately representative of me</th>
<th>Strongly representative of me</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>I look forward to becoming a parent with confidence in my role as a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A2</td>
<td>I feel I can catch on quickly to the basic skills of caring for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A3</td>
<td>I think I will have difficulty interpreting my baby’s cries, knowing whether he or she wants to be fed rather than played with or held.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A4</td>
<td>I imagine myself getting uptight if my baby becomes fussy or</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
irritable for longer than a few minutes.

A5 I expect to be comfortable playing actively with my baby and getting him or her to smile at me.  

1 2 3 4 5 6 7

A6 I feel unprepared in becoming a parent.  

1 2 3 4 5 6 7

A7 In imagining myself in most circumstances, even when I am tired, able to cope well with meeting my baby’s needs.  

1 2 3 4 5 6 7

A8 Touching, holding, and being affectionate with my baby will be comfortable and pleasurable for me.  

1 2 3 4 5 6 7

A9 I think I will be able to trust my feelings and intuitions about taking care of my baby.  

1 2 3 4 5 6 7

A10 I wonder if I really can understand my baby’s needs.  

1 2 3 4 5 6 7

A11 I am unsure just how much attention I should give my baby.  

1 2 3 4 5 6 7

A12 I expect to be able to soothe my baby easily when he or she is crying or fussing.  

1 2 3 4 5 6 7

A13 I am concerned that my patience with my baby may be limited.  

1 2 3 4 5 6 7

A14 I expect to feel comfortable and  

1 2 3 4 5 6 7
natural using baby-talk.

A15 I find nothing unusually complicated or difficult about the prospect of feeding, playing with, or providing day-to-day care for a child. 1 2 3 4 5 6 7

A16 The thought of being solely responsible for my child is frightening. 1 2 3 4 5 6 7

**Spanish.** Durante el embarazo, muchos padres que están esperando su bebé empiezan a pensar de sí mismo en su nueva etapa de vida con un hijo(a). Acompañando esto podría haber una variedad de sentimientos que incluyen placer y satisfacción, también así como la posibilidad de alguna aprensión sobre el nuevo papel de uno como madre. Usando las declaraciones debajo, por favor díganos cómo se siente de convertirse en madre. Por cada artículo, CIRCULE el número (1-7) que refleja sus sentimientos de este momento con más precisión.

<table>
<thead>
<tr>
<th>A1</th>
<th>Yo espero convertirme en madre con seguridad en mi papel de madre.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No me representa para nada</td>
<td>Me representa un poco</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2</th>
<th>Yo siento que podré aprender rápidamente las habilidades básicas de cuidar por un hijo(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td>No me representa para nada</td>
<td>Me representa un poco</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A3</th>
<th>Pienso que yo tendrá dificultad interpretando los llantos de mi bebé, sabiendo si quieren que le den de comer en vez que jueguen con él/ella o que quiere que lo/la abracen.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No me representa para nada</td>
<td>Me representa un poco</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A4</th>
<th>Yo me imagino que estaré tensa si mi bebé se pone colérico o se pone</th>
</tr>
</thead>
<tbody>
<tr>
<td>No me representa para nada</td>
<td>Me representa un poco</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
irritable por más de pocos minutos.

A5 Yo espero poder estar a gusto jugando activamente con mi bebé y consiguiendo que el/ella me sonría. 1 2 3 4 5 6 7

A6 Siento que no estoy preparada en convertirme en madre. 1 2 3 4 5 6 7

A7 Yo me imagino que en la mayoría de las circunstancias, hasta cuando este cansada, seré capaz de manejar bien para cumplir las necesidades de mi bebé. 1 2 3 4 5 6 7

A8 Tocar, abrazar, y ser cariñosa con mi bebé será cómodo y agradable para mí. 1 2 3 4 5 6 7

A9 Yo pienso que podré confiar en mis sentimientos e intuiciones sobre cómo cuidar de mi bebé. 1 2 3 4 5 6 7

A10 Yo me pregunto si en realidad podré entender las necesidades de mi bebé. 1 2 3 4 5 6 7

A11 Yo estoy insegura de cuánta atención le debería de dar a mi bebé. 1 2 3 4 5 6 7

A12 Yo espero poder calmar a mi bebé fácilmente cuando esté llorando o cuando se queje. 1 2 3 4 5 6 7

A13 Yo estoy preocupada de que mi paciencia con mi bebé tal vez sea limitada. 1 2 3 4 5 6 7

A14 Yo espero sentirme a gusto y natural hablando como un bebé a mi bebé. 1 2 3 4 5 6 7
Yo no encuentro nada inusualmente complicado o difícil del prospecto de alimentar, jugar con, o dar cuidado diario a un bebé.

El pensamiento de ser la única persona responsable de mi hijo(a) es espantoso.

### Postpartum Version

**English.** In thinking about their new role as a parent, many people experience a range of feelings that include pleasure and satisfaction, as well as possibly some apprehension about their new role as a parent. Using the statements below, please tell us how you feel about being a parent. For each item, CIRCLE the number (1-7) that most accurately reflects your current feelings.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1._I feel confident in my role as a parent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2._I feel I have caught on quickly to the basic skills of caring for a child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A3._I have difficulty interpreting my baby’s cries, knowing whether he or she wants to be fed rather than played with or held.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A4._I get uptight if my baby becomes fussy or irritable for longer than a few minutes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A5._I am comfortable playing actively with my baby and getting him or her to smile at me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A6._I feel unprepared being a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
parent.

A7. In most circumstances, even when I am tired, I am able to cope well with meeting my baby’s needs.  

1 2 3 4 5 6 7

A8. Touching, holding, and being affectionate with my baby is comfortable and pleasurable for me.  

1 2 3 4 5 6 7

A9. I trust my feelings and intuitions about taking care of my baby.  

1 2 3 4 5 6 7

A10. I wonder if I really understand my baby’s needs.  

1 2 3 4 5 6 7

A11. I am unsure just how much attention I should give my baby.  

1 2 3 4 5 6 7

A12. I am able to soothe my baby easily when he or she is crying or fussing.  

1 2 3 4 5 6 7

A13. I am concerned that my patience with my baby is limited.  

1 2 3 4 5 6 7


1 2 3 4 5 6 7

A15. For myself as a parent, I find nothing unusually complicated or difficult about feeding, playing with, or providing day-to-day care for a child.  

1 2 3 4 5 6 7

A16. The thought of being solely responsible for my child is frightening.  

1 2 3 4 5 6 7
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>No me representa para nada</th>
<th>Me representa un poco</th>
<th>Me representa moderadamente</th>
<th>Me representa completamente</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1_3</td>
<td>Me siento segura en mi papel como madre.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A2_3</td>
<td>Yo siento que aprendí rápidamente las habilidades básicas de cuidar por un hijo(a).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A3_3</td>
<td>Yo tengo dificultad interpretando los llantos de mi bebé, sabiendo si quieren que le den de comer en vez que quiere que jueguen con él/ella o que quiere que lo/la abracen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A4_3</td>
<td>Yo me pongo tensa si mi bebé se pone colérico o irritable por más de algunos minutos.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A5_3</td>
<td>Yo estoy a gusto cuando juego activamente con mi bebé y consigo que el/ella me sonría.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A6_3</td>
<td>Yo siento que no estoy preparada para ser madre.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A7_3</td>
<td>En la mayoría de las circunstancias, hasta cuando estoy cansada, soy capaz de manejar bien para cumplir las necesidades de mi bebé.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Spanish. Pensando en su nuevo papel como madre, muchas personas tienen una variedad de sentimientos que incluyen placer y satisfacción, también así como la posibilidad de alguna aprensión sobre su nuevo papel como madre. Usando las declaraciones debajo, por favor diganos cómo se siente de ser madre. Por cada artículo, CIRCULE el número (1-7) que refleja sus sentimientos de este momento con más precisión.

A8_3  Tocando, abrazando y siendo cariñosa con mi bebé es cómodo y agradable para mí.  
1 2 3 4 5 6 7

A9_3  Yo tengo confianza en mis sentimientos e intuiciones sobre cómo cuidar de mi bebé.  
1 2 3 4 5 6 7

A10_3  Yo me pregunto si en realidad entiendo las necesidades de mi bebé.  
1 2 3 4 5 6 7

A11_3  Yo estoy insegura de cuanta atención le debería de dar a mi bebé.  
1 2 3 4 5 6 7

A12_3  Yo puedo calmar a mi bebé fácilmente cuando llora o se queja.  
1 2 3 4 5 6 7

A13_3  Yo estoy preocupada de que mi paciencia con mi bebé es limitada  
1 2 3 4 5 6 7

A14_3  Me siento a gusto y natural hablando como un bebé a mi bebé.  
1 2 3 4 5 6 7

A15_3  Yo como madre, no encuentro nada particularmente  
1 2 3 4 5 6 7
complicado o difícil de alimentar, jugar con, o dar cuidado diario a mi bebé.

A16_3 El pensamiento de ser la única persona responsable de mi hijo(a) es espantoso.


**APPENDIX E**

Social Support

**Scale Name:** Medical Outcomes Study Social Support Survey


**English**

People sometimes look to others for companionship, assistance, or other types of support. Individuals experience a variety of support throughout their lives. In the following section of the survey, we’d like to ask about the support that is available to you.

**B1** About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?

Write in number of close friends and close relatives ______

How often is each of the following kinds of support available to you if you need it?

CIRCLE ONE response to each statement.

<table>
<thead>
<tr>
<th>None of the Time</th>
<th>A Little of the Time</th>
<th>Some of the Time</th>
<th>Most of the Time</th>
<th>All of the Time</th>
</tr>
</thead>
</table>

**B2** Someone to help you if you were confined to bed.

| 1 | 2 | 3 | 4 | 5 |

**B3** Someone you can count on to listen to you when you need to talk.

| 1 | 2 | 3 | 4 | 5 |

**B4** Someone to give you good

| 1 | 2 | 3 | 4 | 5 |
advice about a crisis.

B5 Someone to take you to the doctor if you needed it.

B6 Someone who shows you love and affection.

B7 Someone to have a good time with.

B8 Someone to give you information to help you understand a situation.

B9 Someone to confide in or talk to about yourself or your problems.

B10 Someone who hugs you.

B11 Someone to get together with for relaxation.

B12 Someone to prepare your meals if you were unable to do it yourself.

B13 Someone whose advice you really want.

B14 Someone to do things with to help you get your mind off things.

B15 Someone to help with daily chores if you were sick.

B16 Someone to share your most private worries and fears with.

B17 Someone to turn to for suggestions about how to deal
with a personal problem.

**B18**
Someone to do something enjoyable with.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

**B19**
Someone who understands your problems.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

**B20**
Someone to love and make you feel wanted.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

**Spanish**

Las personas a veces buscan a otros por compañerismo, asistencia, o otros tipos de apoyo. ¿Qué tan frecuente es cada uno de los siguientes tipos de apoyo disponible para usted si usted lo necesita?

**B1_3**
¿Cómo cuántos amigos y familiares cercanos tiene usted (personas con quienes usted se siente cómoda y puede hablar de cosas que está pensando)?

Escriba el número de amistades y de familiares cercanos ______

¿Qué tan frecuente es cada uno de los siguientes tipos de apoyo disponible para usted si usted lo necesita? CIRCULE UNA respuesta por cada frase.

<table>
<thead>
<tr>
<th>Ninguna parte del tiempo</th>
<th>Poco del tiempo</th>
<th>Alguna parte del tiempo</th>
<th>Mayoría del tiempo</th>
<th>Todo el tiempo</th>
</tr>
</thead>
<tbody>
<tr>
<td>B2_3 Alguien que le ayude si usted estuviera restringida a la cama.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B3_3 Alguien con quién puede contar para escucharla cuando usted necesite platicar.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B4_3 Alguien que le dé un buen consejo acerca de una crisis.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
B5_3 Alguien que la lleve al doctor si usted lo necesitará. 1 2 3 4 5
B6_3 Alguien que le demuestre cariño y afecto. 1 2 3 4 5
B7_3 Alguien con quién pueda pasarla bien. 1 2 3 4 5
B8_3 Alguien que le dé información para ayudarle entender una situación. 1 2 3 4 5
B9_3 Alguien en quién confíe o plátique acerca de sí misma o de sus problemas. 1 2 3 4 5
B10_3 Alguien que la abrace. 1 2 3 4 5
B11_3 Alguien con quién se reúna para relajarse. 1 2 3 4 5
B12_3 Alguien que le prepare sus alimentos si usted no puede hacerlo por sí misma. 1 2 3 4 5
B13_3 Alguien cuyo consejo realmente desea usted. 1 2 3 4 5
B14_3 Alguien con quién hacer cosas para ayudarle a distraerse. 1 2 3 4 5
B15_3 Alguien que le ayude a hacer quehaceres diarios si usted estuviera enferma. 1 2 3 4 5
B16_3 Alguien con quién comparta la mayoría de sus íntimas preocupaciones y
temores.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B17_3 Alguien con quién pueda recurrir para alguna sugerencia de cómo manejar un problema personal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B18_3 Alguien con quién hacer algo agradable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B19_3 Alguien quién entienda sus problemas.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B20_3 Alguien a quién querer y hacerla sentir deseada.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX F

Depression

Scale Name: Edinburg Postnatal Depression Scale


English

[New mothers] Pregnant women may experience a wide range of feelings. [As you have recently had a baby,] we would like to know how you are feeling.

Please CIRCLE the ONE answer that comes closest to how you have felt in the past week.

In the past week:
E1 I have been able to laugh and see the funny side of things

3 – As much as I always could
2 – Not quite so much now
1 – Definitely not so much now
0 – Not at all
E2  I have looked forward with enjoyment to things
    3 – As much as I ever did
    2 – Rather less than I used to
    1 – Definitely less than I used to
    0 – Hardly at all

E3  I have blamed myself unnecessarily when things went wrong
    3 – Yes, most of the time
    2– Yes, some of the time
    1 – Not very often
    0 – No, never

E4  I have been anxious or worried for no good reason
    3 – No, not at all
    2 – Hardly, ever
    1 – Yes, sometimes
    0 – Yes, very often

E5  I have felt scared or panicky for no good reason
    3 – Yes, quite a lot
    2 – Yes, sometimes
    1 – No, not much
    0 – No, not at all

E6  Things have been piling up for me
    3 – Yes, most of the time I haven’t been able to cope at all
    2 – Yes, sometimes I haven’t been coping as well as usual
    1 – No, most of the time I have coped quite well
    0 – No, I have been coping as well as ever
E7  I have been so unhappy that I have had difficulty sleeping
   3 – Yes, most of the time
   2 – Yes, sometimes
   1 – Not very often
   0 – No, not at all

E8  I have felt sad or miserable
   3 – Yes, most of the time
   2 – Yes, quite often
   1 – Not very often
   0 – No, not at all

E9  I have been so unhappy that I have been crying
   3 – Yes, most of the time
   2 – Yes, quite often
   1 – Only occasionally
   0 – No, never

E10 The thought of harming myself has occurred to me
    3 – Yes, quite often
    2 – Sometimes
    1 – Hardly ever
    0 – Never
Mexican

[Nuevas madres] Mujeres embarazadas pueden experimentar una diversidad de emociones. [Como usted hace poco tuvo un bebé,] nos gustaría saber cómo se ha estado sintiendo. Por favor CIRCULE la

En la última semana:

E1 He podido reír y ver el lado bueno de las cosas

   3 – Tanto como siempre
   2 – No tanto ahora
   1 – Mucho menos
   0 – No, no he podido.

E2 He mirado el futuro con placer

   3 – Tanto como siempre
   2 – Algo menos que antes
   1 – Definitivamente menos que antes
   0 – No, nada

E3 Me he culpado innecesariamente cuando las cosas marchaban mal

   3 – Sí, la mayoría de las veces
   2 – Sí, algunas veces
   1 – No muy frecuentemente
   0 – No, nunca

E4 He estado ansiosa y preocupada sin motivo

   3 – No, nada
   2 – Rara vez
   1 – Sí, a veces
   0 – Sí, muy frecuentemente
E5  He sentido miedo o pánico sin motivo alguno
    3 – Sí, muy frecuentemente
    2 – Sí, a veces
    1 – No, no mucho
    0 – No, nada

E6  Las cosas me han estado agobiando
    3 – Sí, casi siempre
    2 – Sí, a veces
    1 – No, casi nunca
    0 – No, nada

E7  Me he sentido tan infeliz, que he tenido dificultad para dormir
    3 – Sí, casi siempre
    2 – Sí, a veces
    1 – No muy frecuentemente
    0 – No, nada

E8  Me he sentido triste y miserable
    3 – Sí, casi siempre
    2 – Sí, muy frecuentemente
    1 – No muy frecuentemente
    0 – No, nada

E9  He estado tan infeliz que he estado llorando
    3 – Sí, casi siempre
    2 – Sí, muy frecuentemente
    1 – Sólo ocasionalmente
    0 – No, nunca
E10 He pensado en hacerme daño a mí misma

3 – Sí, muy frecuentemente
2 – A veces
1 – Rara vez
0 – Nunca
APPENDIX G

Prenatal Care

**Source:** Self-designed questions.

**English**

Some, but not all, women receive regularly scheduled health care during their pregnancy, referred to here are routine prenatal checkups. There is a lot of variety in the amount and characteristics of prenatal care women receive during their pregnancies.

The following questions ask about your experiences with routine prenatal checkups and care (NOT including any separate visits to WIC or that are just for tests or ultrasounds). Please CIRCLE the ONE response that best describes your experiences.

**C1** How many routine prenatal checkups have you had so far during your pregnancy?
- Zero……………………1
- One to three……………2
- Three to seven………...3
- Eight to twelve………4
- More than twelve…….5

**C2** Thinking about the prenatal provider you have seen most often, what type of provider are they?
- An obstetrician (OB-GYN)…………………………………………………………………………………………1
- A certified nurse-midwife (CNM)…………………………………………………………………………………..2
- A certified professional midwife (CPM) or licensed midwife (LM) or home birth midwife...3
- A family doctor (MD) or general practitioner (MD, GP) .................................................................4
- Other provider (please specify)__________________________________________________________5
C3  For approximately how many of your routine prenatal checkups, have you seen the provider you described in the previous question (C2.)?

For less than a quarter of my routine prenatal checkups (Less than 25%)…………1

For between a quarter and a half of my routine prenatal checkups (25%-49%)……2

For about half of my routine prenatal checkups (50%)…………………….. 3

For more than half but less than all of my routine prenatal checkups (51%-99%)…4

For all of my routine prenatal checkups (100%)……………………………………5

A. IF you have seen multiple different providers, how many providers have you seen for your routine prenatal checkups? ______

C4  Is it your preference to have the prenatal provider you see most often (the one you described in questions C2 and C3) attend your birth?

It is my preference……………………………………………………1

It is not my preference…………………………………………………2

I don’t have a preference about which provider attends my birth….3

I don’t know………………………………………………………….4

I don’t have a provider I have seen more than once………………….5

C5  During your pregnancy, have you officially switched care providers? That is, did you stop seeing one provider for routine prenatal checkups and start seeing a different provider whom you continue seeing for routine prenatal checkups?

Yes, I chose to switch care providers…………………………………1

Yes, I switched care providers but it was not my choice. ………..2

No, I did not switch care providers…………………………………..3

A. IF you answered YES, please explain________________________________________________________
C6 Where do you go most of the time for your routine prenatal checkups?
   Hospital clinic.................................................................1
   Health department clinic.................................................2
   Private doctor’s office.....................................................3
   Midwife’s office.............................................................4
   Home (yours or your provider’s).........................................5

C7 How much time do you typically spend with your prenatal provider during a routine prenatal checkup?
   5 minutes or less...................................................................1
   Between 6 and 15 minutes......................................................2
   Between 16 and 30 minutes...................................................3
   Between 31 and 60 minutes...................................................4
   More than 60 minutes...........................................................5

Spanish

Algunas, pero no todas, mujeres reciben cuidado de salud programado regularmente durante su embarazo, referido aquí son chequeos rutinarios prenatales. Hay mucha variedad en la cantidad y características de cuidado prenatal que mujeres reciben durante sus embarazos.

Las siguientes cuestiones preguntan sobre sus experiencias con chequeos rutinarios prenatales y cuidado (NO incluye ninguna visita separada al WIC o pruebas de laboratorio o ultrasonidos). Por favor CIRCULE UNA respuesta que mejor describe su experiencia

C1 ¿Cuántos chequeos rutinarios prenatales ha tenido hasta ahora durante su embarazo?
   Cero.................................................... 1
   Uno a tres................................. 2
   Cuatro a siete......................... 3
   Ocho a doce......................... 4
   Más de doce..................... 5

C2 ¿Pensando en el proveedor prenatal que usted ha visto más seguido, que tipo de proveedor es?
   Un obstetra (OB-GYN) ..................................................... 1
Una enfermera-partera certificada (CNM) ......................................................2
Una partera certificada profesional (CPM) o partera licenciada (LM) o partera de parto en casa .................................................................3
Un/a doctor/a de familia (MD) o médico general (MD, GP) .................4
Otro proveedor (por favor especificar) _________________________________ 5

C3 ¿Aproximadamente cuantos de sus chequeos rutinarios prenatales ha visto el proveedor descrito en la pregunta previa (C2)?

Por menos de un cuarto de mis chequeos rutinarios prenatales (Menos de 25%)........................................................................................................1
Entre un cuarto y medio de mis chequeos rutinarios prenatales (25%-49%) ........................................................................................................2
Por alrededor de medio de mis chequeos rutinarios prenatales ............3
Por más de medio pero menos de todos mis chequeos rutinarios prenatales (51%-99%) ......................................................................................4
Por todos mis chequeos rutinarios prenatales (100%) .........................5

A. ¿SI usted ha visto múltiple proveedores diferentes, cuantos proveedores ha visto para sus chequeos rutinarios prenatales? ______

C4 ¿Es de su preferencia tener a su proveedor prenatal que usted ve más seguido (el que describió en la pregunta C2 y C3) atienda su nacimiento?

Es mi preferencia........................................................................................1
No es de mi preferencia..............................................................................2
No tengo preferencia sobre cual proveedor atienda mi nacimiento……..3
No se........................................................................................................2
No tengo un proveedor que he visto más de una vez.........................5

C5 ¿Durante su embarazo, ha oficialmente cambiado los proveedores de cuidado? Es decir, paró de ver a un proveedor de chequeos rutinarios prenatales y empezó a ver a un proveedor diferente que usted continua viendo para sus chequeos rutinarios prenatales?
Sí, yo decidí cambiar de proveedores de cuidado…………………………1

Sí, yo cambie de proveedores de cuidado pero no fue mi decisión…… 2

No, yo no cambie de proveedores de cuidado……………………………3

A. SI respondió SÍ, por favor explique_______________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

C6 ¿A dónde va la mayoría del tiempo para sus chequeos rutinarios prenatales?
Clínica del hospital................................................................. 1
Clínica del departamento de salud.................................2
Oficina de doctor privado.......................................................3
Oficina de partera..............................................................4
Casa (de usted o su proveedor)..............................................5

C7 ¿Cuánto tiempo pasa típicamente con su proveedor prenatal durante sus chequeos rutinarios prenatales?
5 minutos o menos.............................................................1
Entre 6 y 15 minutos..........................................................2
Entre 16 y 30 minutos.........................................................3
Entre 31 y 60 minutos........................................................4
Más de 60 minutos............................................................5
APPENDIX H

Quality of Prenatal Provider Interactions

Scale Name: Prenatal Interpersonal Processes of Care


English

Prenatal providers can differ in the care they provide to their clients. We would like to know about your experiences with prenatal care. Thinking about the prenatal provider you have seen most often during your pregnancy, please circle one response to each statement.

<table>
<thead>
<tr>
<th>How often:</th>
<th>None</th>
<th>Some</th>
<th>Most</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>does your provider tell you how to pay attention to your symptoms and when to call your provider?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>D2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>does your provider make you feel that your everyday activities such as diet and lifestyle will make a difference in your pregnancy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
D3 does your provider tell you what you could do to take care of yourself and your pregnancy at home? 1 2 3 4
D4 does your provider make you feel that following their advice would make a difference in your health or the health of your baby? 1 2 3 4
D5 does your provider take your concerns seriously? 1 2 3 4
D6 does your provider ignore what you tell them? 1 2 3 4
D7 does your provider listen carefully to what you have to say? 1 2 3 4
D8 does your provider give you enough time to say what you think is important? 1 2 3 4
D9 does your provider tell you what they are doing as they give you a physical examination? 1 2 3 4
D10 does your provider explain why a test (such as an ultrasound, blood or urine test) is being
D11  does your provider ask if you feel comfortable following advice that they give you?  1  2  3  4

D12  does your provider ask you how you feel about the advice they give you?  1  2  3  4

D13  does your provider ask if you will be able to follow their advice?  1  2  3  4

D14  does your provider try to include you in decisions about your pregnancy care?  1  2  3  4

D15  is your provider compassionate and caring?  1  2  3  4

D16  does your provider compliment you on how well you take care of yourself during your pregnancy?  1  2  3  4

D17  does your provider help you feel less worried about your pregnancy?  1  2  3  4

D18  are you asked if you would like to bring your husband, partner, or someone important to you to  1  2  3  4
your next prenatal visit?

D19 does your provider seem to care about you as a person? 1 2 3 4

D20 does your provider address you by the name that you prefer? 1 2 3 4

D21 does your provider make you feel as if you aren’t welcome? 1 2 3 4

D22 is your provider rude to you? 1 2 3 4

D23 does your provider treat you in a friendly and courteous manner? 1 2 3 4

Spanish

Proveedores prenatales pueden variar con el cuidado que proveen a sus clientes. Nos gustaría saber sobre su experiencia con sus cuidados prenatales. Pensando sobre su proveedor prenatal quien usted vio más seguido durante su embarazo, por favor CIRCULE UNA respuesta por cada declaración.

¿Qué tan frecuente:

D24 le dice su proveedor cómo poner atención a sus síntomas y cuando llamar a su proveedor? 1 2 3 4

D25 hace su proveedor que sienta que sus actividades diarias como dieta y estilo de vida harán una diferencia en su

118
embarazo?

<table>
<thead>
<tr>
<th>D26</th>
<th>le dice su proveedor lo que puede hacer para cuidar de sí misma y de su embarazo en su casa?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D27</th>
<th>hace su proveedor que sienta que siguiendo sus consejos hará una diferencia en su salud y la salud de su bebé?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D28</th>
<th>toma su proveedor sus preocupaciones seriamente?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D29</th>
<th>ignora su proveedor lo que usted dice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D30</th>
<th>escucha su proveedor atentamente a lo que tienes que decir?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D31</th>
<th>le da su proveedor suficiente tiempo para decir lo que cree usted que es importante?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D32</th>
<th>le dice su proveedor lo que él está haciendo mientras le hacen su chequeo físico?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D33</th>
<th>le explica su proveedor por que los exámenes (como el ultrasonido, exámenes de sangre u orina) se hacen?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D34</th>
<th>su proveedor pregunta si se siente cómoda siguiendo sus sugerencias que le da?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D35</th>
<th>le pregunta su proveedor como se siente sobre las sugerencias que le da?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D36</th>
<th>le pregunta su proveedor si va a poder seguir sus consejos?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
D3\textsuperscript{c} intenta su proveedor incluirla en decisiones sobre el cuidado de su embarazo?  

D3\textsuperscript{e} es su proveedor compasivo(a) y amable?  

D3\textsuperscript{f} la complementa su proveedor de que tan bien se cuida durante su embarazo?  

D4\textsuperscript{c} la ayuda su proveedor para que se sienta menos preocupada de su embarazo?  

D4\textsuperscript{f} le preguntan si le gustaría traer a su esposo, pareja, o alguien importante a su siguiente visita prenatal?  

D4\textsuperscript{g} parece que su proveedor se preocupa por usted como persona?  

D4\textsuperscript{h} le llama su proveedor por el nombre que usted prefiere?  

D4\textsuperscript{i} hace su proveedor que se sienta como si no es bienvenida?  

D4\textsuperscript{j} es su proveedor grosero con usted?  

D4\textsuperscript{k} la trata su proveedor en una manera amigable y cortes?
**APPENDIX I**

Childbirth Experience

**Scale name:** Childbirth Experience Questionnaire (CEQ)


**English**

We are interested in your experience of childbirth. For each of the items listed below, indicate how much you agree or disagree with the statement. “Provider(s)” refer to any doctors, midwives, or nurse-midwives who attended you during labor and birth. CIRCLE ONE response for each item.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Totally disagree</th>
<th>Mostly disagree</th>
<th>Mostly agree</th>
<th>Totally agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1</td>
<td>Labor and birth went as I had expected.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I2</td>
<td>I felt strong during labor and birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I3</td>
<td>I felt scared during labor and birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I4</td>
<td>I felt capable during labor and birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I5</td>
<td>I was tired during labor and birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I6</td>
<td>I felt happy during labor and birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I7</td>
<td>I have many positive memories from childbirth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I8</td>
<td>I have many negative memories from childbirth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I9</td>
<td>Some of my memories from childbirth make me feel depressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
I10 I felt I could have a say whether I could be up and about or lie down. 1 2 3 4
I11 I felt I could have a say in deciding my birthing position. 1 2 3 4
I12 I felt I could have a say in the choice of pain relief. 1 2 3 4
I13 My provider(s) devoted enough time to me. 1 2 3 4
I14 My provider(s) devoted enough time to my partner. 1 2 3 4
I15 My provider(s) kept me informed about what was happening during labor and birth. 1 2 3 4
I16 My provider(s) understood my needs. 1 2 3 4
I17 I felt very well cared for by my provider(s). 1 2 3 4
I18 My impression of the team’s medical skills made me feel secure. 1 2 3 4
I19 I felt that I handled the situation well. 1 2 3 4

For the following questions, indicate your opinion by marking on the line between the two end-points. For example:
How much do you like apples?

Not at all     X     My favorite fruit

I20 As a whole, how painful did you feel childbirth was?

No pain     Worst pain imaginable

I21 As a whole, how much control did you feel you had during childbirth?
I22  As a whole, how secure did you feel during childbirth?

Not at all secure  Completely secure

If you have any additional comments you would like to share about your labor and/or birth experience, please write them below:
Estamos interesados en su evaluación de su experiencia de parto. Para cada artículo debajo, indique que tan satisfecha o insatisfecha está con ese aspecto de su experiencia de parto. “Proveedor(s)” se refiere a cualquier doctor, partera, o enfermera-partera quien atendió su parto y nacimiento de su hijo(a). CIRCULE UNA respuesta por cada pregunta.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Totalmente en desacuerdo</th>
<th>Por la mayoría en desacuerdo</th>
<th>Por la mayoría de acuerdo</th>
<th>Totalmente de acuerdo</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1</td>
<td>El parto y el nacimiento fue como yo esperaba</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I2</td>
<td>Me sentí fuerte durante el parto y el nacimiento</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I3</td>
<td>Me sentí asustada durante el parto y el nacimiento</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I4</td>
<td>Me sentí capaz durante el parto y el nacimiento</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I5</td>
<td>Yo estaba cansada durante el parto y el nacimiento</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I6</td>
<td>Me sentí feliz durante el parto y el nacimiento</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I7</td>
<td>Yo tengo muchos recuerdos positivos de el parto</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I8</td>
<td>Yo tengo muchos recuerdos negativos de el parto</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I9</td>
<td>Algunos de mis recuerdos de el parto me hacen sentir deprimida</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
I10 Yo sentí que pude tener algo que decir si quería estar levantada y moviéndome o estar acostada.  

I11 Yo sentí que pude tener algo que decir en decidir mi posición cuando tuve que empujar para que saliera el bebé.  

I12 Yo sentí que pude tener algo que decir en decidir la opción de alivio del dolor.  

I13 Mi proveedor(es) dedicaron suficiente tiempo para mí.  

I14 Mi proveedor(es) dedicaron suficiente tiempo para mi pareja.  

I15 Mi proveedor(es) me mantuvieron informada sobre lo que me estaba pasando durante el parto y el nacimiento.  

I16 Mi proveedor(es) entendieron mis necesidades.  

I17 Me sentí muy bien cuidada por mis proveedor(es).  

I18 Mi impresión de las
habilidades del equipo médico me hizo sentir segura.

I19 Yo sentí que maneje la situación bien. 1 2 3 4

En las preguntas siguientes, indique su opinión marcando en la línea entre los dos puntos finales. Por ejemplo:

Cuantó le gustan las manzanas?

• • 
Para nada Mi fruta favorita

I20 En general, ¿qué tan doloroso sintió que fue su parto?

• • 
Ningún dolor El peor dolor imaginable.

I21 En general, ¿cuánto control sintió que tuvo durante el parto?

• • 
Ningún control Control completo

I22 En general, ¿qué tan segura se sintió durante el parto?

• • 
De ningún modo segura Completamente segura

Si usted tiene comentarios adicionales que quisiera compartir sobre su experiencia de parto y/o nacimiento de su hijo(a), por favor escribalo debajo:
**APPENDIX J**

Locus of Control

**Scale Name:** Spheres of Control Scale-3 - Interpersonal Control Subscale (odd numbered items); Personal Control Subscale (even numbered items)


**English**

Individuals have different ways of looking at and interacting with the world. We are interested in how you view and experience the world. There are no right or wrong answers. For each item, CIRCLE the number (1-7) that most accurately reflects your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Totally Disagree</th>
<th>Some-what Disagree</th>
<th>Some-what Agree</th>
<th>Totally Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1</td>
<td>When I get what I want it's usually because I worked hard for it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K2</td>
<td>When I make plans I am almost certain to make them work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K3</td>
<td>I prefer games involving some luck over games requiring pure skill.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K4</td>
<td>I can learn almost anything if I set my mind to it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K5</td>
<td>My major accomplishments are entirely due to my hard work and ability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K6</td>
<td>I usually don't set goals because I have a hard time following through on them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K7</td>
<td>Competition discourages excellence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K8</td>
<td>Often people get ahead just by being lucky.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K9</td>
<td>On any sort of exam or competition I like to know how well I do relative to everyone else.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
K10 It's pointless to keep working on something that's too difficult for me. 1 2 3 4 5 6 7
K11 Even when I'm feeling self-confident about most things, I still seem to lack the ability to control social situations. 1 2 3 4 5 6 7
K12 I have no trouble making and keeping friends. 1 2 3 4 5 6 7
K13 I'm not good at guiding the course of a conversation with several others. 1 2 3 4 5 6 7
K14 I can usually establish a close personal relationship with someone I find attractive. 1 2 3 4 5 6 7
K15 When being interviewed I can usually steer the interviewer toward the topics I want to talk about and away from those I wish to avoid. 1 2 3 4 5 6 7
K16 If I need help in carrying off a plan of mine, it's usually difficult to get others to help. 1 2 3 4 5 6 7
K17 If there's someone I want to meet I can usually arrange it. 1 2 3 4 5 6 7
K18 I often find it hard to get my point of view across to others. 1 2 3 4 5 6 7
K19 In attempting to smooth over a disagreement I usually make it worse. 1 2 3 4 5 6 7
K20 I find it easy to play an important part in most group situations. 1 2 3 4 5 6 7

Spanish

Individuos tienen diferentes maneras de ver y interactuar con el mundo. Estamos interesados en como usted ve y experiencia el mundo. No hay respuestas correctas ni incorrectas. Para cada artículo, CIRCULE el número (1-7) que más precisamente refleje su opinión.
<table>
<thead>
<tr>
<th>Asignación</th>
<th>Descripción</th>
<th>Totalmente Inexacto</th>
<th>Algo Inexacto</th>
<th>Algo Exacto</th>
<th>Totalmente Exacto</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1_3</td>
<td>Yo puedo usualmente lograr lo que quiero cuando trabajo duro por ello.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K2_3</td>
<td>En mis relaciones personales, la otra persona usualmente tiene más control sobre la relación que yo.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K3_3</td>
<td>Una vez que hago planes yo estoy casi cierta de que funcionaran.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K4_3</td>
<td>No tengo problemas haciendo y mantenerlos amigos.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K5_3</td>
<td>Yo prefiero juegos involucrando algo de suerte que de pura habilidad.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K6_3</td>
<td>No soy buena en guiar el curso de la conversación con varias personas.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K7_3</td>
<td>Yo puedo aprender cualquier cosa si pongo mi esfuerzo en hacerlo.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K8_3</td>
<td>Yo puedo usualmente desarrollar una relación cercana personal con alguien quien yo encuentre atractivo.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K9_3</td>
<td>Mis mayores logros son enteramente debido a mi trabajo duro y mis habilidades.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K10_3</td>
<td>Yo puedo usualmente dirigir una conversación hacia el tema que yo quiero discutir.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K11_3</td>
<td>Yo usualmente no establezco metas porque tengo un tiempo difícil de seguir adelante con ellas.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K12_3</td>
<td>Cuando necesito asistencia con algo, frecuentemente lo encuentro difícil de obtener que otros me ayuden.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K13_3</td>
<td>La mala suerte a veces me ha prevenido de lograr cosas.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K14_3</td>
<td>Si hay alguien que quiero conocer yo puedo usualmente organizarlo.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K15_3</td>
<td>Casi cualquier cosa es posible para mí si realmente lo quiero.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K16_3</td>
<td>Con frecuencia me resulta difícil comunicar mi punto de vista a través de los demás.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K17_3</td>
<td>La mayor parte de lo que pasara en mi carrera está más allá de mi control.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K18_3</td>
<td>Cuando he intentando de calmar el desacuerdo a veces lo hago peor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K19_3</td>
<td>Yo lo encuentro inútil seguir trabajando en algo que es muy difícil para mí.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K20_3</td>
<td>Yo lo encuentro fácil de jugar un papel importante en la mayoría de situaciones de grupos.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX K

Self-Esteem

Scale name: Rosenberg Self-Esteem Scale


English

Below is a list of statements dealing with your general feelings about yourself. For each item, CIRCLE the number (1-4) that most accurately reflects how you feel about yourself.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>I feel that I'm a person of worth at least on an equal basis with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L2</td>
<td>I feel that I have a number of good qualities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L3</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L4</td>
<td>I am able to do things as well as most other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L5</td>
<td>I feel that I do not have much to be proud of.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L6</td>
<td>I take a positive attitude toward myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L7</td>
<td>On the whole, I am satisfied with myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>English</td>
<td></td>
<td>Spanish</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------</td>
<td>---</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>L8</td>
<td>I wish I could have more respect for myself.</td>
<td></td>
<td>Debajo esta una lista de declaraciones tratándose de sus sentimientos generales sobre usted. Por cada artículo, CIRCULE la opción (1-4) que más precisamente refleja cómo se siente sobre usted misma.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I certainly feel useless at times.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At times, I think I am no good at all.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L9</td>
<td></td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L10</td>
<td></td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L1</td>
<td>En general, estoy satisfecha conmigo misma.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L2</td>
<td>A veces pienso que no soy buena en nada.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L3</td>
<td>Tengo la sensación de que poseo algunas buenas cualidades.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L4</td>
<td>Soy capaz de hacer las cosas tan bien como la mayoría de las personas.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L5</td>
<td>Siento que no tengo demasiadas cosas de las que sentirme orgullosa.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L6</td>
<td>A veces me siento realmente inútil.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L7</td>
<td>Tengo la sensación de que soy una persona de valía, al menos igual que la mayoría de la gente.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
<tr>
<td>L8</td>
<td>Ojalá me respetara más a mí misma.</td>
<td></td>
<td>Muy en desacuerdo En desacuerdo De acuerdo Muy de acuerdo</td>
<td></td>
</tr>
</tbody>
</table>
En definitiva, tiendo a pensar que soy una fracasada.

Tengo una actitud positiva hacia mí misma.
APPENDIX L

Transcription Conventions

=    a latched statement

[    beginning of overlapping speech

]    end of overlapping speech

(#)   a pause with the number designating the length of the pause in seconds

(.)   a micropause lasting less than .2 seconds

-    speech that is cut-off or abruptly stopped

___   emphasis

.(hhh) audible inhalation

(text) unclear speech

...   speech omitted for brevity
References


