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Processes Used by Urban Black Women to Prepare for Childbirth: A Grounded Theory

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Processes Used by Urban Black Women to Prepare for Childbirth: A Grounded Theory

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Processes Used by Urban Black Women to Prepare for Childbirth: A Grounded Theory

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Women prepare for childbirth in a variety ways. These preparations include visits to healthcare providers, seeking information from family, friends, and the media, and attendance at childbirth classes. Documentation of birth preparation comes primarily from studies of middle class white women. Few researchers have identified or included middle class black women in their samples. Instead, research with black women often highlights pregnancy problems in low income populations. Also unexamined, except tangentially, is how the social context impacts childbirth for black women. Therefore, nursing practice knowledge lacks an understanding of the processes black women use to prepare for birthing within their social context.

The aim of this qualitative study was to identify a theory that described the processes used by urban black women to prepare for childbirth. Also explored was the social context within which these processes occurred.

Women in the last four months of pregnancy were recruited through churches, hair salons, newspapers, radio and internet web sites. Data were collected from five focus groups and two individual interviews (n=22). More than half the women reported income adequate for daily needs, were partnered or married, were employed, had at least a high school education and were younger than 23 years. Data analysis followed the grounded theory methods advocated by Strauss and Corbin (1998).

The theory describing the processes used by the participants was *weighing the impact on me*. These women actively engaged in determining the best course of action for themselves. They weighed and considered advice from others, what relationships were crucial, what information was most important to them, and many other issues. Woven throughout were the importance of relationships and the social context in which the women lived.

The processes used for birth preparation were divided into four, *discovering pregnancy*, *managing pregnancy*, *preparing for delivery*, and *experiencing personal change*. These processes were not sequential but represented the dynamic and constant need to assess and decide the best choices in preparing for childbirth. Building on this theory, future research should identify ways in which black women can more readily access the quality healthcare and services they so desire.

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Chapter 1: Introduction

Birthing in America is an event greeted with great joy that can be life changing (Davis-Floyd, 2003). Many women face childbirth with anticipation. They are eager for pregnancy to end but uncertain about approaching labor and birth. During pregnancy, preparations are made for childbirth. These preparations may include visits to healthcare providers, seeking of information from family, friends, and the media, and childbirth classes (Lowdermilk & Perry, 2004; Olds, London, Ladewig & Davidson, 2004). However, examination of the effects of these birth preparations has come primarily from studies focused on middle class white women (Davis-Floyd, 2003). Few authors have identified or included middle class black women in their samples. Instead, research with black women during pregnancy and birthing often highlights pregnancy problems in low income populations (Sawyer, 1999). Also unexamined, except tangentially, is how black women's social context impacts childbirth. There is a need to understand the process black women use within their social context, to prepare for birthing. Thus the objective of this study was to illuminate the issues affecting pregnant black women in their preparation for childbirth.

Perinatal disparities and social environment

Evidence of black women's social environment comes partially from health statistics. Despite dramatic medical advances, black women continue to experience poorer health in general than white women (Satcher et al., 2005; Williams & Jackson, 2005). Health disparities are especially marked regarding differences in pregnancy outcomes for blacks and whites. For example, in 2003, black infant mortality rates were

2.4 times that of whites (March of Dimes, 2007). As startling as this discrepancy is, these differences remain unchanged from the previous decade. Preterm black birth rates were 17.8 per 1000 live births compared to 11.3 for whites. Low birth weight (less than 2500g) was the leading cause of death for black infants, twice the rate for white infants (Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005). In regard to maternal health outcomes related to pregnancy, black women are four times more likely to die of pregnancy complications than whites (Bruce, 2002).

Figures from Texas mirror national perinatal statistics. In 2003, black infant mortality was 2.4 times that of whites (Texas Department of State Health Services (DSHS), 2007). Between 1994 and 2004, the preterm birth rate in Texas was highest for black infants (18.6%) followed by Hispanics (13.2%), Native Americans (12.6%), whites (12.3%) and Asians (11.5%) (March of Dimes, 2007).

In Travis County, black infant mortality in 2003 was 20.7 per 1000 live births compared to 6.2 for Hispanics and 4.1 for whites. Low birth weight that same year was 11.7 per 100 live births for blacks, 6.9 for Hispanics and 6.6 for whites (DSHS, 2004).

Despite two decades of research delineating factors contributing to disparities and interventions to improve them, the gap remains unchanged (Giscombé & Lobel, 2005; Smiley, 2005). Pregnant black women and their babies continue to experience greater morbidity and mortality than their white counterparts (Gennaro, 2005).

Some studies have found that social factors play a crucial role in perpetuating health disparities (Hogan, Njoroge, Durant, & Ferré, 2001; Quill & desVignes-Kendrick, 2001). The interaction of stress and racism has been identified as a social contextual factor negatively impacting birth outcomes in black women's pregnancies (Giscombé & Lobel, 2005; Hogan & Ferré, 2001). Stress and racism may likewise impact the process black women go through in preparation for giving birth. However, to date no studies have

delineated the factors which influence the processes black women use in preparing for birth. The Centers for Disease Control (CDC) urges researchers to use strategies to identify social issues and sources of stress that affect black women's pregnancies (Rowley, 2001). Rowley notes that recommendations include looking to black women themselves for the answers (Rowley).

Black women's voices

Black women have already addressed issues regarding the context in which they live. Issues around race, gender, and class have been identified as sources of inequity and stress. While they may occur individually, most often they intersect. For example, race and gender discrimination can result in lower wages. These three issues may be experienced as daily hassles or as more serious long term physical and emotional threats to stability (Banks-Wallace, 2000; Cannon, Johnson & Sims, 2005; Collins, 2004; hooks, 1995, 2000; Hudson-Weems, 2004; Jones & Shorter-Gooden, 2003; Roberts, 1997; Sawyer, 1999; Shambley-Ebron & Boyle, 2004; Taylor, 1998, 1999).

Because pregnancy is considered a time of disequilibrium physically and emotionally (Olds, London, Ladewig & Davidson, 2004), being pregnant is likely to augment the stress that black women already experience on a day to day basis. Still, black women have a history rich in the ways in which they have worked to insulate themselves against and protect themselves from a noxious environment (Cannon, Johnson & Sims, 2005; Feifer & Maher, 2003; Hudson-Weems, 2004; Jones & Shorter-Gooden, 2003; St. Jean & Feagin, 1998). Therefore, the health promotion and collective processes black women use to navigate pregnancy and prepare for birthing may reflect not only the social context in which they live but their resilience in the face of adversity. Certainly, despite living in a stressful environment, the majority of black women's pregnancies result in normal, healthy births. How black women's preparation for childbirth might mitigate the

negative influence of issues around race, gender, and class remains to be discerned. There is further need to give voice to these women and their understanding of their experiences.

STUDY PURPOSE AND DEFINITIONS

Perinatal issues in Texas

Birth outcomes and infant health outcomes in Texas are the poorest for blacks compared to other minorities and whites as documented in the Health Disparities in Texas report (Anzaldua & Sanchez, 2002). The report adds that black neonatal and infant mortality rates are twice those of all other infants born in Texas. Furthermore, those with the greatest health disparities experience a number of problems in accessing care. The report goes on to state that personal barriers such as lack of health insurance (28% for blacks) and transportation are significant. Geographic barriers include lack of physicians, medical infrastructure, and services to inner city areas. Inner city urban areas are where black segregation occurs and where the greatest numbers of impoverished and low income populations reside. Additionally, there are 100 counties in Texas that have no services for pregnant women. The State of Texas Children report (McCown and Deviney, 2005) notes that consequently 28% of black women receive little or no prenatal care. This is greater than the 2000 to 2002 national average of 18.7% for blacks, 17.6% for Hispanics, 10.7% for Asians, and 7.6% for whites.

Social context of pregnancy

Locally, the black population in Travis County is listed as 9% of the total population (United States Census Bureau, 2006). While this number is smaller than the state and national averages of 13%, the Austin black community confronts many of the same issues faced by blacks elsewhere. These issues are outlined in the, “City of Austin

Study of the Quality of Life for African Americans" (2005). The report uses census data as well as information gleaned from community forums to examine ten measures, both direct and indirect, of quality of life. Using Census data, the report notes that locally, blacks with college degrees are 19% compared to 40% for the rest of Austin, earn half what whites do (one of the highest disparities in the nation), and are homeowners 37%, compared to the Austin average of 45%. Census data has been supplemented with feedback from blacks in Austin using a community forum format. Six discussion groups, were facilitated using a hired consultant. Each forum included eight to 12 panelists for a standing room only audience. In all, 60 panelists participated as well as 700 audience members. The global question posed was, "Do African Americans experience challenges different from others in Austin?" The "overwhelming" response was "yes." Thus one of the conclusions of the Quality of Life Report is that for Austin blacks, "The cost of inequality in this community manifests itself in an unequal education system, a lack of affordable housing, and a lack of employment opportunities – which themselves result in even further social alienation and isolation" (p. 3).

Health recommendations advanced by the Austin Quality of Life report include improving access to primary and preventive care. Also suggested is to simplify eligibility for public assistance programs. Recruitment of black health professionals, including nurses, is likewise advocated by the report. Other health measures proposed in the report are: develop disease prevention education; increase access to local hospital services; increase access to mental health programs; target health disparities; and increase the number of neighborhood screening programs.

Implications of this report for pregnant black women living in Austin are several. First, they may have fewer financial, educational, and transportation resources during pregnancy than other pregnant women. Second, they may not have access to healthcare

services and providers who understand their issues and concerns. Third, they may not have access to hospital services targeting pregnant women. Fourth, they may experience acute stress in the form of daily hassles or chronic long term stress as a result of unequal treatment. How pregnant black women respond to these challenges may depend on status (SES) as well as other factors that may influence the processes used to prepare for birth. Thus, the purpose of this study was to elucidate the basic social processes black women in an urban southwestern community use to prepare for childbirth.

DEFINITIONS

Childbirth preparation

Childbirth preparation denotes those activities that pregnant women actively undertake to ready themselves for the delivery of their infant. These activities may differ from person to person and may be influenced by the social context in which pregnancy occurs. Most often it first involves the seeking of prenatal care. It also includes, but is not limited to, obtaining birthing information and support from: verbal discussions with family, friends, and healthcare providers; interaction with other pregnant women; acquired written materials such a books, pamphlets, and popular magazines; multimedia sources such as television, the internet, and audiovisual materials; and attendance at prenatal, childbirth or other classes which offer physical or emotional preparedness for childbirth.

Black women

This term is often used interchangeably with the term African American. However, in this paper, the term black is preferred because it is more comprehensive; many persons of color identify themselves as black instead of African American (Johnson & Staples, 2005).

BACKGROUND

Childbirth preparation

Pregnancy and birth are developmental milestones in adulthood (Lowdermilk & Perry, 2004). During pregnancy leading up to labor, mothers are concerned with safety for themselves and their babies (Rubin, 1975). One way of maintaining safety is to be informed about the birthing process and to participate in decision making surrounding this event (Sleutel, 2002). Lederman (1996), in studies of stress and anxiety in pregnancy, emphasized social support, education, and other activities to help prepare women for childbirth. How well a woman prepares during pregnancy for delivery and motherhood can ultimately influence the woman's identity and her becoming a mother (Mercer, 2004; Mercer & Walker, 2006).

Benefits

Preparation for childbirth has long been recognized as having many benefits for childbearing women (Haire, 1999). These benefits include increased knowledge and acquisition of skills for coping with labor (Schott, 2003), reduced anxiety about birthing (Bechelmayr, 1995; Hibbard, Robinson, Pearson, Rosen, & Taylor, 1979) and promotion of a positive birth experience (Zwelling, 1996). Also identified as desirable outcomes are increased health promotion behaviors (Jackson, 1995), and the use of fewer medications in labor (Bradley & Schira, 1995). If childbirth classes are taken, an added benefit is an opportunity to form supportive and long term networks (Schott, 2003; Spiby, Henderson, Slade, Escott, & Fraser, 1999). In a position paper, the International Childbirth Education Association (2003) reaffirms its philosophy that childbirth educators are important sources of information, support, and skills for parents in preparation for labor, birth and parenting.

Variety in preparation

Historically, preparation for childbirth and parenting were imparted through the personal wisdom of mothers and female relatives (Lowdermilk & Perry, 2004; Nolan, 1997). Lay black "grannies" as midwives played an important role not only in the birthing of African American babies but in passing on experiential and health promoting knowledge (Lee, 1996). Beginning in the early 1900's, birthing moved out of the home environment and into hospitals. Physicians took the place of midwives. Subsequently, medicated births became the norm with less emphasis on childbirth preparation. A resurgence of interest in unmedicated, natural childbirth began in the 1950's. There followed consumer interest in formalized childbirth classes (Lowdermilk & Perry). Attendance at childbirth classes has become the norm for middle class pregnant mothers (Nichols & Humenick, 2000).

While childbirth classes are varied in content, venue and format (Maestes, 2003; Schott, 2003), formal educational preparation for birthing is almost universally taught sometime in the third trimester, which encompasses the last three months of pregnancy. Increasing the proportion of pregnant women who attend formal childbirth classes was first identified as a goal in the 1989 document "Caring for our future: The content of prenatal care." This document produced by the Public Health Service, became the gold standard for prenatal care in the United States. Since then, Healthy People 2010 and the World Health Organization (Chalmers, Mangiaterra, & Porter, 2001) have included this objective. Additionally, both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2002) as well as others (Gagnon, 2005; International Childbirth Education Association, 2003; Spiby, Henderson, Slade, Escott & Fraser, 1999; Zwelling & Phillips, 2001) have promoted attendance at childbirth classes.

Despite the importance given to childbirth classes (Hart, 2000), there is practically no data regarding utilization rates by race or ethnicity (Lu et al., 2003).

In a broad context, preparation for childbirth can occur in a variety of ways. It can occur informally through the experience of family and friends. It can also occur formally via healthcare providers or organized classes. There is no scientific evidence that one form of childbirth preparation is superior to another (Lowdermilk & Perry, 2004). Pregnant black women, as others, may use a variety of ways to prepare for childbirth. Whether or not black women feel they have the same options for birth preparation, such as childbirth classes, has not been determined. What influence black women's social circumstances have on the process of birth preparation also remains to be explored.

Social context

The health of black women is closely tied to the social context in which they live. While access to professional healthcare may be limited, black women may have other resources. Many expectant women look to their extended family for health advice and support. Beyond blood relatives, there is kinship encompassing a network of close friends who function to provide services, financial help, emotional support and assistance in solving problems. Thus there is a strong sense of caring for one another that sustains black families through crises and day to day living (Leininger & McFarland, 2002, chap.17).

Religion may also influence healthcare beliefs and practices of black women. While there is diversity of religious faiths, belief in a higher power often influences all aspects of life including health. Places of worship can offer spiritual encouragement, additional networks of support, and physical resources in times of need (Leininger & McFarland, 2002, chap.17).

Effect of racism

One of the major overriding issues for black women in the United States is racism. While American society purportedly proffers the same opportunities and equal treatment for all its citizens, paradoxically, it creates an opposite reality for many black women. This reality is filled with repeated encounters in which black women are treated based on historical and present day stereotypes. Stereotypes and myths convey negative images that serve to disempower and marginalize black women (Collins, 2004; Shambley-Ebron & Boyle, 2004; Taylor, 1998, 1999; Yancy, 2000). Racism is multifaceted and can be experienced both overtly and covertly. Racism is best represented as being on a continuum where overt racism is at one end while covert racism is at the other end of the spectrum (Jones & Shorter-Gooden, 2003).

Racism also isolates black women physically, by steering them towards segregated and hypersegregated communities which are asset poor, resource depleted, educationally inferior, and lacking in public transportation (Massey & Denton, 2003). Physical isolation is inevitably social isolation (Smelser, Wilson, & Mitchell, 2001). Williams and Collins (2001) add that segregation is a fundamental reason for racial disparities in health. These environments are often unhealthy and unsafe (Silbergeld & Patrick, 2005; Taylor, 2005). Only 2% of blacks live in the suburbs according to Massey and Denton. These existing conditions challenge black women to succeed while acknowledging potential negative consequences of living in such an environment. Living in a racist environment can result in chronic stress with subsequent adverse health outcomes for women. This is especially speculated to be true for pregnancy (Lu & Halfon, 2003). How this influences childbirth preparation, if at all, is unknown.

Effect of gender bias

Gender bias, during pregnancy, as at other times, is also a concern. Black women may experience "double jeopardy." They may feel discriminated against in the workplace because of their gender as well as their race. They may be physically or verbally harassed but not complain for fear of losing their jobs (St. Jean & Feagin, 1998). Furthermore, healthcare providers may dismiss their concerns and only offer options based on perceived stereotypes (Brown et al. 2003; Smedley, Stith, & Nelson, 2003). Likewise, male partners may be uncaring and insensitive to the needs of pregnant black women. Thus sexism like racism may result in psychological stress during pregnancy as at other times. This may affect the choices black women make during pregnancy and the social processes they use in preparing for the birthing experience.

Effect of socioeconomic status

The role of SES of blacks in American society has been discussed by numerous authors (Brown et al., 2003; Massey & Denton, 3002; Johnson & Staples, 2005; McAdoo, 2007; McKinnon & Bennett, 2005; St. Jean & Feagin, 1998; Satcher et al., 2005). While two thirds of blacks are middle class, low SES blacks are overrepresented in America, compared to other racial groups (McKinnon & Bennett). These differences in SES result in differences in general health outcomes (Williams & Jackson, 2005). In pregnancy, lower SES is likewise implicated in part by poorer outcomes (Gennaro (2005). Several authors have reviewed studies which show that differences in SES do not wholly explain the marked perinatal disparities between black and white women (Gennaro; Giscombé & Lobel 2005; Hogan, Njoroge, Durant, & Ferré, 2001). These authors point to research which shows that college educated black women still have disproportionately worse pregnancy outcomes compared to whites. Yet lower SES may be one of the factors contributing to stress experienced by some black women.

Racism and healthcare

The literature is replete with the multiple ways in which blacks have experienced racism and discrimination in healthcare (Krieger, Smith, Naishadham, Hartman & Barbeau, 2005). The history of racism in healthcare of blacks has been well-documented and continues to occur on a number of different levels. First, segregation determines the kind of available healthcare facilities. In a review of the literature, Smith (2005) outlines how prior to the civil rights movement, African Americans were prevented from getting services at white hospitals, were relegated to segregated wards, or denied service altogether. With the Civil Rights Act of 1964, federal dollars were prohibited from being used to fund programs or institutions that practiced discrimination. Today, while hospitals themselves do not have segregated areas, there is de facto segregation. Some hospitals have moved to more affluent white suburban areas and out of predominantly black urban areas. The effect has been to augment high risk services to the more affluent, and profitable suburbs. Smith concludes that the result has been to increase segregation and health disparities and the cost of special services in already segregated black areas. Smith also notes that primary care continues to be even more separate and unequal than hospital care. Thus African Americans have reduced levels of access to and use of healthcare services (Weinick, Zuvekas, & Cohen, 2000).

Besides segregation of healthcare infrastructure, there is also inequity in care. Congress, worried by reports of health disparities, requested an Institute of Medicine (IOM) report assessing kinds and quality of healthcare (Smedley, Stith & Nelson, 2003). The IOM report showed that blacks receive poorer quality of care in the emergency room and when being treated for a variety of health conditions including heart disease and cancer. In reviewing numerous health studies, Satcher, former Surgeon General, concluded that while blacks are overrepresented in diseases of hypertension, stroke, heart

disease, diabetes, HIV and AIDS, cancer, and asthma, they are less likely to be offered needed treatment in a timely manner and are more likely to die (Smiley, 2006). Williams and Jackson (2005) added, "Racial differences in the quality and intensity of treatment persist after SES, insurance status, patient preference, severity of disease, and coexisting medical conditions are taken into account" (p.329). Poor blacks most often live in neighborhoods where they are offered fewer medical procedures and inferior care (Baicker, Chandra, Skinner & Wennberg, 2004). Furthermore, physicians in poorer areas are more likely to be less highly trained with limited ability to provide needed referrals (Bach, Phan, Schrag, Tate & Hargraves, 2004) and advocate for their clients (Rosenbaum, 2002). The implications for black women are that they may experience more health problems during pregnancy and childbirth and yet have less access to healthcare facilities and quality care compared to whites. During pregnancy, women are encouraged to engage in protective and health promotion activities in preparation for childbirth. Whether or not racism and discrimination in healthcare provision influence black women's childbirth preparation, however, has not been a focus of the literature.

Differential treatment in pregnancy

Disparities by race and ethnicity of prenatal care content were studied by Gavin, Adams, Hartmann, Benedict, & Chireau (2004) in a group of Medicaid clients in four states, including Texas. Blacks were more likely to have started prenatal care later, had no prenatal care, or had inadequate prenatal care. Likewise, vitamin prescriptions were less likely to have been filled. Diagnostic and screening tests such as maternal alpha fetoprotein, ultrasound, and complete blood counts, were ordered later in pregnancy and significantly less often. More frequently ordered were tests for diseases related to high risk behaviors. The authors suggest that, while patient factors may have contributed to the study's findings, racial profiling was also a possible explanation. Bias, stereotyping, and

prejudice are known to exist in general healthcare delivery (Smedley, Stith, & Nelson, 2003; Bettancourt & Maina, 2004).

The presence of racism in healthcare may be one of the factors which have a deleterious effect on pregnant black women as they prepare for childbirth. It may mean healthcare practitioners are not highly trained or practice in settings where healthcare choices are limited. A racist healthcare system may also mean that pregnant black women must constantly confront racial stereotypes from those providing care. Health promotion during pregnancy is also affected. Segregated neighborhoods have few store offerings of fresh fruits and vegetables, limited opportunities for daily exercise, and higher levels of violence and environmental toxins (Williams and Collins, 2004; Smiley, 2006). For poor black women additional stress may come from being unable to access quality healthcare and the resources needed to engage in health promotion during pregnancy. The cumulative stress of living in such an environment is already speculated to be partially responsible for perinatal health disparities (Hogan & Ferré, 2001). How this impacts the process of preparation for childbirth needs to be studied.

SIGNIFICANCE TO NURSING

Nurses play a significant role in childbirth preparation. They interact with pregnant women, their partners and families throughout pregnancy and childbirth. Assisting childbearing couples to be mentally, physically, and emotionally ready for birth during the prenatal period is an integral part of the nurse's role. Also important is nursing assessment of the pregnant woman's knowledge about the birthing process, and provision of medical information as needed (Lowdermilk & Perry, 2004; Olds, London, Ladewig & Davidson, 2004). Nurses likewise evaluate and support the health promoting behaviors important in preparing women for birthing. Mental preparedness involves promoting a sense of confidence in approaching childbirth and anticipatory guidance about hospital

birthing (Enkin et al., 2000). Nurses may lead childbirth classes or be responsible for curricula (Schott, 2003). Finally, and most importantly, discussion of social support available to the pregnant woman during childbirth is a topic nurses should explore (Hardin & Buckner, 2004).

Nurses' awareness of health disparities

Familiarity with the social environment of pregnant black women may not be part of some nurses' consciousness. Therefore, some nurses may be unaware of the stress black women experience as the result of discrimination based on race, gender and SES and resultant barriers to care. Nurses may also be oblivious to stereotypes and covert discrimination they themselves use in dispensing unequal treatment to pregnant black women.

A 2005 survey entitled "Americans' Views of Disparities in Healthcare" (Robert Wood Johnson Foundation) examined the extent to which Americans are aware of health disparities. College-educated whites, which include nurses, were more likely to be aware of health disparities. Still, 64% of Americans thought that African Americans receive the same quality of physician medical treatment as whites. However, 23% of African Americans reported receiving poor quality medical care because of their race compared to one percent of whites. When hospitalized, only 36% of African Americans felt they received the same quality of healthcare as whites. Also, a majority (74%) of African Americans expected physicians to understand their personal cultural background.

Nurses as part of broader American society have contributed to disparities in healthcare by administering unequal treatment. A large nursing organization has acknowledged discrimination and racism in nursing. "The American Nurses Association (ANA) is committed to working toward the eradication of discrimination and racism in the profession of nursing, in the education of nurses, in the practice of nursing, as well as

in the organizations in which nurses work" (ANA, 1998). Porter and Barbee (2004) recommend conducting nursing research on racism in clinical and practice settings to help in the elimination of racial and ethnic health disparities. "Nurses, in order to actively participate in eliminating disparities, must consider critically the issue of how race and racism within the broader contexts of power relations and social inequality influence the quality of their services" (p.11).

Nurses may have minimal awareness of their role in maintaining black/white perinatal health disparities and unequal treatment. This lack of awareness likely includes minimal awareness of the significant contributions culture plays in preparation for childbirth for pregnant black women. Additionally, nurses may be uninformed about coping strategies and resources black women use to prepare themselves for birthing. Thus, studying the process of childbirth preparation in black women will lead to a better understanding of the issues black women face, their impact on preparedness for birthing, and the nurse's expected role. An essential outcome of this research may be the discernment of nursing practices which need to change to better serve this pregnant population.

SPECIFIC AIMS AND GOALS

The commitment of health professionals to close the perinatal disparities gap has not produced research focused on black women. Whether or not living in a stressful environment influences black women's preparation for childbirth has likewise not been reported. Therefore, the goal of this study was to uncover the basic social processes urban black women use to prepare for childbirth. Since most black women are middle class, it was hoped they would be well represented in the sample. Grounded Theory (GT) methodology was specifically selected for this study because it allowed the voices of black women to lead the study findings.

Grounded theory methodology concentrates effort on the process of generating theory versus theoretical content (Denzin & Lincoln, 2005; Patton, 2002; Strauss & Corbin, 1998). As with any theory, theory generated through GT methods must convey concepts and the ways in which they are interrelated (Creswell, 1998). For Strauss and Corbin, GT is theory related to a particular phenomenon. In this study, the phenomenon under consideration was childbirth preparation. Dey (1999) states that the hallmark of GT is that it uses interactionist methodology. "Hence grounded theory is oriented to explicating 'basic social processes' in dynamic terms- or, to put it crudely, how actions have consequences" (p. 63). Patton (2002) adds that GT is ideal for researching questions related to process.

The objective of this study was to understand the processes used by pregnant black women in their preparation for childbirth and to develop a theoretical framework. Qualitative methods are appropriate for investigating and understanding the experiences of people (Strauss & Corbin 1998). Strauss and Corbin explicate further by saying qualitative methods "can be used to obtain the intricate details about phenomenon such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods" (p.11). Thus, qualitative methods and specifically GT methodology provided the best direction for accomplishing the goal of understanding the processes of birth preparation as seen through the eyes of pregnant black women. The specific aims of this study were to 1) describe the processes used by urban black women in preparation for birth and 2) develop a theory that explains this phenomenon.

Focus group sessions and two interviews were the tools of data collection. A systematic approach to the analysis allowed for constant comparison of the data generated. Ultimately, a theory emerged from the data to describe similarities in the

process of childbirth preparation used by a group of black women living in an urban southwestern city.

ASSUMPTIONS

The perinatal health disparities between blacks and whites are a reflection of the social environment in which black women live. That not all black women experience poor birth outcomes may be related to an adaptation by these women to their environment and an ability to overcome adversity. It may also be related to other factors such as differences in socioeconomic status. What these processes are, how they unfold, and their impact on preparing for the birth experience is of importance to nurses. By understanding the childbirth preparation processes black women use, nurses can better augment those processes and support black women in the continuing effort to improve disparities in pregnancy outcomes.

The assumptions of this study were:

1. Pregnant black women engage in preparation for childbirth.
2. Birth preparation occurs in an environment where black women may experience discrimination.
3. The use of grounded theory methodology is appropriate for discovering the processes used by black women to prepare for childbirth.
4. Black women are willing to share their childbirth preparation experiences with other black women. They are also willing to share their experience with white women who are sensitive to their life experiences.

LIMITATIONS

Studies undertaken using qualitative methods have certain confines. One of these constraints is the possibility that the researcher might misinterpret the data during

analysis. Denzin and Lincoln (2005) note that describing what is happening and how it occurs is far different from explaining why it transpires, "… the question of why things happen the way they do can lead to inferential leaps and empirical speculations that propel qualitative analysis far from its stock-in-trade" (p.499).

Subjectivity is a second restriction of qualitative research and may be unconsciously present in participants or researchers. All individuals are products of their cultures and as such bring biases, beliefs and assumptions to the research study (Strauss & Corbin, 1998). Strauss and Corbin caution that participants may relate some but not all of their experiences because of emotionality attached to the topic or experience. Likewise, memory of experiences or events may be incomplete. Furthermore, respondents may reply in a socially desirable manner. Researchers also have their own biases which will influence results of a study. Denzin & Lincoln (2005) state, "Thus our theoretical analyses are interpretive renderings of a reality, not objective reportings of it" (p.510).

While not a limitation, findings of a purposeful study population are not meant to be generalized. Instead, the data are representative of the study participants only. Study results are specific to a certain group of individuals under specific conditions at a certain point in time (Creswell, 2003).

SUMMARY

This study examined the birth preparation processes used by urban black women in a southwestern city. Grounded theory methodology was employed as the most suitable qualitative method for studying this research population. The results of the study were used to generate a theory which describes the process urban black women use as they move through pregnancy in preparation for birthing their child.

Nurses and childbirth educators should be guided by practices that are evidenced based. Because research findings can guide nursing practice, there must be a partnership between researchers and practitioners (Rosswurm & Larrabee, 1999). Results from this current study identified that nurses can help or hinder the childbirth preparation process by the way in which they interact and dialogue with pregnant black women. In particular, understanding the social context in which black women live and its influence on childbirth preparation broadens the perspective of perinatal nurses and providers of childbirth information and education.

Finally, it is believed that this research provided a vehicle through which black women could tell their stories and bring to consciousness the issues that most impacted their childbirth preparation. Awareness of these issues is important for healthcare recipients as well as healthcare providers. Without the voices of these women, finding solutions to disparate and unequal perinatal care is incomplete.

Chapter 2: Literature Review

INTRODUCTION

Whether or not a literature review is appropriate to grounded theory methodology has been disputed. Creswell (2003) argues that qualitative research can use literature reviews in one of three ways: 1) in the introduction as background to the need for the study; 2) in a separate section emphasizing a review of theory oriented studies; or 3) at the end to compare and contrast themes in the literature with findings in a study. Because grounded theory uses a comparative method of data analysis, Creswell notes that most often the literature review is presented at the end of a study. However, Glaser and Strauss (1967) in their early development of grounded theory cautioned against having any presumptions based on prior theoretical knowledge when approaching a grounded theory study. "An effective strategy is, at first literally to ignore the literature and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas" (p.46).

Strauss and Corbin (1998) more recently acknowledge that researchers bring to their work a wealth of experiential and literature based knowledge. The need then is to allow for this knowledge to augment and not limit theory development. Strauss and Corbin argue that the literature, while not needing to be comprehensive, can sensitize the researcher as to what questions might need to be asked of participants, what to look for in the data, areas for theoretical sampling, and ways of extending an already existing theory. Dey (1999) adds that sensitivity to published theories can help the researcher to "develop categories and then relate them" (p.4).

All grounded theorists would agree that a literature review should not bias the direction in which researchers are to go. Rather, there should be an immersion in the data

such that an inductive theory emerges. Thus, the literature review for this study functioned as a way of providing background and as a sensitizing framework. The review also identified gaps in our knowledge and affirmed the need for this study.

CONCEPTUAL ORIENTATION

Becoming a mother (BAM) and acquiring the maternal role has been the subject of much research. While the focus has been on explaining the ways in which women take on the mothering role, the theoretical frameworks proposed are also applicable to preparation for childbirth. Preparing for childbirth and BAM both involve processes that are influenced by intervening factors. The three best known theorists in this area are Rubin, Lederman, and Mercer.

Rubin

Rubin (1984) proposed that maternal role attainment (MRA) involves maternal tasks. The first of these is ensuring "safe passage" for self and baby throughout pregnancy and childbirth. To guarantee safe passage, mothers work to obtain knowledge of what to expect and how to cope with pregnancy and childbirth. The second maternal task is "acceptance by others." Here Rubin discusses the importance of family acceptance of the pregnancy. Inherent is conceding that pregnancy can also stress family relationships which are usually supportive. The third task "binding-in to the child," Rubin sees as the mother's awareness that she is carrying a live child. Finally, "giving of oneself" is the task in which mothers understand the physical and psychosocial demands required for the unborn child. All tasks are seen as being addressed simultaneously throughout pregnancy. Because women's experience of labor and delivery was far different during Rubin's time than today, her theories did not address the intrapartum period (Gay, Edgil, & Douglas, 1988).

Lederman

Lederman (1984) situates the development of the motherhood role in the psychosocial changes of pregnancy. As part of this process, mothers prepare to be a mother by imagining themselves with a child. This is done through "fantasy" and "dreams," allowing the mother to prepare for the trials of childbirth and motherhood. How well this preparation proceeds depends on "life experiences" including viewing other women, especially their own mothers, as positive role models. "Conflict resolution" of psychological tension experienced by the pregnant women is seen by Lederman as necessary in order to feel confident and prepared for the task ahead. Often this includes overcoming fears about labor such as helplessness, loss of control, pain, and loss of self -esteem. "Maternal attachment behavior" indicates maternal awareness of the child to be before birth, and nurturance and protection of the child after birth.

Mercer

Mercer (2004) argues against using the term MRA and instead for BAM. She states, "Women's descriptions of the life-transforming experience in becoming a mother with the concomitant growth, development, and new self-definition are not adequately encompassed in MRA terminology" (p. 231). In a review of the research, Mercer (2006) identifies four stages in BAM. Only the first occurs prior to childbirth. The mother works towards maintaining a healthy pregnancy, seeking and enlisting family support, and making preparations for the baby. The second, third and fourth stages take place after birth and involve learning to care for the infant, establishing normalcy, and achieving a maternal identity.

SIMILARITIES IN FRAMEWORKS

It is possible to identify commonalities inherent in these three frameworks which apply to childbirth preparation. First, the ways in which mothers approach mothering and birthing can be seen as a process. This may not be a linear progression but rather one in which pregnant women move back and forth through the process as they imagine or are confronted with situations that need to be physically or psychosocially accommodated. For example, Rubin's (1984) maternal tasks, Lederman's (1984) psychosocial changes and Mercer's (2006) four stages of "becoming a mother" all identify a process which is in constant flux. This suggests that the process of preparing for birth is also a fluctuating process. As pregnant women negotiate new information, work through physical and emotional changes, or resolve conflicts, they may progress or have setbacks in their preparation for birthing. All three theorists further discuss factors which potentially restrict or enhance this process.

Central to the process of BAM or preparing for birthing is a search by pregnant women for discernment about what they are to do. This is a second commonality between Rubin, Lederman and Mercer. Rubin (1984), Lederman (1984) and Mercer (2006) discuss how mothers search for women who have been in the same role who they can copy or mimic. Pregnant women mostly look to their own mothers. Rubin emphasizes that even with past experience women seek to refine their understanding of their role. Mercer (2006) identifies women's social contacts as giving direction to pregnant women. Mercer, Rubin and Lederman view fantasy and dreams as other ways pregnant women try out or imagine their responses to various situations. Mercer (2006) notes that attendance at prenatal classes is often a way of gathering information and interacting with other pregnant women. Regardless of how it occurs, Rubin, Lederman and Mercer say pregnant women search for insight about the ways they are to conduct themselves, as a mother, or

by extension as a woman in labor. Thus, the degree to which women are satisfied with their understanding of what they are to do in labor can influence birth preparation.

Besides a search for information, women's preparation for mothering or childbirth is impacted by their social environment. Lederman (1984) and Rubin (1984) believe that the quality of the relationship women have with their own mothers is important. In Lederman's research, when this relationship was positive it was associated with less fear about labor and birth. When a pregnant woman's own mother cannot be a source of information or affirmation, there is a greater need to look elsewhere. Mercer (2006) notes however, that a pregnant woman's intimate circle of family and friends may be a source of support or stress. From these people, family values and cultural expectations are imparted. Mercer locates family and friends within the larger community that provides services such as healthcare, protection, and employment. This community is then positioned within society at large. Whether or not a woman's social setting provides physical, emotional and financial support during pregnancy will influence her preparation for childbirth. Consequently, interactions between a pregnant woman, her family, community, healthcare providers, and larger society will influence birth preparation.

A third factor in the process of preparation as seen by Rubin (1984), Lederman (1984) and Mercer (1984) is each woman's intrinsic characteristics. Lederman found that feelings of preparedness for childbirth were low when women had excessive fear and ambivalence towards birth. Mercer identified many personal variables in BAM including age, self concept, self assurance, depression and anxiety.

In a review of the literature pertaining to childbirth preparation, most studies appear to address three themes espoused by Rubin (1984), Lederman (1984), and Mercer(1984). That is, most of the literature pertains to acquisition of information or knowledge, social support systems, or personal characteristics, all of which influence the

experience of pregnancy and thus the process of preparation for birthing. A review of the literature follows.

ACQUISITION OF KNOWLEDGE

Knowledge needed for birth preparation as reported in the literature and reviewed below, is acquired from several and sometimes opposing sources. The first is what is learned from informal sources and includes family members, friends and acquaintances within the social sphere of the pregnant woman. A second sometimes contradictory source, is formal sources of information from healthcare professionals, published materials, or formal education classes. Women's own intuition or personal knowledge can be a third source of knowledge. Pregnant women may access multiple sources of information yet give deference to one kind of information over another. Furthermore, they may be confused by the various sources of information and need help ascertaining what is important to know.

Formal versus informal sources

Davis-Floyd (2003), anthropologist, public advocate for non medicalized birth, and co-founder of the Coalition for improving Maternity Services, has written extensively about birthing. In a qualitative study of 100 women, all well-educated, middle class, and white, first time mothers reported being panicked "at their near-total lack of knowledge about birthing and babies" (p.31). Thus a search for knowledge was a major theme in these pregnancies. Knowledge most valued was intellectual and scientific in nature. Less valued was "intuitive, emotional or bodily knowledge" (p.31). Because it was perceived that physicians sometimes withheld birth information, these women turned to books and formalized childbirth education for information. Close bonds with other pregnant women, sometimes strangers, created a community where women helped each other prepare for

birth by sharing knowledge through personal stories. This was especially evident during baby showers where information was shared and social support received. While Davis-Floyd's work is internationally recognized, it cannot be generalized to groups outside her sample, such as those marginalized, in different social environments, or without access to formalized classes.

Savage's (2006) phenomenological study also explored the ways first time mothers learned about labor and birth preparation. The sample of nine women, two of whom were black and seven Caucasian, ranged in education from 11th grade to a masters degree. There were no differences in responses based on race/ethnicity. Five had attended prenatal classes. None, even those espousing natural birth, were confident of their own intuition about birth as a source of knowledge. Instead they looked to their own mothers for information and help. With the realization that friends, family, and healthcare providers were withholding important childbirth information, the women felt let down. Also, knowledge participants gained about birth preparation from other women often conflicted with that of healthcare providers. Most helpful in deciphering birth preparation information deemed important were other women's birth stories. While mothers and obstetricians were the most frequent sources of information, also used were the internet, books, childbirth classes, family, and friends. Cited barriers to learning were embarrassment, financial limitations, and lack of technical skills.

In a review of three decades of childbearing information books, Pincus (2000) found that one ideology celebrated women's inner knowledge in knowing how to prepare for normal birth, while the other ideology viewed physicians as the experts whose knowledge was necessary for medical interventions to prevent complications. Alternatively, Zwelling and Phillips (2001), in espousing family-centered maternity care, emphasized the family's role in providing "education about childbirth and parenting that

empowers childbearing families" (p.5). Unaddressed by these authors was inclusion of the perspectives of pregnant black women.

Multiple sources

Engaged mothering was a process identified by Sawyer (1999) in the grounded theory study of 17 first time mostly married, employed, college-educated middle class blacks. Participants were interviewed about their experiences of pregnancy and motherhood. Engaged mothering signified the active involvement of these women in preparing for birth and motherhood. This process included active participation in birth preparation through taking multiple classes; reading of books, pamphlets, and newsletters; sorting through advice from multiple sources; and observing other parents. All the women related experiences during pregnancy in which negative assumptions or stereotypes were made about them. Despite negative incidents, all participants exhibited a strong sense of self-assurance and a positive view of motherhood. The women also shared that having a baby was a great joy in their lives. The four stages used in preparing for motherhood were: getting ready, dealing with the reality, settling in, and dreaming. Women moved through the stages differently, each at her own pace.

Sifting of information

Svensson, Barclay, and Cooke (2006) in a longitudinal, multiple methods Australian study also reported ways expectant couples acquire birthing knowledge. The sample included 205 couples of Anglo descent, educated, employed, and 26 to 34 years of age. Through in-depth interviews and focus groups, participants discussed the dilemma of having access to voluminous amounts of information but wanting current, accurate, reliable, and trustworthy information. Sometimes this information was acquired from strangers or by watching and learning from others. Couples differed in the amount of

information and support they sought. Some were partial to the reassurance offered by their own mothers while others were conflicted by their mother's advice. Other reliable sources of information and support came from peers or professionals. Antenatal classes attended by all were described as essential in offering birthing information and opportunities to interact with other couples who could clarify information already acquired. Especially valued was shared experiential knowledge. Researchers concluded that social support was a much valued aspect of classes. This study affirms previous ones that highlight the need for multiple sources of information. It also suggests that information acquisition may not be as important as the opportunity to socialize with other pregnant women.

National surveys

"Listening to Mothers I" (Declercq, Sakala, Corry, Applebaum, & Risher, 2002) was the first national United States (U.S.) survey of women's childbearing experiences. Participants' attitudes, feelings and knowledge about childbearing were elicited. Of 1583 U.S. women, blacks represented 9% of the weighted sample. Using phone interviews and online surveys, 70% of first time mothers reported taking childbirth education classes compared to 19% of repeat mothers. Of these women, 88% attended classes at a hospital site or the provider's office. Fewer women took classes at home (4%) or at a community site (7%). Unreported was class attendance by race, ethnicity, income level and other demographic variables.

A follow up survey (Declercq, Sakala, Corry, & Applebaum, 2006) enrolled 1573 mothers from the previous 2002 study. Of those participants surveyed, 56% had at least some college while 48% earned at least $50,000. Previous topics were explored in more depth as well as newer topics. Sources of childbirth information were more clearly identified in this second survey. Again the data was weighted to create a sample

representative of the national childbearing population, with black women representing 9%. Less important in this study was the role childbirth classes played. First time mothers identified books (33%), friends and relatives (19%), providers (18%), and the internet (16%) as the most important sources of information about pregnancy and childbirth. Repeat mothers depended on their own prior experiences, healthcare providers, the internet, and books. The number of new mothers who took childbirth classes dropped from the previous study to 56% compared to 9% for experienced mothers. Where classes were taken remained unchanged. The most common reasons for attendance were an interest in labor and birth information, preparation for natural birthing, and recommendation of caregiver. Only 11% saw childbirth education classes as a routine part of pregnancy. Mothers stated that classes provided them with a better understanding of care options, more confidence in their ability to give birth, better communication with their caregiver, greater trust in the hospital, less fear of medical interventions, and greater trust in their caregiver. Still, 14% were more afraid to give birth after taking classes. Mothers who watched childbirth through TV shows (68%) said the shows helped excite them and inform them about what it would be like to give birth.

By the end of pregnancy, most women (71%) were confident but at the same time fearful (53%) or felt unprepared (24%) about approaching birth. As expected, first time mothers were less confident, more fearful, and felt more unprepared than multiparous mothers. No significant differences by race or ethnicity were found for confidence as labor approaches and the internet as the most important information source. This study however, was the first to report that expectant black non-Hispanic women (60%) were more likely to take childbirth classes compared to whites (58%) and Hispanics (51%). Compared to all groups, statistically significant was that black women were the least overwhelmed when giving birth, wanted no medical interference unless necessary, most

likely to have a cesarean, and least likely to rate maternity care as good or excellent. More than whites but less than Hispanics, black women used the internet to search for birth information, but it was not their most important source. The widely available written and audio visual resources available to pregnant women may help to explain why so few women saw childbirth classes as a routine part of prenatal care and why nationally there is less attendance at classes. Yet, it was black women who attended the most and were the most accepting of the birthing process.

A special program

Schaffer (2002) described development of a childbirth program for women with special needs who were teens, drug abusers, victims of domestic violence, or contemplating adoption. The goal of the women's physicians and hospital-based childbirth educators was to increase attendance at childbirth classes. Surveys of physicians and pregnant patients identified barriers to patient participation as lack of transportation and child care, a feeling of intimidation by the hospital environment, and cost of classes. By addressing barriers, providing incentives and including content the women felt was important, attendance at prenatal classes increased. Attending women agreed that preparation for birth and parenthood was an important aspect of prenatal care. While statistical information about this project include race was not reported, results of the study suggest that when programs are tailored to their audiences, even pregnant women on the periphery of society want childbirth preparation information.

Unimportance of income level in preparation

Johnson-Robledo (1998) investigated the relationship between income and types and levels of childbirth preparation utilized by women, and the relationship between preparation and evaluation of the labor and delivery experience. Forty-five primiparous

women were recruited from healthcare facilities and childbirth education classes and asked to complete surveys for this correlation study. While the sample was evenly divided between high and low income women, 87% were European American and 9% black. Results indicated that lower income women and higher income women both prepared for birth using formal (childbirth classes and provider information) and informal (books and family) information. Overall, levels of preparation were associated with higher levels of both formal and informal preparation and a more positive labor and delivery evaluation. Although lower level income women were less likely to attend childbirth classes, they did not report lower levels of informal, formal, and overall preparedness. Because four black women, three of whom were low income, were the only blacks in this sample, no generalizations can be made about their experiences. However, the results echo other studies noting the variety of sources from which expectant mothers glean information leading to confidence in birth preparation. Also, the study affirms that informal sources of childbirth preparation information can be as adequate as formal ones.

Outcome of preparation

Whether or not childbirth classes have an effect on pregnant women and their births is debatable. In a Cochrane review of six randomized controlled trials, Gagnon (2005) concluded that the effects of formal antenatal education on knowledge acquisitions, anxiety, sense of control, pain, support, breastfeeding, infant care abilities, and social adjustment remain unknown. However, Maestas (2003) conducted a pretest posttest study of 42 Caucasian primigravidas, mostly married, with at least a high school education, and a wide range of incomes. Results indicated that following a childbirth class series, participants had decreased fear of childbirth compared to baseline, but no significant change in the personal value childbirth held for each woman. Bechelmayr

(1995) looked at a sample similar to Maestas using the prettest posttest design. Thirty-five married, mostly college graduates, employed pregnant participants, whose race was not reported, showed a decrease in state anxiety scores from the first to the end of the fourth Lamaze class. Stamler (1998), interviewed seven married, Caucasian, Canadian, employed pregnant women with more than a high school education who had attended childbirth classes. While the classes had focused on expectations of normal labor and control of anxiety and fear, some of the women voiced disappointment that they had not experienced normal labor. The results of Bechelmayr and Stamler would be more meaningful if they had been compared to similar studies of women who received informal childbirth information or social support as ways of alleviating the fear and anxiety of labor. Because Stamler included only white women and Bechelmayr did not report race, black women's experiences may not have been represented.

Criticism of formalized classes

Several authors have criticized childbirth classes as not meeting the needs of pregnant women. Armstrong (2000) reported on a participant observation study at a large urban hospital. In this sample of eight women with first time high risk pregnancies, most were poor, black, unmarried, and less than 24 years old. Data from the semi-structured interviews and participant observations indicated that classes were used to socialize women to accept technological births but failed to address participant's questions about pain and suffering in childbirth. Also lacking was recognition of the social gulf between the instructor and class attendees. Still participants in the study reported receiving some useful birth preparation information although many also sought information from books. While participants viewed classes as essential to prenatal care, the primary reason for attendance at classes was found to be the social support network they provided.

In a similar critique of British antenatal education, Nolan (1997) complained that classes had replaced the knowledge and emotional understanding of birth formerly transmitted through women's networks. Nolan criticized classes as catering to a white middle class clientele offering just enough birthing knowledge to ensure women's cooperation during birthing. Nolan advocated instead building on information, skills and life experiences already possessed by pregnant women in order to increase their self-confidence. Additionally, she saw classes as allowing for interaction with others and a sharing of ideas, anxieties, and fears.

Disparities in racial attendance at classes

Attendance at childbirth classes was researched by Lu et al. (2003). In a secondary analysis of a nationally represented data set, the authors examined whether or not sociodemographic disparities exist in childbirth education class attendance. Telephone interviews in English or Spanish were asked of 1540 mothers. Weighted logistic regression analysis was used to identify sociodemographic correlates of ever attending childbirth classes. Covariates included race-ethnicity, educational attainment, household income, marital status, and maternal age. Controlling for sociodemographic factors, white mothers were twice as likely as black and Hispanic mothers to have ever attended a childbirth class. Barriers speculated to impact class attendance were lack of health insurance coverage, transportation difficulties, inconvenient hours, cultural or language barriers, low valuation, and lack of partner or family support. Results of this study contrast with the second national childbirth survey (Declercq, Sakala, Corry, & Applebaum, 2006), which showed good childbirth class attendance by black women.

Use of the Web

Other authors have reported on innovative ways of assessing and providing childbirth preparation materials for minority women. Unfortunately, the majority of them only address low income women. In the first of its kind, Herman, Mock, Blackwell and Hulsey (2005) investigated use of a pregnancy support web site by low income black women. The Healthy Pregnancy Web site was developed to include health information about pregnancy and birthing, on line access to a nurse, and a discussion board. Nineteen first time pregnant high school graduate black women who were unemployed were given access to the Web site. Usage of the site was tracked primarily during the second trimester. The site provided pregnancy and birthing information including stress management and relaxation techniques. An advanced practice nurse answered questions online while a discussion board allowed participants to communicate with each other. This latter feature proved to be the most popular. While the sample size was too small to generalize to a larger population, the web site was found to be a means of support and a venue for dissemination of information for this population.

Knowledge needs of minority women

Berman (2006) explored the prenatal education needs of minority women, mostly Latin American immigrants, attending a hospital prenatal clinic. Unclear was how many of the four indigenous Americans, if any, were black. Eighty percent of the participants surveyed indicated they thought pregnant women and their partners should attend childbirth education classes taught by someone from each woman's culture. Pregnancy information was most valued as coming from close family members (30%), healthcare providers (30%), and childbirth classes (22%). However, healthcare providers and childbirth educators were considered the most accurate in imparting information. Barriers to class attendance were identified as problems with transportation, childcare, cost, and

schedule conflicts. Delivery, labor pain, and normal labor and birth processes were deemed three of the most important topics for birth preparation.

In a study of four middle class black midwives, Mann, Abercrombie, Dejoseph, Norbeck, and Smith (1999), interviewed the women about their own pregnancy experiences as well as that of their urban, mostly poor black clients. While the focus of the study was not on birth preparation, the results are instructive. Themes about the meaning of pregnancy that emerged were that pregnancy was a transition leading to maturity as an adult and as a mother. During this time, pregnant women were seen as special. "I think there is more made of a woman who's pregnant in terms of celebration, in terms of birth than any other thing that you can think of" (p. 300). A second theme expressed pregnancy as stressful. Sources of stress were lack of material resources and lack of emotional resources. Thus, for this population, being pregnant and giving birth were seen as a momentous and celebratory experience despite significant sources of stress.

Prenatal topics included in childbirth preparation were studied by Vonderheid, Montgomery, and Norr (2003). A cross-sectional, descriptive design was used in 157 low income multiparous Mexican American (30%) and black (70%) women. A number of topics were reported as needed by participants but not given in prenatal discussions with healthcare providers. Mexican American women were more likely to need information about childbirth classes but not get it. Compared to Mexican American women, black women were more likely to discuss with their provider when to call and where to go when in labor. Findings indicated that healthcare providers did not adequately address the health promotion content needed by both ethnic groups and that Mexican American women were more at risk of not having their needs met. The results of this study imply

that a patient-centered focus would more successfully provide women with the birth preparation information and knowledge they need.

Watching and learning

How women acquire knowledge in preparing for motherhood was investigated in an ethnographic study of 15 poor, urban, black women. Watching and mimicking others were reported as strategies (Underwood, 2000). In addition, it was learned that preparation for motherhood occurred first through practice for the role early in life while babysitting young relatives. Later mothering ideas were altered after watching others mother. Participants mostly mimicked patterns of mothering they had observed in their own mother. Svensson, Barclay, and Cooke (2006) also noted that pregnant women obtain childbirth information by watching and learning from others. While women may not have the opportunity to prepare for childbirth while watching and mimicking their own mothers giving birth, still dialogue about past experiences might prove useful.

Summary

In summary, the literature is inconclusive about the best forms of knowledge and ideal ways of obtaining knowledge and information in preparation for birth. Studies have mostly included very small samples of black women who are primarily young, indigent, unmarried, unemployed and on the periphery of society. Research has focused more on the inadequacies of black women in approaching labor and birth rather on their strengths. Few studies have addressed childbirth for the two thirds out of all U.S. black women who are middle income, married, employed, and experiencing normal childbirth. Their voices have not been heard.

SOCIAL SUPPORT

Variety of sources

Many studies have identified the importance of social support for women during pregnancy and by extension during childbirth. Social support is emotional encouragement given to pregnant women. This support may occur in a number of different ways. It may emerge through extended families, church families, the community in which pregnant women live, and society at large. What kind of support is available to expectant black women may influence their ability to prepare for childbirth. Most of the literature already reviewed acknowledges women's need for support in childbirth preparation. This support is likely to be from mothers (Savage, 2006; Svensson, Barclay & Cooke, 2006), other women (Davis-Floyd, 2003), childbirth class participants (Armstrong, 2000; Nolan, 1997; Stamler, 1998; Svensson, Barclay & Cooke, 2006), childbirth educators (Schaffer, 2002), peers and professionals (Herman, Mock, Blackwell, & Hulsey, 2005; Svensson, Barclay & Cooke, 2006), partners or husbands (Mann, Abercrombie, Dejoseph, Norbeck & Smith, 1999), nursing staff, midwives or doulas, and family or friends (Declercq, Sakala, Corry, Applebaum, & Risher, 2002; Zwelling & Phillips, 2001).

Social support in pregnant black women

The importance of social support for pregnant blacks was emphasized by participants in a study about black pregnancy experiences (Mann, Abercrombie, Dejoseph, Norbeck and Smith, 1999). In their study of four black midwives, the authors discovered that during pregnancy black women's need for social support was acute when their surrounding environment was stressful. Mothers, female relatives and female friends provided most social support. Younger women turned to their own mothers while older women looked to their partners. For all women, emotional support from other women

was seen as an asset. Lack of support led to feelings of irritation, vulnerability, and loss of control. Institutions such as schools, churches, and healthcare systems were often viewed as being insensitive, discourteous and offering only conditional support. As one midwife in the study said, "For African American women, stress from the lack of emotional support [by healthcare providers] appears to be embedded in a social context that implies inferiority by supplying experiences of rudeness, long and frustrating waits, and busy distracted care providers" (p.303).

Effects of social support

Support can be instrumental in providing a sense of security in pregnancy and childbirth. In a group of 481 Finnish women, Melender and Lauri (2002) found that those factors which created a sense of security were social support, knowledge, prenatal care experiences, support from one's partner, livelihood, and positive stories. Factor analysis in this study showed that the main components of feeling secure in pregnancy and childbirth were certainty, calmness, and having life in order. The results of this study of mostly married, highly educated, employed, Finnish women with a mean age of 29 years cannot be generalized to other populations. However, it does raise questions about the role of social support for women who have negative prenatal care experiences and a lack of certainty, calmness and life order or for those who do not fit this Finnish profile.

As a coping strategy, social support was used by 20 Finnish women, half of whom were primiparous in a study exploring causes of fear during pregnancy and childbirth (Melender, 2002). In semi-structured interviews, all women expressed fears. Fears were based on uncertainty, lack of experience with childbirth, inadequate knowledge, or negative experiences during pregnancy or childbirth. Coping with fear occurred by talking to people in their social networks or healthcare professionals or by independently

seeking out information from books. Professional support and childbirth education were especially helpful.

The importance of social support in a woman's process of pregnancy discovery and acceptance was identified by Peacock et al. (2001) in a qualitative study of an urban, culturally diverse group of low income primiparas. Of the 84 participants, 28% were black, 26% Mexican, 22% Puerto Rican and 24% white. The median age for black women was 19.5 years compared to an overall median age of 21.5 years. Sixty-three percent of the pregnancies were unplanned. The rate for blacks was 83% compared to 86% for whites, 39% for Mexicans, and 42% for Puerto Ricans. The process of pregnancy discovery and acceptance involved six steps. Through each step of the process, social networks were important in helping women to be convinced that they were pregnant and to seek care. This was especially true for black women who were more likely to reveal the pregnancy first to the baby's father and enter care early. Besides partners, female relatives were often notified. White women were the least likely to tell family members. The results of this study demonstrate that the process of pregnancy is a social process as well as a biological one and support networks are influential in the way women cope with the discovery and acceptance of pregnancy.

Mitigating sources of stress

Social support is highlighted in Mullings et al.'s (2001) research which aimed to identify sources of stress and chronic strain in pregnant black women, contributing to high infant mortality rates in Harlem. Results from the use of qualitative methods and the community partnership revealed that pregnant women experienced stress from the environment, housing, finances, seeking of quality prenatal care and social service delivery. Middle income women were found to substitute one set of stressors for another. For example, they were prepared to "live under conditions of systematic neglect of

community in exchange for the protective features of living in a black community, including more limited exposure to racism in their neighborhoods" (p. 90). Because pregnancy compounded stress, women developed extensive social networks, often women-centered, that helped with economic survival, childbearing decisions and coping with the pregnancy. The support systems offered information, material and emotional help and assisted with decision making. For all women, peers and family, including men, were especially important, although middle income women relied more on friends, while low income women relied more on families.

Family support

Family support is the buffer against the stress laden lives of many pregnant black women. In a phenomenologic study of perinatal loss, Kavanaugh and Hershberger (2005) found that 23 low income black mothers and fathers were not only stressed by the pregnancy loss, but had multiple other life stresses including economic hardship, death of a family member, and unfair or inadequate medical treatment. Coping strategies included use of spirituality, seeking of diversions, and receiving of emotional support from family and friends. Herrman (2006) found that turning to family members, especially female relatives and faith in God were also strategies used by 15 black and one Hispanic teen experiencing repeat pregnancy and multiple life stresses. Some of the teens saw childbirth as a positive event that enhanced family ties and made them closer. In a qualitative study of 26 young black fathers 17 to 23 years of age, Davies et al. (2004) also found a sizeable amount of social support from family and peers. However, family support may not always be unequivocal. Mothers in a study of 19 unmarried low income black teen fathers were more likely to be positive and supporting if the baby was fathered by their son. Yet all these women took on the grandmother role and were at least

minimally involved, often assuming parenting responsibilities when the teenage father could not (Dallas, 2004).

Chatters, Taylor, Lincoln and Schroepfer (2002) used a data set from the National Survey of black Americans, to determine what patterns of informal support respondents received from family members and church members. The sample (n=2,107) was primarily urban (80%), female (62%), married or partnered (42%), with at least a high school education (57%) and of middle income (49%). A multinomial logistic regression was used to analyze the continuous and categorical independent variables. More than half of respondents (55%) received informal support from family and church, from family only (27%), church members only (8%), or no support at all (10%). Respondents who received support from only one source were more likely to get it from families, thus underscoring the importance of kinship bonds which are based on a sense of obligation and responsibility to the family unit. Church support was found to function as a surrogate source of support for those without available family networks. Black women, more than black men, were much more likely to receive support from churches, especially if they were involved in those churches, were parents, and married.

Characteristics in black families

As a support entity, black families have unique characteristics. These families have evolved as a result of political and economic constraints (Johnson & Staples, 2005; McAdoo, 2007). McAdoo states that because black families have not had access to social and political resources, they have developed their own support systems for survival. The strength and resilience of the black family has ensured its survival from slavery to the present. Thus the family has become a place where each person can receive unconditional love, respect for self and others, and be encouraged to be the best they can be in order to survive in a harsh social and economic environment. The strength of the family comes

from quality relationships of its members. Families are flexible and accommodate many different personalities, life styles and conditions of individuals. There is also mutual sharing of knowledge and experience amongst its members. McAdoo adds that the family is also where conflicts are mediated.

Johnson and Staples (2005), who like McAdoo have written extensively about the black family, see other strengths as well. They note that there is role flexibility and shared decision making because most families have dual earners. The black family "is responsible for transmitting the family's cultural traditions and history, reducing child abuse, providing long-term support to teen mothers, assisting adult single parents during crises, and rearing kin children when their biological parents are not able to care for them" (p. xiv). Children are valued and have a central place in black families. "Black love continues to be Black wealth" (p.244). The authors advocate an Afrocentric perspective which includes the view that everyone belongs to someone and that black children are a gift from God. Extended family members make sacrifices for the good of each other and for the benefit of the family and community (Johnson & Staples).

Kinship as a source of support is discussed by Scannapieco and Jackson (1996). The authors describe the resiliency of black families as a protective factor in overcoming adversity in a stressful environment. Kinship care refers to care by related or unrelated extended family members or persons with close non family ties. The authors discuss how kinship historically helped black families survive slavery when family members were separated from one another. Thus care of individuals became the purview of the extended family and the entire community by providing concrete assistance and emotional support as needed.

Type of support and quality of life among blacks was addressed by Blake and Darling (2000). In a survey of 203 urban, religious, highly educated, employed blacks,

the authors reported on familial factors influencing quality of life. The independent variable identified as family resource exchange accounted for 30 per cent of the variance in quality of life among the sample. This indicated that there was much mutual support through the give and take of love, services, goods, information and money. The authors concluded that, "…strong bonds of love and support within African American families can be seen through their extended family system of mutual support" (p. 424). This, they concluded, helped families with the major stressors of discrimination and racism as well as other stressors. The authors also found that reliance on religion was the most commonly used coping style.

Church support

Other authors have also addressed the extended and church family as a means of emotional and material support in confronting economic hardship and emotional distress (Chatters, Taylor, Lincoln, & Schroepfer, 2002; Davies et al., 2004; Leininger & McFarland, 2002). Mosley-Howard and Evans (2000) in their ethnographic study of four families found the following additional characteristics of the black family. Married couple families were the majority of families above the poverty level. Role flexibility, a shared sense of responsibility, commitment to education, transmission of African heritage, and an embracement of church as the center of social life were all common. Families also ensured that members were socialized to recognize and cope with racism. Also, children are valued and elders are held in high esteem (Leininger & McFarland).

Religion, whether Christianity, Islam or Judaism, is pivotal in most black people's lives and another major source of support (Johnson & Staples, 2005; McAdoo, 2007; Leininger & McFarland, 2002). According to Johnson and Staples, seventy-five percent of blacks hold church membership, primarily in Black churches. The authors describe other attributes of the black church. Like the family, the church has served as a buffer

against negative feedback from the larger society. It has also served as extended family. It has functioned as a physical and emotional refuge in times of stress and gives weekly buttressing dealing with personal and social stressors. It is where children learn from adult role models and where children and adults have their self esteem raised. Finally, the church is also where children often first learn to read and speak publicly. Leininger and McFarland also point out that religion is central to the health beliefs of the black family. God is viewed as a healing power and religious moral teachings influence good health practices. Religious members of the community often visit the ill to offer spiritual guidance and support.

Negative support

Besides family and religion, communities and the society in which black women live may or may not be a source of support. Pickett, Collins, Masi and Wilkinson (2005), in a review of the literature on neighborhoods in which black women live and their effect on pregnancy, concluded that, "These studies suggest that the social networks of African-American women in a racist society may be strongest when they reside in areas where they are not in a racial minority" (p. 2230). Thus for women living in affluent neighborhoods with fewer African-Americans this may lead to an increased risk for adverse pregnancy outcomes. The authors looked at racial density and positive income incongruity on low birth weight in blacks living in Chicago. They concluded that living in an area with a high concentration of people of similar race or ethnicity and having positive income incongruity appears to be beneficial by providing social support and mitigating the effects of stress, thus reducing the risk of a low birth weight baby and premature delivery.

Negative societal support for pregnant women is evident in the social context in which they live where they experience the triple issues of discrimination based on race,

gender, and social class. It may be difficult to determine which has contributed most to adverse health in pregnant black women. Kawatchi, Daniels and Robinson (2005) argue that both class and race have an independent and simultaneous effect. Moradi and Subich (2003) argue that because black women's lives often include racism and sexism, it may not be possible to determine the effects of each as they may be fused together. Williams and Collins (2001) argue that racial segregation and low SES are primarily responsible for racial health disparities. Undoubtedly all three factors contribute in a major way to the unsupportive social environment in which pregnancy and preparation for birth occur. . Factors such as SES, health behaviors and stress, especially in the form of racism, may be additive over one's lifetime leading up to the pregnancy, and may be transmitted across generations as well (Lu & Halfon, 2003).

Another example of the negative effect of racism and discrimination on the social environment of black women comes from research by Collins, David, Handler, Wall and Andes (2004). They determined the association between black women's lifetime exposure to interpersonal racial discrimination with very low birthweight (VLBW) less than 1500g and preterm (PT) less than 37 weeks gestation. One hundred and four black women with VLBW or PT infants were compared to 208 non low birth weight full term infants. All participants were residents of Chicago and two thirds were on Medicaid. Five domains of interpersonal racial discrimination were studied: at work, at school, getting medical care, getting service at a restaurant or store. Answers were dichotomized as none or regularly. Multivariate logistic regression analyses were performed. The adjusted odds ratio for VLBW for black mothers who experienced interpersonal racial discrimination in one or more domains was 1.7 with a 95% CI. For three or more domains it was 2.6. Thus, exposure to interpersonal racial discrimination was found to be a common risk factor for VLBW. The strongest association was in finding a job and in

place of employment. Thus, the effects of living in a social environment that is not supportive and that does not enhance one's self esteem and self worth has negative consequences for pregnant black women.

Summary

To reiterate, social support during pregnancy as women prepare for childbirth comes in many forms and through many different sources. For black women, the immediate family, kinship, and religious communities, mostly Christian, are often the main sources of support which help to mitigate multiple sources of stress. Birth is a joyous occasion welcomed not only by parents but by the larger social circles of which black women are members. How social support impacts the process black women use to prepare for birth has not yet been addressed.

PERSONAL CHARACTERISTICS

Anxiety

Just as personal characteristics influence becoming a mother (BAM), so too may they be an influencing factor in childbirth preparation. Personal characteristics may include age, education, life experiences, personality, attitudes, and behaviors. While the literature is less robust in delineating personal characteristics potentially influential in childbirth preparation, several studies demonstrate the role of these individual traits. A case in point is Bechelmayr's (1995) study which found that women who had differing anxiety levels differed in their response to childbirth classes. While all women benefited from the classes, those with high anxiety benefited the most. Johnson-Robledo's (1998) study of the relationship between income and childbirth preparation analyzed levels of childbirth preparation. In her sample of which 9% were black, women who prepared the

most for childbirth were more likely to evaluate their labor and birthing experience in a more positive way.

Satisfaction with care

Whether or not satisfaction with prenatal healthcare influences childbirth preparation is unknown. However, in a study examining satisfaction with prenatal care and subsequent utilization of those services, satisfaction was not found to be an important factor (Handler, Rosenberg, Raube, and Lyons, 2003). In a sample of 125 Medicaid and 275 non-Medicaid black women, the overall satisfaction with care was high (80%). Non-Medicaid women were significantly less satisfied with their care than Medicaid women. Still prenatal care services utilization did not differ between the two groups even though the personal characteristics between the two groups did differ. Compared to the non-Medicaid women, the Medicaid sample was generally older, multiparous, less likely to have wanted the pregnancy, less likely to have more than 13 years of schooling, and more likely to be on welfare with low incomes. The non-Medicaid women were more likely than Medicaid women to be vocal in expressing their needs and dissatisfaction with their care. All women, regardless of personal characteristics and coping styles, recognized the value of and wanted early prenatal care.

Coping styles

Because coping styles of individuals have been found to influence response to stress, they may also influence preparation for childbirth. Stancil, Hertz-Picciotto, Schramm, and Watt-Morse (2000) examined perceived stress and increased blood pressure in 94 pregnant black women 18-30 years of age with at least a high school education, poor, married, and multiparous. Perceived stress scores predicted increased blood pressure in the third trimester. Fifty four percent reported ever experiencing racial

discrimination, 29% while applying for a job and 29% at work. Women who were likely to report perceived stress tended to be young, had lower education, or had high incomes. High racial or sexual discrimination was also a source of perceived stress. An active coping style of talking or taking action was associated with lower perceived stress while those who responded more passively reported higher perceived stress. In another study (n=474), college educated women with middle to high incomes (85%), some of whom had previously given birth, also reported stress. Workplace stress resulted from being the first, the only, or one of the few African Americans in their place of employment (Jackson, Phillips, Hogue, & Curry-Owens, 2001).

Stress and coping styles were also studied by Dole et al. (2004) who assessed the association between psychosocial factors and preterm birth, stratified by race, in a prospective study. Sixty-two per cent of the 1898 women surveyed were black. Results indicated that blacks reported a greater number of negative life events, slightly higher levels of depression, and were less likely to be living with a partner compared to white women. They also had higher acceptance of unfair treatment, perceived racial discrimination, and perceptions that their neighborhoods were unsafe. Black women who reported high levels of perceived racial or gender discrimination were more likely than whites and blacks with lower levels of perceived discrimination to deliver prematurely. Coping styles in blacks associated with moderate increased risk of preterm birth included distancing, and high levels of escape-avoidance. In whites, medium or high escape-avoidance resulted in a modest increase in preterm birth. Neighborhood safety did not influence risk for preterm birth in blacks but did in whites. Whether or not personal coping styles influence women's preparation for childbirth is unknown.

Depression

The presence of depression may also influence birth preparation and be under diagnosed as it is in the postpartum period. In a review of the literature, Amankwaa (2003) assessed the link between culture and postpartum depression. She noted that cultural stigma among black women may have prevented them from revealing their depression. Depression for some may have been seen as a symbol of weakness, mental failing, and not having faith in God. These symbols are in contrast to black cultural images of the strong woman who perseveres to overcome all obstacles. Amankwaa further observed that under reporting of depression might also be the result of fear that the medical system would misuse any disclosure of depression.

Culture

The influence of culture, as a personal factor, on childbirth preparation in black women is not known. The difficulty of defining culture is that race and ethnicity are often used as proxies for culture (Gustafson, 2005; Kreuter, Lukwago, Bucholtz, Clark & Sanders-Thompson, 2002). Yet race is a socially constructed term (Beech & Goodman, 2004). This further complicates using race as a synonym for culture and culture as a synonym for race (Gustafson, 2005). The result, according to Gustafson, is a glossing over of significant intra group differences and a misrepresentation of culture as a factor impacting health rather than socio-political factors. Kreuter et al. point out that "African Americans do not share a single monolithic culture. Rather, many cultural subgroups may exist, and any African American may belong to one, none, or several" (p.134). Still, the literature is replete with studies about black cultural values.

The cultural meanings of comfort, presence and involvement during childbirth were explored by Raines and Morgan (2000) in a descriptive qualitative study. Participants were ten black and ten white women for whom no significant differences

existed for demographic variables of age, gravida, parity and use of prenatal care. Results indicated that for most of the black participants, family members provided comfort during labor whereas for whites it was drugs such as epidurals that made them comfortable. The baby's father was important to both groups. More blacks saw mothers, sisters, or female relatives as important. Blacks saw the presence of the physician as important while whites saw the nurse as needing to be present. For both groups, the importance of having someone with them in labor was: to share the experience, have someone familiar there, provide comfort, and create an emotional bond. Blacks expected family members to just be there while whites wanted them to do coaching and encouragement. "Black participants described sources of comfort from a more intrinsic perspective, emanating from long-standing emotional ties and family bonds, almost a sense of belonging and safety within kinship bonds" (p.171).

Straddling two worlds

Perceptions of self and by others may also influence childbirth preparation. Coker (2003) explored with ten black college women their motivation, challenges and sources of strength as they pursued their academic goals. Through the focus group sessions and personal interviews, women voiced reasons for pursuing their education. All were aware of the role sexism and racism had played in their lives. They were worried that they would be perceived to be strong willed, combative, argumentative or belligerent and forced to act less intelligent. They were cognizant of the two cultures in which they lived. On the one hand, the academic environment required reserved verbal expression, while, on the other hand, their Afrocentric culture had a tradition of independent and outspoken women. They faced constant tension between the two. Tension between the demands of black and white worlds was also found in research with 167 college-educated black women (Jackson, Phillips, Hogue, & Curry-Owens, 2001). Jones and Shorter-Gooden

(2003) in a survey of 333 black women also found many examples of what they called shifting. Similar to Coker's participants, Jones and Shorter-Gooden found that black women often modify their speech and behavior as they shift back and forth between white and black worlds. "Our research shows that large numbers of black women in America feel pressured to present a face to the world that is acceptable to others even though it may be completely at odds with their true selves" (p. 61). That black women are sometimes guarded in their behavior might impact the process of childbirth preparation, and the study of it, especially if it involves interaction with whites. For example, black women may not feel comfortable in expressing their true needs in childbirth classes whose participants and teachers are predominantly white.

Sense of empowerment

Authors who write about black women often focus on the personal ways in which these women empower themselves while living in a world defined by Eurocentric values, which negate blackness. Black women learn to trust themselves and their ways of knowing (Banks-Wallace, 2000). They cast aside society's negative images of themselves and acknowledge instead the veracity of their experiences. They reserve the right to create their own labels for themselves by coming together and sharing experiences (Hudson-Weems, 2004). They laud the strength they see in themselves and other black women struggling to resist and survive in a world defined by whiteness (Cannon, Johnson & Sims, 2005, Feifer & Maher, 2003). They reserve the right to define themselves based on historical context and real life encounters (Cannon, Johnson & Sims). Thus, knowledge gained from experience of self and other black women is more credible and empowering than that which is learned from the dominant white culture (Banks-Wallace; Hudson-Weems; Taylor, 1998, 1999; Yancy, 2000). Personal empowerment as a strategy has also been used to decrease stress, increase social support

and improve the health of rural black mothers and their children (Baffour, Jones, & Contreras, 2006). It is possible that empowered black women may utilize and access childbirth preparation knowledge and social support differently than others.

Brown and Toussaint (1997) in their book "Mama's Little Baby: The Black Woman's Guide to Pregnancy, Childbirth, and Baby's First Year," encourage an attitude of empowerment in preparation for childbirth. They encourage black women to take control of their lives and be well informed about the birthing process in order to participate in decision making.

> The more good information you have about what's available, the more time you have to think about them and come up with your own birthing 'philosophy,' the more likely you will be less intimidated and more outspoken about your desires, and increase your chance of having a safe and satisfying birth with minimal intervention (p. 6).

Summary

In conclusion, personal characteristics may include a multitude of factors influencing women's preparation for labor and birth. More studies are needed to clarify what those factors are and how they influence childbirth preparation. How black women perceive themselves, their attitudes, their emotional state, their life experiences, their coping strategies, their view of healthcare, and their cultural orientation may be some of the factors impacting the process of childbirth preparation.

SUMMARY

Childbirth preparation, like BAM, is most likely a process that starts early in pregnancy and accelerates in the third trimester. How women prepare for the events of labor and birth may or may not differ from one population of expectant women to another. The literature suggests that all women use a variety of formal and informal sources of knowledge and information and a combination of social support entities for

birth preparation. What effect childbirth classes have on birth outcomes is unknown. Pregnant women's own personal characteristics also have bearing on the preparation process. However, black women live in a social environment unlike those of other minority, racial and ethnic groups. Thus, their childbirth preparation may be uniquely colored by experiences of stress and resiliency. Because there is a paucity of reports on well-educated, middle income, black women's experiences of preparation for normal birthing, these women's voices need to be heard.

Chapter 3: Method

INTRODUCTION

The epistemological and ontological foundations of qualitative research methods are well-suited to nursing. Both qualitative research and nursing employ an all encompassing holistic view instead of a rigid predetermined stance (Cesario, Moprin, & Santa-Donato, 2002; Yegdich, 2000). Reality is contextual. According to Cesario and Santa-Donato, qualitative studies of pregnancy, childbirth, or parenting experiences are common in maternity nursing. The current popularity of qualitative research is predicated on knowledge generated from human experience which can be useful and practical. This has resulted in an increased use of qualitative research in nursing (Sandelowski, 2004).

Rolfe (2006) argues that each method, methodology or mix thereof is justified in light of each study's context. Sandelowski (2000) echoes this sentiment saying that methods used should be judged on their usefulness and appropriateness. Creswell (1998) states that while typical methods are used with certain methodologies, mixing and matching is possible.

In this chapter, grounded theory will be described as a methodology in studying the processes used by black women to prepare for childbirth. Issues such as protection of subjects, study design, data collection procedures, recruitment and sampling, informed consent, analytical procedures, bias control, rigor, and trustworthiness will be addressed.

GROUNDED THEORY DEVELOPMENT

Prior to the development of grounded theory methods, theorizing occurred primarily through the use of deductive techniques which involved testing and verifying theories that had been mentally constructed. Instead of these quantitative methods,

Glaser and Strauss (1967) advocated that theories should be inductive and arise from the interplay of data collection and analysis (Dey, 1999; Strauss & Corbin, 1998). Grounded theory was first proposed by sociologists Glaser and Strauss in 1967 but was later modified. It concentrates effort on the process of generating theory versus theoretical content (Denzin & Lincoln, 2005; Patton, 2002; Strauss & Corbin).

Researchers who use grounded theory methodology attempt to discern theories related to a particular phenomenon. Similar to phenomenology, grounded theory requires researchers to suspend a priori ideas. Theory emanates from data, a term referred to by Glaser and Strauss as grounded (Creswell, 1998, 2003; Crotty, 2003; Strauss & Corbin, 1998). Strauss and Corbin state that not only must theory be grounded in data, but that researchers must also be creative in analyzing the data. For Strauss and Corbin, therefore, grounded theory is both art and science. It is not until the end of a study that theory is put forth. As with any theory, it must convey concepts and the ways in which they are interrelated (Creswell, 1998). For Strauss and Corbin, theory is a systematic, logical explanation of those concepts. Patton (2002) states that the fundamental question in grounded theory is: "What theory emerges from systematic comparative analysis and is grounded in fieldwork so as to explain what has been and is observed" (p. 125)?

Systematic data analysis

According to Denzin and Lincoln (2005), a major contribution of grounded theory is the systematic approach to data analysis. Creswell (1998) and Denzin and Lincoln discuss these methods. Researchers conduct individual or focus group interviews until data is saturated, called theoretical saturation, and nothing more can be learned. Additional data may come from participant observations and documents. Analysis occurs at the same time as data collection, in a non-linear fashion. As information is collected, data is categorized according to like properties called open coding. In axial coding, the

data are reassembled according to an identified phenomenon and its identifying features. This is followed by selective coding in which categories are incorporated into a story and tentative hypotheses formed. The final outcome as set forth by Creswell is a theory for a specific condition or population. It is an inductive method which develops abstract interpretations of participants' meanings and actions and places them in an organized theory (Denzin & Lincoln; Patton, 2002).

Objectivity

A systematic approach to data analysis and maintenance of objectivity are important aspects of grounded theory. While there is recognition that subjectivity cannot be completely eliminated, techniques are employed to recognize and limit bias. One such method is comparative thinking where data are compared with each other from all angles and under diverse conditions (Denzin & Lincoln, 2005). The system of coding developed also standardizes grounded theory research and provides a measure of rigor and objectivity (Patton, 2002). For Strauss and Corbin (1998), the challenge is to uphold objectivity while maintaining sensitivity to what the data convey. For them, objectivity is essential for the interpretation of data while sensitivity allows for nuances of meaning and recognition of how concepts are interrelated. Constantly asking participants to validate and clarify interpretation of data helps in maintaining objectivity and rigor.

Reasons for selecting grounded theory

According to Strauss and Corbin (1998), there are several legitimate reasons for selecting grounded theory methodology. This includes the preference of the researcher and more importantly the nature of the research problem. Areas about which little is known or about which much is known that might generate new understandings, lend themselves to grounded theory. Strauss in particular believed that grounded theory could

uncover the complexity and variability of phenomena. A phenomenon might be a process, an occurrence, an event, or a happening that is significant to a group of people. Strauss realized that people act based on the meaning an action holds for them and that there are interrelationships between context and action. Corbin adds that, "the object, then is to become sensitive to the number and types of properties that might pertain to phenomena that otherwise might not be noticed or noticed only much later" (p. 82). The goal of the researcher is to relate structure, or the circumstances in which phenomena occur, with process. Process is defined as the actions and interactions of people in response to the phenomena.

Preparation for childbirth is an experience that has been studied. Various aspects of childbirth preparation such as sources of knowledge, social support, and factors impacting preparation have been reported in the literature. The populations most often studied are white, middle class women. What has not been adequately addressed is childbirth preparation of minority women, in particular black women. While black women's birth preparation may be similar to other groups of women, the social context in which black women live is very different than that for others. This suggests the need for a grounded theory study to examine the process of childbirth preparation of black women living in a context of racism and discrimination. Of interest are the actions and interactions of black women with their environment and their subsequent influence on ways in which these women prepare for the birthing experience. Other qualitative methods results may be equally valuable but are not designed to identify the conditions, actions or interactions, and consequences associated with this phenomenon. Furthermore, interrelated concepts which are part of a framework to explain and predict the phenomenon of childbirth preparation in black women can only come through the use of grounded theory. Clinically, understanding the phenomenon of childbirth preparation

allows for better communication and understanding between clients and providers. It also can result in the development of appropriate care strategies.

SPECIAL CONSIDERATIONS

The past history of research within the black community has often been one in which participants became victims of unethical experimentation, the most quoted example being the Tuskegee Syphilis Study (Mokwunye, 2006; Patterson et al., 2005). This and other atrocities have led to distrust of researchers by some blacks. In addition, blacks may have experienced racial bias within the healthcare system which may further dissuade them from participation in health research (Kumanyika, 2006). Thus, past abuses and perceived discrimination are the two main barriers to enrollment in clinical research (O'Brien et al., 2006). Banks-Wallace (2000), Taylor (1998), and Shambley-Ebron and Boyle (2004) encourage researchers to be sensitive to and include in research discourse of racism as it impacts the lives of African American women.

In general, blacks recognize the usefulness of research and indicate willingness to participate especially when complete information is presented in clearly understood terms (Corbie-Smith, Thomas, Williams & Moody-Ayers, 1999; Freimuth et al., 2001). Other factors which affect research participation are: assurance of privacy and confidentiality, perception of low risk, trust in the researcher (Freimuth et al.), attractive incentives such as free gifts or monetary reimbursement, and flexible scheduling (Freimuth et al.; Mokwunye, 2006). Individuals are most willing to participate if the research is non-invasive, or involves group discussion or completion of a survey. Finally, researchers must be proactive in addressing scientific misconduct. Concerns and fears by participants around racism and mistrust in the healthcare systems and larger society must be addressed as legitimate (Freimuth et al.). Thus, it was important in this study to mirror these concerns as noted in this study's data collection procedures.

Protection of subjects

The code of ethics adopted by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) incorporates three major principles in the protection of research subjects. These are beneficence, respect for human dignity, and justice. While all research must adhere to these ethical principles and insure that participants not incur physical, emotional, or other risks, certain populations are considered more vulnerable than others (Creswell, 2003). Pregnant women as a vulnerable group are protected by strict requirements issued by the United States government. Thus, pregnant women are prevented from participation in a study unless risks to them and their fetuses are minimized (Polit, Beck, & Hungler, 2001). Because the women in this study were pregnant and belonged to a minority group, they were vulnerable and at increased risk for harm. Moore and Miller (1999) note that persons who are doubly vulnerable experience more than one area in which autonomy is reduced. The authors note that those who are vulnerable are unable to make choices to maintain independence or self determine. They are therefore more likely to experience real or potential harm.

Potential risks

Potential risks associated with participation in this study included a range of possibilities. The least of these was inconvenience to participants in terms of scheduling and venue. Potential problems with transportation and childcare could have been additional issues. Also, discomfort with the environment in which the research occurred might have been a problem. This might have been especially true for pregnant women in the third trimester who had decreased mobility and increased physical discomforts because of pregnancy. Psychological or emotional discomfort might have occurred as women told their stories and relived painful or sad experiences in their lives. Relating

stories in a group setting may have diminished privacy and confidentiality, especially if group members were acquainted with one another. In relating their experiences, there was also a risk that the researcher might misunderstand participants or inadvertently be insensitive to verbal or body language. Likewise, other focus group members could have been judgmental of one another in their responses. Anderson and Hatton (2000) note that vulnerable persons and researchers may be different with respect to socioeconomic status, education, language and ethnicity. The same may be true for focus group members. This may have an impact on the communication process.

Potential benefits

Although there were anticipated risks to participation in this study, there were also potential benefits. Moore and Miller (1999) observe that participants may feel they are contributing to the advancement of knowledge and better practices in nursing. They may gain a sense of emotional release as they share their stories with other participants and with the researcher. They may acquire new knowledge about childbirth preparation from other women. Additionally, a sense that their experience is normal and similar to other black women may be reassuring. Finally, participants may gain emotional support from group members and the researcher.

Maximizing benefits

Several specific steps were incorporated in the research design to minimize the risks and maximize the benefits. Every effort was made to make certain that participants understood the purpose, procedure and written forms to be used. A research site was chosen which was accessible and as physically comfortable as possible, with easy access to restrooms. In the event that participants became emotionally distressed as a result of the research experience, they were told they would be referred to their primary provider.

The researcher shared with the participants her philosophy that women have important scientific contributions to make and that their voices must be heard. Finally, the researcher acknowledged that while her intent was to be an unbiased, sensitive, and active listener, she might inadvertently not exhibit such behaviors and welcomed feedback from participants. Because a black moderator experienced in focus group techniques was assisting, it was hoped that participants felt comfortable.

Prior to initiation of the study, approval of the research proposal was sought through the Departmental Review Committee of the University of Texas at Austin School of Nursing and also the University of Texas Institutional Review Board (IRB). These institutional bodies are tasked with ascertaining that researchers adhere to a recognized code of ethics. This review process ensured that the researcher had considered all necessary precautions to protect participants from human rights violations (Creswell, 2003). Once IRB approval was obtained, recruitment of participants proceeded.

STUDY DESIGN

Grounded theory is an appropriate methodology for studying pregnant women. Support for this comes from the work of one of the foremost authorities on grounded theory, Corbin (Strauss & Corbin, 1998). The current study, like Corbin's, addressed pregnancy and how black women moved through the process of birth preparation. Thus, grounded theory was a suitable methodology for this study as listening to what pregnant black women had to say about birth preparation was at the heart of the research question. Strauss and Corbin (1998) believe that just as the concepts must be allowed to emerge as the research proceeds, so too must the design be allowed to emerge. For the purposes of this study, the design was set forth a priori with adjustments made as warranted by the ensuing research.

Data collection began with recruitment of participants through the use of radio ads (Appendix A). Also used were internet and newspaper ads and flyers (Appendix B) at local churches and hair salons. After inclusion criteria were determined, those who elected to voluntarily participate were mailed a research packet form. A date was set for their participation in a focus group with five to seven other women. While it was estimated that three to five focus groups would be needed to gather enough data, sampling was dictated in part by the emerging theory. Theoretical sampling and theoretical saturation determined the actual number of focus groups. Focus groups were held at a local clinic and led by a black moderator who asked semi-structured interview questions while the researcher recorded field notes. Interview questions were modified to give breadth and depth to the emerging theory and associated concepts. Each focus group session was audio taped and lasted 90 minutes. The total time for all study activities was two hours. The women were then thanked and paid $60 for their participation.

DATA COLLECTION PROCEDURES

Techniques and procedures for data collection and data analysis closely followed the guidelines set forth by Strauss and Corbin (1998) in their book, "Basics of Qualitative Research."

Recruitment

Access to potential research participants was sought through several different avenues. Strauss and Corbin (1998) note that sites chosen for sampling should be directed by the research question. Thus, the sites chosen for this study were ones frequented by pregnant black women. While recruitment at Austin healthcare facilities that offer prenatal services to black women such as private practices, and community clinics, would have been ideal, a more effective method was through the use of public media and sites

frequented by potential participants. Newspapers and radio stations serving the Austin black community as well as churches and hair salons were targeted. These sites were contacted, apprised of the research, and asked to carry an advertisement or flyer (Appendix B) inviting participation in the study. Once the ads had been aired on the radio, seen in the newspaper or on web sites, and placed at churches or in hair salons, the snowball technique was also found to be helpful in recruiting participants. As women learned of the study through one another, they were encouraged to contact the researcher for inclusion as participants in the research.

Sampling

Snowball sampling is recommended by Strauss and Corbin (1998) in identifying initial participants. However, the authors caution that sampling must then proceed according to the precepts of theoretical sampling. This involves sampling based on concepts that surface during analysis that have significance to an evolving theory. For example, had the focus groups indicated that birth preparation occurred mainly very early in pregnancy, then sampling would perhaps have included more women in their first or second trimesters. Theoretical sampling is cumulative and builds on prior data collection and analysis. It attempts to broaden and deepen understanding of concepts as they emerge from concomitant data collection and data analysis. Thus, as data analysis occurred in this study, theoretical sampling might have been necessary. Participants were recruited who added breadth and depth to the developing concepts. Strauss and Corbin admit that theoretical sampling may not be practical for beginning researchers and so while not ideal, recognize the role of convenience samples. In this study, data collection and analysis proceeded simultaneously, as theoretical sampling occurred based on the concepts that emerged. However, convenience sampling was mostly used drawing from the media ads and snowballing, as previously noted.

Inclusion criteria

As with theoretical sampling, Strauss and Corbin (1998) note that inclusion criteria for a study cannot be decided a priori, except for initial participants. Rather, who should be included in a study is guided by the constant comparative method of data analysis. The only inclusion criteria for initial participants in this study was self identification as an indigenous black woman, first pregnancy in the last four months, uncomplicated pregnancy (defined as pregnancies requiring routine surveillance only), currently receiving prenatal care, and age 21 years or older. Teenagers are often in school, face their own developmental issues, have special childbirth and parenting classes provided through schools, and thus may not be representative of the average preparation for childbirth experience. While preparation for childbirth may occur throughout pregnancy, the third trimester is often a time when women with uncomplicated pregnancies intensify their preparation for childbirth and may even participate in childbirth classes (Nichols & Humenick, 2000). The final sample included participants who represented the diversity found among African Americans in terms of age, marital/partner status, education, and socioeconomic status.

Participants who responded to the advertisements and flyers and who contacted the researcher by phone were invited to participate in the research after further explanation about the study (Appendix C), determination that inclusion criteria had been met (Appendix D), and the researcher had identified herself as a doctoral student at the University of Texas at Austin School of Nursing. Additional questions and concerns were also addressed. For those women agreeing to participate, they were given a choice of times to meet. A cover letter (Appendix E) and postcard (Appendix F) were mailed to them giving details about the research and about the agreed time and place where the

research was to be conducted. They were also mailed a consent form for them to read prior to the meeting date (Appendix G).

Sample size

The actual number of study participants is determined by theoretical saturation (Strauss & Corbin, 1998). For these two authors, theoretical saturation implies that enough sampling has been done so that each category, theme, or concept identified is well developed and that the relationships between them are made clear. Strauss and Corbin further state that there must be adequate sampling to explain the range of conditions under which events occur in each category. It was anticipated that for this study no less than three focus groups of six to eight women would be necessary. Sawyer (1998), in her grounded theory of engaged mothering of black women, used three focus groups averaging three to eight participants per group. However, because recruitment was challenging, five focus groups were convened for this study. Additionally, two individual interviews were conducted, by mutual consent due to scheduling conflicts.

Informed Consent

Respect for participants is the hallmark of ethical research (Creswell, 2003). In addition to IRB approval, informed consent recognizes that participants have rights that must be protected during data collection. Creswell outlines the essential components of informed consent as: 1) the right to participate voluntarily without coercion, 2) the right to withdraw from the study at any time, 3) the purpose of the study and its potential impact on participants explained in an understandable way, 4) the expected procedures, 5) the right to ask questions and obtain a copy of the results, 6) the respect for privacy, 7) anticipated benefits to participants, and 8) signatures of both participant and researcher. In keeping with these guidelines, a consent form (Appendix G) was mailed to participants

at least two weeks prior to data collection with instructions that it be discussed and signed after arrival for the scheduled research session. Copies of the consent form were likewise made available at the meeting site.

Overview

Prior to the focus group discussion, the researcher introduced herself, explained her interest in this topic, and gave a review of the research purpose and procedure. She told the participants about the study and the importance of results in helping providers better meet the needs of pregnant black women. Participants were then told that the purpose of the research was to elicit responses to a group of semi- structured questions around the process of preparation for birthing. Their participation and responses were encouraged, but they were told not to feel pressured to respond in any particular way. Any answer they gave would be viewed as a valued response. The interviewer would ask further probes to elicit better understanding, clarify a response, or validate a perception. Furthermore, each participant was reminded that she had the right to participate as little or as much as she desired and could elect to terminate the session at any time. Remuneration will be forthcoming even should a participant elect to withdraw early before the session was ended. Each session was expected to last about two hours for all study activities. Participants were reminded that each session was being taped, but that pseudonyms they provided would be used in writing up the research results. Participants were also asked to use their chosen pseudonym during the focus group discussion in order to further guard privacy. Furthermore, tapes would be erased once the research was concluded. Any hand written notes taken during the sessions would be shredded and destroyed at the completion of the project. All research materials would be kept in a locked cabinet in the researcher's office for the duration of the study. Participants were then asked to sign the consent form.

Demographic survey

Once the focus group discussion had ended, participants were asked to complete a demographic form (Appendix H). They were asked if they preferred to fill out the form independently or to have the interviewer assist with the writing of responses. The total amount of time spent by each participant was estimated at about two hours for the majority of participants. Once the demographic form had been completed, the participants were thanked for their time, reminded that they could elect to receive the written research results and give written feedback on the proposed theory, and compensated for their time. In recognition of the fact that sitting for two hours takes a physical and emotional toll on third trimester pregnant women, and because some of the participants were professional women whose time was valuable and who traveled some distance to attend the research session, each participant was compensated $60.

Individual and group sessions

Collection of data was accomplished primarily through focus groups. The women were told during recruitment that the session would be led by a black moderator with experience conducting focus groups who herself has given birth several times. The researcher was likewise to be present in order to answer questions about the research and to take field notes. Field notes were described to the participants as recordings of nonverbal behavior, the setting in which the research occurred, and the researcher's thoughts and observations. Individual interviews were conducted when women signed up for focus groups but were the only ones who showed up at the research site for the scheduled focus group. These women, by mutual agreement with the researcher, were individually interviewed, on an agreed upon date and time by the primary investigator.

A research tool

Banks-Wallace (2000) promotes the use of dialogue and storytelling as a means of sharing experience, knowledge and wisdom amongst black women. She adds that this approach fosters the sense of community of participating women. Thus, focus groups are an appropriate research tool for exploring knowledge and experiences (Morgan and Krueger, 1998). Morgan and Krueger add that interaction between the researcher and participants is as important as dialogue. Focus groups have been used extensively in research with black female populations. Examples include: pregnancy (Peacock et al., 2001), cancer (Jernigan, Trauth, Neal-Ferguson & Caretier-Ulrich, 2001), and views on research (Corbie-Smith, Thomas, Williams, Moody-Ayers, 1999; Freimuth, et al., 2001).

Setting

Focus groups and individual interviews for this study were conducted in a conference room at a neighborhood clinic with ample parking. While six to eight persons are ideal for focus groups (Morgan & Krueger, 1998), it was difficult to schedule such groups. A snack was provided as a way to promote a casual atmosphere, allow for informal discussion prior to the focus group session, and as a way to meet the black moderator and white researcher. Banks-Wallace (2000) suggests that because black women live in a society that devalues them, researchers should provide these women with opportunities for nurturance through group activities such as sharing a meal.

Advantages

Focus groups are a research tool that offers a fast, inexpensive, and expedient way of data collection simultaneously from several people (Morgan & Krueger, 1998). Examination can be made of not only what people think but how and why they think that way in a dynamic group process (Kitzinger, 1995). Bender and Ewbank (1994) caution

that focus groups work best when the topic is narrowly focused and when it is of interest to both the researcher and the research participants Advantages of focus groups are that they do not discriminate against people who cannot read or write and can encourage participation from those less comfortable with face-to-face interviewing. The disadvantage of having a group process is that it may silence alternative points of view and compromise confidentiality (Kitzinger).

For the focus group sessions and individual interviews, a guide (Appendix H) composed of semi-structured questions was used. These questions were developed based on a review of the literature and input from six content experts regarding appropriateness of wording, content and scope.

The demographic form administered was developed (Appendix I) to describe sociodemographic characteristics of participants. Demographic data included: age, parity, number of prenatal care visits, marital/partner status, educational level, self described socioeconomic status, employment status, and sources of emotional support received.

DATA ANALYSIS AND MANAGEMENT

Following completion of the focus group sessions, the moderator and researcher met to compare observations and impressions of the group dynamics and group process. The digitalized audio tapes were then sent to a professional transcription service for word processing. The moderator helped clarify for the researcher unclear dialogue or language that was unfamiliar to the researcher. A synopsis and feedback form (Appendix J) were then mailed to the focus group participants who had volunteered to review them. These synopses were also reviewed by the moderator for accuracy. Only two participants out of ten returned the feedback form about the synopsis of the session each had attended. Both commented that the synopses were accurate and nothing should be added.

As the written transcripts became available, they were reviewed by the researcher for accuracy. There followed the process of data analysis. Based on recommendations by Strauss and Corbin (1998), the three types of coding procedures used in developing the grounded theory were: open coding, axial coding, and selective coding. The first step involved was line-by-line analysis or open coding, the purpose of which was to identify a key word or words that encapsulated the meaning of each sentence. These were then grouped into initial categories. For example, the sentence "It's frustrating moving and some days I'm fine or one minute I'm fine to be sitting there and then I look depressed face" was coded as "emotional lability."

Open coding was followed by axial coding during which the properties and dimensions of a category that had been identified were detailed. The relationship between a category and its subcategories were delineated. For example, the category of managing pregnancy symptoms involved finding treatments, trying out remedies and seeking validation. Both open coding and axial coding occurred simultaneously as new data was compared to the old in substantiating the categories.

The final process was substantive coding during which previously identified categories were incorporated into the grounded theory. Thus the data was continuously compared with previous data and categories refined until what emerged was a grounded theory of urban black women's preparation for childbirth.

Descriptive statistics were used to report summary profiles of participants from the demographic form. Data was entered using the 12.0 version of SPSS for Windows computer program. The demographic form provided data which augmented and helped in the development of the emerging grounded theory.

Open coding

Interview and focus group data were analyzed according to the procedures and techniques outlined by Strauss and Corbin (1998). Strauss and Corbin state that analyzing data correctly does not allow us to speak for participants but rather facilitates their voices being heard clearly. Analysis begins with a detailed examination. This is termed line-by-line analysis or open coding. It is necessary in order to generate initial categories and to discover relationships between concepts. Therefore, each word, sentence or paragraph is examined and a range of interpretations entertained. Noting how the interviewees respond is as important as what they are saying. By careful inspection, data in this study was compared to one another, looking for similarities and differences. For example, there were many references by participants to physical symptoms they experienced during pregnancy.

The "constant comparison" method of data analysis (Struass & Corbin, 1998) is the foundation upon which theory development is based and is at the core of grounded theory. By continuously looking at data side by side, the researcher is able to notice similarities and differences in the data. Thus, properties and dimensions are systematically developed based on what is in the data. In other words, constant comparison reassures the researcher that theory is grounded in the data. This provides an objective way of constructing categories that are conceptually similar rather than an arbitrary classification system. Thus, the researcher will become sensitive to the range of possible properties of the childbirth preparation phenomenon. The goal is to move from the particular details of the data to a more abstract conceptualization by asking "what is going on here?" Open coding then is the conceptual process of examining and comparing data to place them in categories which have properties and dimensions. This process advocated by Strauss and Corbin was used in analyzing the data generated from the focus

groups and two individual interviews. The constant comparative method was useful in identifying categories and their properties. It also ensured that the theory was grounded in what the women had to say about their pregnancies and birth preparation. For example, the references participants made to physical and emotional changes in pregnancy lead to the category of managing pregnancy symptoms.

Axial Coding

Once open coding is complete, the process of axial coding begins. This involves relating each category to its subcategory. Subcategories concern themselves with the when, where, why, who, how and consequences. In axial coding, the properties and dimensions of a category that were first identified are detailed. Also delineated are conditions, actions/interactions and consequences which are linked to the phenomenon. The relationship between a category and its subcategories is revealed as well as the relationship of other categories to each other. Axial coding identifies conditions under which phenomenon occur; responses to issues or events; and subsequent consequences. Both open coding and axial coding occur simultaneously and end only when categories are saturated and no new information surfaces. For the purposes of this study, five focus groups and two interviews were needed to fully develop the categories in axial coding and achieve saturation. An example of this process was the identification of recognizing the need to know as a category. This category was further subdivided into: finding role models/mentors; talking with mothers; and taking questions to healthcare providers.

Selective coding

The third step in analyzing the data is selective coding. This step involves further fine-tuning of categories and their incorporation into a theory. Categories are adjusted to fit not just one piece of data but all pieces of data. The interrelationships between the

different categories are recognized and the way in which they fit into a theory. A main category or theme is then identified. "A central category has analytic power. What gives it that power is its ability to pull the other categories together to form an explanatory whole" (Strauss & Corbin, 1998, p.146). Once the central category is identified and named, it is related to other concepts. This then represents the theory emerging from the data. Theory necessarily explains not only the categories but the processes such as actions/interactions that influence or are influenced by conditions under which individuals find themselves. Written memos used contain researcher notes and thoughts about the analysis process. Use of memos and diagrams used throughout help the researcher "gain distance from the data, forcing him or her to work with concepts rather than with details of data" (Strauss & Corbin, p. 153). In this study, the method of selective coding was used to relate the categories to one another, identify the relationships between categories and allow the overall theory to emerge from the data. Memos and diagrams were used to assist the researcher during this phase of data analysis.

Finally, an examination of the theory was made for internal consistency and logic. The question asked was, does the theory represent an abstraction of the data? Validation of this emerging theory occurred by comparing it to the data collected and being reassured that it explained most if not all of the variations. The focus group moderator functioned as an objective consultant and reviewed the data analysis and theory development for inconsistencies and errors. She agreed with the categories that had emerged and the labels attached to them and did not offer any changes. She also approved of the overall theory of "*weighing the impact on me*."

BIAS CONTROL AND RESEARCH RIGOR

Participants as well as researchers bring biases, suppositions and predetermined beliefs to the research process. Therefore, researchers must be constantly on guard

against intruding their own bias into the research process, especially with the analysis of data (Dey, 1999; Strauss and Corbin, 1998). Researchers must acknowledge their personal biases and invite reviewers to identify lapses in objectivity (Creswell, 2003; Dey; Silverman, 2005).

The investigator is a nurse with more than three decades experience working with childbearing families. During some of that time, she was employed as a nurse practitioner for a black obstetrician who provided services to a mostly black pregnant population. What she understood working with this population was the range of life experiences these women had. There was no assumption that pregnancy was necessarily different from that of other ethnic groups. The researcher is a Scottish/Irish American who has been socialized by the larger white middle class society and as such is aware of several instances in which her behavior was racist. The investigator has also been a childbirth educator and believes that childbirth preparation classes can be useful in anticipatory guidance for a hospital birth. Thus, during this study, it was important for her to be alert to how her background and belief systems might influence the research and participants.

In addition to identifying ways in which the investigator might influence the research, bias can also be controlled by inviting an independent outside expert to examine the research process. This entails a review of all aspects of the study for potential bias. Especially important is inspection of written transcripts, field notes, memos, and steps taken in data coding and data analysis (Creswell, 2003; Strauss & Corbin, 1998). For the purposes of this study, the dissertation committee filled the role of expert reviewers as each member had in depth knowledge of some facet of the study and provided critical feedback. A nurse consultant also reviewed the development of the theory for consistency and accuracy.

TRUSTWORTHINESS OF FINDINGS

Besides controlling for bias, strategies are necessary to promote trustworthiness of the findings. These include: 1) the constant comparative method (Strauss & Corbin, 1998), 2) feedback from participants (Creswell, 2003; Dey 1999; Silverman, 2005), 3) use of dense descriptions in reporting findings (Creswell, 2003), and 4) use of experts as previously described (Creswell; Strauss & Corbin). This study followed the above recommendations to increase the trustworthiness of the research process employed and the subsequent results. As noted elsewhere, the constant comparative method was used throughout data analysis. While few in number, some participants agreed to give feedback about accuracy of the data. Purposeful rich descriptions of results were used to convey the study's findings. Finally, the dissertation committee, a panel of six experts experienced in working with pregnant women, black populations, and/or qualitative research reviewed the research process, methods used, and results to offer constructive criticism.

SUMMARY

Grounded theory is an appropriate research methodology for studying the childbirth preparation process black women use in interacting with their environment. While certain issues may present themselves during the research process, most challenging is data analysis. Not only must the researcher adhere to prescribed procedures, but must also use creativity in arriving at a theory which explicates the process of birth preparation used by black women, under a variety of conditions. As an outsider, the investigator throughout this study tried to be sensitive to the data in order to render an accurate interpretation of these women's voices.

Chapter 4: Presentation, Analysis And Interpretation Of Data

The purpose of this study was to describe the basic social processes used by black women in an urban southwestern community, to prepare for childbirth. A grounded theory was developed from analysis of individual interviews and focus group data with black women in the last four months of pregnancy. The data analysis revealed that women pass through several processes in their preparation for childbirth. Subcategories emerged that described the properties and dimensions of each category. Categories were then clustered together into an overarching theory. The social context in which these processes were evident was also revealed. The emergent theory and related social processes will be described in detail in this chapter.

Focus group participants

These data were collected using focus group discussions and two individual interviews with black women who were in the last four months of pregnancy. The study was advertised via flyers distributed at community sites including churches, hair salons, nail salons, a recreational center, as well as through paid advertisements on a radio station, a newspaper, and two web sites with a black target audience. Most interested women stated that they were responding to radio ads or had heard about the study through a friend. Volunteers called the primary investigator (PI) for additional information and telephone screening. Women meeting inclusion criteria were then scheduled for a focus group session or a personal interview.

The focus groups met at a community wellness center. They were led by a black moderator who had herself given birth three times. The PI also attended each focus group. In two instances, a focus group was scheduled but only one woman arrived. On both occasions and by mutual agreement with the PI, individual interviews were

conducted by the PI. All focus groups and individual interviews were organized using a set of discussion questions (Appendix H). The questions focused on pregnancy and preparation for birthing. In total, five focus groups and two individual interviews were held with a total number of 22 women participating. The number of women who attended the focus groups ranged from two to seven per group.

The original intent of this study was to recruit 24 participants who met inclusion criteria. However, recruitment proved to be challenging. Of the 30 women who volunteered to participate, two had their labor induced before the focus group date, two others went into spontaneous labor before the assigned date, one delivered a stillbirth at 28 weeks, one delivered a premature infant at 35 weeks, one was given a cesarean for a breech baby, and two could not be re-contacted. Furthermore, there was a high rate of no show for the focus groups. Thus, the final number of participants was 22 women. In addition, the original intent of having focus groups of six to eight women was difficult to achieve due to scheduling issues.

Other challenges were manifest during the conduction of the focus groups. Occasionally, a participant said little to nothing during the discussion, although the moderator tried to encourage participation by all. Two women in particular participated very little. At one of the focus group sessions, one of the participants was noted to be in her second pregnancy since she brought her toddler to the focus group. During the session, the toddler became disruptive. In order to maintain the flow of the discussion, the researcher elected to take the child out of the room to entertain him. Thus, field notes were mostly absent from that session. At another focus group session, one of the participants brought a friend who was pregnant. This woman signed the consent form but was not interviewed for inclusion criteria prior to the session, although she stated that she

was in the third trimester of her first pregnancy. She was subsequently found to have met the inclusion criteria and participated actively in the discussion.

The women who came to the focus groups seemed mostly animated and enthusiastic about participating in the discussion. Twice the discussion groups lasted longer than the allocated two hours. At the conclusion of those sessions, participants were advised that the focus group had ended, but the women chose to continue. They continued their discussion about topics unrelated to the research. One focus group session lasted four hours and ended only when the researcher excused herself due to a prior commitment. The women then continued their discussion in the parking lot.

Sample characteristics

Demographic characteristics of the study participants are presented in Table 4.1. All of the women stated they were in the last four months of their first pregnancy (n=21) except for one (n=1) who was in her second pregnancy. (She was included because she provided the transportation for another participant who stated she would leave if both could not be included. The multiparous woman was advised that the discussion was to center around the first pregnancy. She acquiesced and gave valuable information about her first pregnancy). Their ages ranged from 19 years to 34 years with 59% (n=13) 23 years and younger. The remainder, 41% (n=9) were between 26 and 34 years. All women had at least a high school education. Those who had at least some college, 78% (n=17) far outnumbered those with just high school (n=5). Four of the women (18%) had an undergraduate college degree and four (18%) had a graduate degree.

Seventy seven percent of the women (n=16) in the sample had a partner, with those married (n=9) outnumbering those who were single with a partner (n=7). Those who were single without a partner (n=6) were all between the ages of 19 and 23 years except for one woman who was 31 years old.

Table 4.1: Demographics of the Study Sample

	Frequency	Percent
Age		
19	2	9.1
20	2	9.1
21	4	18.2
22	4	18.2
23	1	4.5
26	1	4.5
27	1	4.5
29	1	4.5
30	3	13.6
31	1	4.5
32	1	4.5
34	1	4.5
Total	22	100
School Years		
12	5	22.7
13	3	13.6
14	1	4.5
15	5	22.7
16	4	18.2
18	2	9.1
19	2	9.1
Total	22	100
Marital Status		
Married	9	40.9
Single with partner	7	31.8
Single without partner	6	27.3
Total	22	100
Income		
Adequate	12	54.5
Inadequate	8	36.4
Maybe	2	9.1
Total	22	100
Employment		
Yes	15	68.2
No	7	31.8
Total	22	100

Fifty five percent of participants stated that their income was adequate for their daily needs. Eight women (36%) stated their income was inadequate for their daily needs. An additional two women (9%) were unsure whether or not their income was adequate for their daily needs. Of the sample, 68% (n=15) were employed, with the remaining 32% (n=7) being unemployed. Thus, the demographics do not represent a primarily middle class sample. Participants said little about their employment except for one woman who talked about being a teacher.

Discussion group processes

Prior to beginning the research, the PI reviewed with the moderator the aim of the research, the procedure, the need for confidentiality, and the interview questions with possible probes. The focus groups were conducted in the conference room of a local clinic. All five sessions were moderated by a black woman who had prior experience moderating focus groups for the PI. The only white woman was the researcher. Two additional individual interviews were conducted alone with the researcher. Three of the focus groups lasted the anticipated 90 minutes, one lasted two hours and one lasted four hours. One of the individual interviews lasted two hours and one lasted 40 minutes.

The moderator and the researcher worked to achieve a relaxed environment for each discussion group. Upon arrival for each session, the women were invited to partake of the snacks which consisted of juice, fruits, cheese and crackers. In all cases, the women helped themselves. They were encouraged to get up and get more snacks and to leave for the bathroom as necessary during the discussions. The gathering of participants' phase often took 30 minutes. This time proved valuable for the mothers to get to know each other. The researcher would sometimes excuse herself and leave the moderator alone with the women before the actual focus group discussions began. This was a

conscious effort by the researcher to help build trust between the moderator and the focus group participants.

During recruitment, the researcher was often confronted in the black community with questions about why she was studying black women. Sometimes the question was asked as to what differences the researcher expected to find between black and white women. The researcher would respond that she expected to find few if any differences and that this research was in no way intended to discover deficits or negatives. Rather the goal of the research was to explore how living in an environment of inequality might impact the process of preparation for the birthing experience. It was from these encounters during recruitment that the researcher felt the need to address this issue prior to the beginning of each taped session. Thus at the start of each session, the researcher specifically stated that this study was not about differences between black and white but rather to give voice to black women about their pregnancy experiences in preparing for childbirth. In this way, the researcher tried to reassure women that their ideas and opinions would be valued.

During the group discussions and individual interviews, women responded to the semi-structured questions by sharing their experiences of being pregnant and the ways in which they were preparing for the birth of their child. While the pregnant moms often started by trying to figure out what the moderator was asking, as they became more comfortable in the setting, they began to share more freely some of their thoughts and reactions. What one woman stated often triggered a memory of a similar experience in other participants. Sometimes the women shared information and sometimes they gave advice. While they conveyed agreement on many points of discussion, there were also differences of opinion. At times one participant was able to sway another participant to her point of view. All women maintained cordiality towards one another and seemed

eager to hear what each person had to say. Even the two women who participated very little in the discussion indicated by their body language that they were engaged and taking in the discussion.

Results

The audio recordings transcribed amounted to ten hours and nine minutes of collected data. This came to a total of two hundred and two pages of transcription.

Thirteen categories emerged from the data. These categories were clustered together into four processes which represented the processes that study participants used in preparing for childbirth. The overarching grounded theory that surfaced was *weighing the impact on me*. Throughout the verbal exchanges with the pregnant moms and when the researcher analyzed their conversations, moms were found to actively engage in trying to determine what the best course of action was for them and their pregnancy. They were found to weigh and consider advice from others, what relationships were crucial, what information was most important to them, and many other issues that arose.

Woven throughout these processes, from beginning to end, were two significant issues. The first was the importance of relationships. Relationships were often in flux, with certain ones coming to the forefront while others receded into the background. Of second importance was the social context in which the women found themselves. Beyond their families and friends, the women were very much aware that they live in a world that often treats black people differently. Thus, throughout pregnancy there was an underlying recognition of this milieu, in encounters with the public as well as encounters with the healthcare system. Finally, while it was apparent to the researcher that relationships and social context were important throughout the four processes of preparation, there was also an understanding that these processes produced changes in the participants. What follows is a discussion of how these processes of childbirth

preparation unfolded for study participants. Any names used are pseudonyms the mothers chose for themselves.

DISCOVERING PREGNANCY

Interrelating With Others

Many of the participants talked about what it was like to discover they were pregnant. Each had her own reaction to the news of pregnancy. For many, the news was a shock. They had not anticipated being pregnant and becoming a mother. For others, it was welcome news. How they reacted to the news depended in part on weighing their relationships with others, especially their spouse and father of the baby. Thus, the first category to emerge in the first process was *interrelating with others*.

One mother weighed the quality of her relationships when she became pregnant.

> So, um I can kind of relate to what Rose was saying about being in a relationship because, um, of course this [pregnancy] was a surprise to me. And um I'm just glad that I have support from him [father of the baby] and from my friends. Because so many people have, I guess, are in situations where they don't have somebody that they're the sole provider. And even me, just being, my grandmother raised me. It was just me and my sister and my grandmother. So I know that it can be done but I'm thankful that I don't have to go through that.

Another mother had used fertility drugs and decided to adopt. She explained her and her husband's joyous reaction to being pregnant:

> And then when I found out I was pregnant, just total shock. So and then, like absolutely euphoria…we had been trying to get pregnant for what seemed like forever. And he (husband) said it's like this is an absolute miracle. It's a blessing, you know, this is an absolute gift from God because this, it wasn't even supposed to happen….

One mother voiced regret. Although she said she was happy, she did not sound happy. She indicated less support and seemed to have fewer options to weigh. "I mean I'm happy about it but wish he [father of the baby] would have told me this before [that

he did not want to be involved]. I mean I have to take care of it (the baby), it's my responsibility and nobody else's."

A fourth mother explained her dilemma about finding out she was pregnant, not having a supportive relationship with the father of the baby and weighing options.

> Because me and the father of my child, we weren't really together technically at the time when I got pregnant. And so, I mean he wants to be with me and I'm just kind of on the fence about him. And it's just been a lot of drama between us. Kind of just a lot of drama. And he's not real sentimental about the fact that I'm pregnant. He don't really try to ease the stress. I think he does things sometimes to make me upset.

An explanation of how one mom weighed being pregnant in an abusive relationship was: "One of the reasons I brought up the relationships issue is because …I feel like emotionally and mentally and my ability to endure and enjoy the pregnancy was greatly affected by the fact that I was in an unhealthy relationship."

In summary, the category of interrelating with others was the first to emerge in the process of discovery of pregnancy. The news of pregnancy was processed differently by each mother and was influenced by the relationships she had with those around her. Each mother weighed her relationships, especially with her husband or the father of the baby. The more positive the relationships with others, the more initial happiness each mom felt about being pregnant.

Accepting pregnancy

The second category in the first process was *accepting pregnancy*. Accepting pregnancy was the process each participant went through to acknowledge conception. Some participants took longer than others to accept their pregnancies. For each mom, the quality of her relationships, often with her partner, plus the degree to which she desired to be pregnant, determined her acceptance. Again she had to weigh and consider what the best course of action would be for her. There were three reactions by women to the news

that they were pregnant. Some were accepting, some were overwhelmed, and others were negotiating with themselves. These were three identified subcategories. The pregnant women who were happy about the pregnancy and in supportive relationships were immediately accepting of it. Words used to describe their feelings about pregnancy were: "euphoria," "happy," "excited," and "elated." One mom said, "But as soon as I found out that I was pregnant, I know a lot of people wait to tell people, especially after having a miscarriage, but I was happy. I wanted everyone else to be happy with me too."

Participants who did not have a supportive relationship with their partner often started out feeling negative about being pregnant but then after weighing and considering their support systems, accepted the pregnancy. These were the negotiating women. An example of a negotiating mom's statement was:

> When I found out I was pregnant it was a big shock. No one thought I would want to be with kids. I'm not a kid person. I felt sad because me and the baby's daddy were not together. I didn't really want to be with him. But then my family was very supportive. I have two sisters who have been through it. So now I'm okay. I feel happy about it (the pregnancy).

Only one participant seemed overwhelmed by the pregnancy. She talked about her family's reaction and her relationship with her partner. It was clear that in weighing her options she felt burdened, and weighed down by the pregnancy and especially the potential financial stress. Yet she stated that she accepted the pregnancy.

> The baby's father left a couple of weeks almost [after I found out I was pregnant]….I've been told that my baby is going to be ugly just like her mama. I may not be a beautiful person on the outside but I'm beautiful on the inside… The type of business that I do now it (the baby) ought to grow up in a house or something….When you have your son or your daughter you'll start getting postcards for why the baby won't stop crying….Next they worry about CPS…. I took a step in my life where I have to show my mom then who's the grown up. Because if you always ask your family's help they're going to be like, oh she can't (manage for herself). They (family) may not always be there for you either unless you have a backup plan behind every other backup…. I mean I'm happy about it but I wish he (baby's father) would have told me (that he was leaving)

> this before. I mean I have to take care of it (the baby), it's my responsibility and nobody else.

To reiterate, accepting pregnancy was the second category in the first process. Some participants immediately were accepting and overjoyed at being pregnant. These were the mothers who had good relationships, especially with their partner. Others were uncertain about how they felt and negotiated with themselves about whether or not continuing the pregnancy was the right course for them. These women often had a more tenuous relationship with their partners but had good family support. The positive relationships with their families allowed them to accept the pregnancy. Only one participant seemed overwhelmed by pregnancy. She had neither a good relationship with the baby's father nor with her immediate family and yet she accepted her pregnancy.

Awareness of social context

Awareness of social context was the third category in the first process. Manifested in the discussions with moms was that they were very much aware of the social environment in which they lived. This was primarily attention to the experience of prejudice from some in society. Most of the women discussed racism and discrimination against blacks and in particular black women. Often they had to weigh what reaction would be best for them. Some reacted negatively while others tried to ignore the presence of prejudice. One middle class pregnant mom commented:

> But I think that a lot of black women do experience some form of discrimination even if they're in the hospital, for example, if they don't have a husband or if it's just you know them and their mom because they're young and they're not married or whatever. I think that some people will tend too have an attitude like, oh well, it's another one. It's another, you know, teenage mother, that's probably just going to go out and do the same thing all over again because she didn't take care of business the way she should have the first time….And I think that while it won't come right out…I think it's more the prejudice, more of the attitude, more of the mental vision, the stereotype of the person, of the mother, as opposed to actually taking the action and doing the discrimination so.

In relating a story about being treated as different, a young mother weighed how she would react in such a situation and gave her advice to the group.

> At one point I was living in a black neighborhood, going to school in a white neighborhood. It's a difference. I think I got to the point to where I kind of let it roll off my shoulders. I know I'm different from them. I know regardless of what I say too, I could be the most intelligent person in the world. You know I could be the president, you're still going to look at me different….Just ignore it I guess. I know it hurts. It's going to hurt because you don't want to be singled out because of your skin. But what can I say, pray for people.

One participant told the story of trying to get Medicaid when she was pregnant. She felt she was constantly treated with disrespect. Her treatment led her to forgo Medicaid in favor of working two jobs each with long hours. She expressed great difficulty in coming to terms with what was best for her and her baby. "And I didn't know if it was okay. I kind of felt guilty about that. But it's like, you know, what do you do? You're weighing your options." She continued:

> I think people have their own individual preconceptions….I've heard a lot of people think that all black people just want to be on welfare and that we go out and we get pregnant because we figure the government will take care of us, our life will be somehow easier for us. Like it's a luxury to live in a project apartment and not have to pay any rent. It's not. You sacrifice for that situation….I never feel right in there (Medicaid office). It's just enough to kind of just make you want to just, you know, leave and suffer sometimes.

In response to a question about differential treatment because of race, participants had mixed reactions. A teacher in the group commented on what happened when she had to remove her wedding band due to swelling, and the subsequent ensuing reaction to her. She said she was uncertain whether or not it was due to race or "it's just me."

> Something I'm really frustrated about is that I'm not able to wear my wedding band right now because I'm swelling. And I've noticed that just society in general if you don't wear your wedding band when you're pregnant you don't get the same response….And I had a mother (of a student) ask me 'are you even married?' And it was like, well if I wasn't what would it matter to you? And I was like yes I'm married. We've been married for two years, trying to be as pleasant with this conversation as possible, but she really pissed me off.

This sentiment was echoed by another mom who indicated that she was weighing the impact of wearing or not wearing her wedding band. She indicated that sometimes she tried to wear the band to avoid people staring at her. Her comments were made in the context of a discussion about race and stereotypes about black women as being sexually promiscuous and unwed mothers. She said:

> But that's one thing that's whoa, my hands are swollen. I don't wear my wedding band. I'm not wearing my watch. I don't have my class ring on. So, I've just noticed a difference in how people respond to you. They are not, from my experiences, they have not been as willing to help or as friendly, or, you know, previously I'd go to Wal-Mart, and oh, my goodness, how far along are you? You look so cute, you're growing. You know, all those little comments. And now, like you just get a stare. People give the eye. I stopped wearing my wedding band….But I'll say, depending upon where you go they look at you like, look at her. She's an unwed mother and a whore. I'm like I'm not unwed. And it's so amazing that in 2008 that we also still worry about…that they're looking at us like that. And it makes you feel uncomfortable.

Finally, one mom summed up the thoughts of many of the moms "If I had to think about it, yeah, I experience prejudice. But I try not to think about it. I just block it out." Her comments indicated that for her, she had concluded that the best course of action was not to dwell on the negative treatment encountered as a pregnant black woman.

In conclusion, the first process marked the beginning of pregnancy preparation for childbirth. Each mother weighed options as to what was best for her. Relationships played an important role in determining whether or not the woman accepted, negotiated or became overwhelmed by the pregnancy. While partners and families could be very supportive, the larger social context could also be negative. Some women reacted to this social context, others tried to consciously ignore it.

MANAGING PREGNANCY

As pregnancy progressed, the women were confronted with continued decision-making. Each woman's experience with pregnancy was different. The uniqueness of each

pregnancy was noted by a number of participants. Some women experienced only physical changes while others also experienced emotional changes. Often, their life circumstances changed. Some moved to a different location to be closer to family. Others finished projects that needed to be completed before the baby's arrival. Some stopped working or going to school. Again, as in the first process, relationships and awareness of social context were ever present. Some relationships became more important than others. Moms often mentioned that their relationship with their spouse or partner became much deeper and closer. Families too were seen as very important. As moms managed this period of pregnancy, they sought guidance. They asked questions, sought information, asked for help, and in doing so had to make decisions about what was important to them. The first category in the second process to become clear was *changing life circumstances*.

Changing life circumstances

The pregnant participants noted that pregnancy became a time when they felt an urgency to weigh decisions about their living circumstance. Changing life circumstances was a category in which women implemented major changes that needed to be made before the baby's arrival. This often entailed moving to a different domicile, changes in employment, or change in their life's priorities. For example, one mother explained how pregnancy had forced her to reorder what was important. In the past, she had focused on making sure her life was perfect but now was satisfied to concentrate only on the pregnancy. She voiced what other moms also indicated, "So anyway it's been interesting, it's been, it's definitely a life changing experience for me. I can say that."

Changing life circumstance for some moms meant moving back home to live with parents. This was especially true for younger women. They wanted to be close to family or relatives who could be their support systems. One young mom was in her last year of

undergraduate university study but suddenly felt scared about being pregnant and far away from home. She agonized about the decision but finally decided that because of prior health issues it would be best for her to be near family.

> The beginning of my pregnancy was so stressful because it was my first pregnancy. Actually, I honestly never wanted kids but it wasn't a thought. But I was in my last year at a university outside of Houston, so like, you know, I went through a lot dealing with the fact that I wasn't going back to school because I didn't want to be too far away from home knowing that I was pregnant and had prior health issues as far as like, well, I'd pass out and have seizures or whatever. And we don't know if that is it yet. So, knowing I was pregnant I was real scared. So, I came home ….

Another participant tried to decide if it would be better to continue living on her own, move in with her boyfriend, or move back home. Her sister attempted to dissuade her from giving up her independence and moving back in with their parents. The participant persisted and felt she knew what was best for herself.

> I'm not ready for this. I want to come home….I mean, my boyfriend has his own place but I'm really not feeling that right now because I know I'm going to need a little help. And my mom can help me better than he can.

Also as a part of changing life circumstances, pregnancy was a time to bring closure to unfinished business. There was recognition of the limited time to make life circumstance changes. The weighing and considering of what course of action to take brought on additional stress and uncertainty. For example, one mother talked about the stress of buying and moving into a new house. This was compounded by decisions about whether or not to leave her job, and whether or not her husband should leave his job and return to school.

> We were in the process of, we're actually still in the process of buying my mom's house and so there was a lot of stress with taking care of that because it's going back and forth….And aside from buying the house there's still the question with my job. Do I stay? Do I go back to work? What do I do? And um okay now I need to get things together because it's getting so close…and it's like okay, well,

> my husband's not satisfied with his job, so….And I was just like there's so much going on in my head ….

Pregnancy and the weighing of when to leave and return to work were life changing circumstances voiced by other participants as well. One mother lost her job during pregnancy which in turn greatly impacted her and her husband's lifestyle and life circumstances. She was obviously conflicted about the best course of action to take for herself and her baby, and still undecided what to do.

> I had a job until they found out I was pregnant, and then they made me take maternity, made me take medical leave. So, I've been sitting at home, you know….And there are people like are you going to go back? No. Why not go back? I says why would I go back to something like that? And I was having to work seventy hours a week 'cause they don't pay you anything. You just do the job because you love the job. You going to come back (to work)? I don't know. Because I can't you know. They're open from like four in the morning until one o'clock in the morning, and you can't necessarily find a baby sitter….I'm probably going to have to work from home. Somebody told me I could be a substitute. It scares me to be a substitute teacher because I don't like other people's kids.

Another aspect of changing life circumstances was evaluating resources. This subcategory involved evaluating human resources whether family, co-workers or spouses and partners. As seen in previous comments, pregnant mothers often thought of family as an important resource. Still the participants considered how and in what way families might be important. Sometimes families were seen as a financial resource. Sometimes families became a source of moral support, or a source of information. Often there was the realization that families were important but that family dynamics could also be a source of stress. Thus, as one aspect of changing life circumstances each mom had to weigh the impact of her family. An example of family as financial resource and emotional support was given by one mother who explained why her own mother insisted on buying her daughter a car.

> She (mom) went out of town for three, for a month. And she called me everyday….She was like I had to come home. I got me a new car just so I could, they can make sure if something happened. I was like, okay, I'm only four months. But if you go into labor? I'm like I'm only four months. We're going to get you a car so because no one's going to be here with you. So, I'm like, okay. I don't care just bring this car. So they were gone then she (mom) came back. She couldn't take it. She wants to be there everyday. And I'm like, as long as my mom is there, I'm fine.

Another participant told of why her parents were buying things for the baby:

> Yes. It's crazy. Stuff that I wouldn't have bought, you know the parents get the budget. The grandparents, they get to do it because they don't have to. See? That's why they do stuff. I'm happy to do this. But when you were kids and you wanted something, they said you crazy. But when the grandkids come they get everything they want. Oh they're not mine. So…

A woman whose three brothers were geographically scattered, talked about how excited they were about her pregnancy and wanting to be involved. She voiced regret they might not be present at the birth. At the same time, she found she could not agree with everything the family said. Yet she felt the need for family. "My family, like I mentioned earlier, we've had a lot of conversations about what to do, what not to do….It's been really good, though. It's brought my family a lot closer."

For some, family was a source of conflict. A participant voiced the positive and negative aspects her family played in her life.

> All of my family's here except for one of my sisters who lives in Houston. So all of them are here, and it seemed like it's a great thing, but I think we get along better when we're like not together, when we only have to see each other every so often.

Besides family, other human resources weighed and considered by participants as sources of information or support included extended family, friends, co-workers, pastors, church members, and other pregnant mothers. However these other resources usually played a much more peripheral role than those in the women's' immediate family. Moms listened to what these resources had to say but did not necessarily follow their advice.

For example, one participant was asked if she talked to women in her church about her pregnancy to which she responded:

> There's been a few people at church that I've asked a lot of questions….but it has really been just like basic information. And one of them is also a nurse. So got some information from her about her pregnancy and relating it to my own, but mostly it's been with B. my best friend and my own research.

A co-worker of one of the women frustrated her because he was constantly giving unwanted advice. She indicated he thought having gone through pregnancy with his wife that he was an authority on the subject.

> I had a discussion with an African-American coworker of mine. And he tends to think that he's a doctor so, when he catches me eating chocolate he snatches it out of my hand. If he sees anything on my desk he takes it off. He tells me to breastfeed. He's trying to promote that. It's crazy because he had his first child recently and he's a coach of his wife.

Most participants found that while families were the major source of emotional support, people in the work environment could also be supportive. This was not true for one participant who lost her job because of pregnancy. In general, however, the work environment took a caring attitude towards those pregnant. Women appreciated this as they tried to manage pregnancy symptoms, doctor's appointments and a flood of information about pregnancy. One participant told of how family and coworkers tried to shield her from emotional distress.

> And so when I got pregnant because my coworkers and my family know that I get overwhelmed with all the big stages in my life, you know, they're just really protective because they want to make sure, you know, I don't have to take a break from my baby.

A teacher explained how the women at work were always chit chatting with her about pregnancy and would occasionally put a pamphlet or helpful suggestion in her mail box. She explained that although it was nice to have, it was different than the support she

received from family, who could always be relied upon to be available. It was clear that this mom saw support from her coworkers as not as essential as that of her family.

> And the ladies at work have been very helpful. Yesterday, matter of fact I got an affirmation and relaxation CD. I get stuff like that....and I have several kids in my classes whose mothers are nannies, so they kind of just call, how you feeling? And dadadada. So just kind of a lot of talking, you know.

Also a part of the subcategory evaluating resources, participants engaged in appraising emotional support from spouses and partners. Most of the women viewed this support as a more important resource than family support. Participants spoke of wanting their husband or partner to be emotionally available to them during the pregnancy. Often they expressed being pleasantly surprised by the closeness that developed between the couple. Words like "bonding" and "there for me" were used to describe the men's behavior. While some of these women also expressed frustration with trying to get their spouses or partners to engage in certain activities, they still saw their men as very central to their enjoyment of the pregnancy. The participants further appraised the ways in which they perceived their partners or spouses. Some women weighed the role they wanted their husband or partner to play and it was at their side. This meant the baby's father would be physically and emotionally present and available to the participants. One mother stated emphatically, "But reality is, if there's one person that you want to support you through that time in your life, it's your partner, it's the person that's supposed to be handling it (pregnancy) with you. And I said a lot of that." Another mother voiced a similar feeling when she said, "Maybe I'm just speaking for myself of what makes the experience (pregnancy) exciting, um, has lots to do with my current relationship." When bleeding necessitated a trip to the ER, a pregnant mom recounted how her husband was at her side encouraging her and giving her strength.

> And so I just broke down. I started crying and even then, you know, and it's new stuff that you find out about the people you're closest with, people you've been

> with for x number of years and you never really heard them encourage you like that before, and you know, I was so upset and he (husband) was like don't cry, don't think any negative thoughts…. And it's like I didn't know he was really capable. I knew he had the ability to cheer me up, but I didn't know he could actually kind of help by instill strength, you know.

For some participants having husbands at their side and yet not overprotective was an issue. One mom explained about her husband. "Okay, because, I mean I have an awesome support system but it can be like kind of suffocating sometimes. Because of B., my husband is just something else." Another mother said:

> Or it's don't' do that, don't touch that, don't move that. And then it's like I told him (husband) I'm pregnant not handicapped…and this one day we were at the grocery store, I think, and we couldn't find parking. And I was like, man, I wish I could park in one of these handicapped spots. He goes I thought you were pregnant not handicapped. Ha ha. You need to find that happy medium.

Not all participants wanted the baby's father at their side. These moms weighed and considered the role of these men. Some women preferred to have the dads minimally involved with the pregnancy and kept the dad on the side. Unlike at my side, on the side meant the participant was not physically and emotionally central to her pregnancy. A mother explained how her partner wanted to be involved but she had decided she preferred her family over him. She decided to keep the baby's father on the side.

> I'm kind of like what she said. I mean, I love him but I don't love him….He wants to be there, but in reality I don't plan to have him, you know, be there….I know it's just not going to work….But if he wants to see the baby I'm not going to stop him. But I'm prepared to have my family to help me and just be strong.

Another mother voiced:

> It's not that I need the help from my partner because I'd rather not deal with the stress of knowing that it's (relationship) not going to work. I think that I should just stop it from beginning and deal and learn how to be a single parent.

When one mother weighed what she saw in other relationships, it made it easier for her to decide not to actively involve the father of her baby in the pregnancy. She had seen her sister go through a difficult relationship, give birth, remarry and be totally

happy. This pregnant mom realized that the future could hold promise for her also, like her sister, of a better relationship with a new partner.

> And a lot in my opinion comes from watching other people's relationships. My sister, the reason why I know I will be okay not being with the father of my child is because now her relationship, the person she's with now is so, you know, I love it. [Laughing] That's how good it is. So I'm okay with not being with the father of my child and knowing that as long as I do what I have to do and you know, stay strong and pray, you know. Everything is going to be okay.

Thus, the role of participants' spouses or partners were part of changing life circumstances, as the relationships changed and became closer or more distant. Some women wanted their partners in the background while others wanted them to be actively involved in the pregnancy.

To review, what emerged in the second process from the category of changing life circumstances were decisions participants made to stabilize their situations. Sometimes this meant changing life habits or changing residences, as well changing relationships. It also meant evaluating resources within and without the family.

Recognizing the need to know

Also within the second process, as moms' pregnancies progressed, they began recognizing the need to know. This category included many aspects of making decisions about information that would be helpful to them in their pregnancies and birth. This category centered primarily on looking to others within their families, amongst their social contacts, within their circle of friends and through their healthcare providers, for direction. Often the participants weighed and considered who they thought was most reliable in disseminating knowledge about pregnancy and birthing.

As part of the category of recognizing the need to know, a subcategory which appeared was, finding role models or mentors who would share advice and experiences about pregnancy and birth. Sometimes this was their own mother and sometimes not.

The most reliable models or mentors were close friends, sisters, or women who had already experienced pregnancy and birth. Those women, frequently close friends, who had recently completed pregnancy, were considered to have the most up-to-date and realistic information. Participants were in close contact with whomever they saw as the best mentor. They would refer to these women when needing advice, information, or answers to questions. The value of experienced mothers was voiced by one of the participants.

> You know, the part that I am going through now (pregnancy), it's not that bad. Yeah, it's not that bad. But I have, um, family members and friends and relatives that have experienced it. It's actually not been a bad experience…

One participant talked about her best friend who was a mentor during pregnancy and always available to answer questions or concerns.

> And of course, you know, we worked together. We lived in the same apartment complex and everything, so we're very close, and we go to the same church. So we see each other all the time. And so I was there with her during the entire pregnancy just like she's been you know there for me, so when I have questions about my pregnancy, you know, is this supposed to happen because I don't remember reading about this in the book? And she'll say well, yeah, it's probably just this. And so it's like total better. But she's been through a lot of the same things that I've gone through, so.

Another mother discussed how she had consulted a friend of hers about labor:

> I have a friend that's young and she has three (kids). She had all of hers natural. She had hers natural without the epidural. And I think you still feel it (labor). You still feel it sometimes, but it's not as bad as you would think.

Watching someone in labor was seen as the best opportunity to observe a role model. Several of the women in the focus groups had had such an opportunity. One woman recounted her experience.

> My best friend. She had a little girl just over a year ago, and so she actually went about three days past her due date, and you know, I was there with her the whole time and her husband and everything….And so when I went in there and visited

> her, I watched her, you know. I listened to her breathing and her talking and everything….I was like did this happen? Did that happen?

A participant talked about how she watched her older sister's pregnancy and how she had consulted others. "I just kind of being able to watch her (sister's) pregnancy, difficult in comparison to what I've experienced, what I've been through….And I ask questions. I ask my mom and my sister and best friend and stuff."

The importance of a sister's prior pregnancy experience was also voiced by another study participant who was struggling with early pregnancy nausea.

> Well, my family is very supportive and they always…I take in what they have to say. Especially my sister….And my sister, she kind of told me, you know, she talked to me about how much this could affect the baby and what I really needed to do to kind of settle down.

Besides finding role models or mentors, research participants also looked to their own mothers for guidance. Thus, the second subcategory emerged which was talking with mothers. Some of these women's mothers were seen as reliable sources of information, especially for younger women. Implicitly trusted was the advice and knowledge imparted by these reliable mothers. One young mother who had moved back home related time and again how she listened to her mother and followed the suggestions and explanations given. Her mother served as a reliable mentor.

> My mom especially I think she's excited because she's going to be a grandma. She's been there for me. You know how when you first start off you have pains in the back and you kind of feel like menstrual cramps or something? I thought I was having a miscarriage. She was the first person I called and she helped me through because I was crying and I was scared. But she was there for me.

Although many of the participants looked to their own moms to mentor them, sometimes they could not accept what their mothers said. For some of the pregnant participants, information mothers gave them were not necessarily applicable to their particular situation. Weighing advice and information was important in deciding what

action one could take for oneself. Information and advice might or might not be useful. These mothers were tolerated rather than viewed as reliable by their daughters. Participants acknowledged what their own mothers said but did not need to follow the advice given. Thus they were tolerated. As one pregnant mother explained, dated information from her mother was not particularly useful.

> You have family members, yeah, they probably have been through it but they're not going through it right now. So, what they gone through twenty-six years ago, and I think it's important, to get-up-to-date-information. You know, because time is changing and there's different things that is available to you, you know.

Another example of a woman who tolerated her mother was a woman who listened to her own mother but chose instead to follow her physician's directive.

> Yeah, I listen to what she (mom) says. I listen. It's very interesting but a lot of the things that she says like when she tells me, you know, your water can break and you can stay home for another three hours or so and then you can go. So different time period, you know….I listen to everything and I take it all into consideration, but I also know what my doctor has told me, and what's going to work best for me because we may not have the same pain tolerance. And the circumstance may be totally different.

A difference of opinion between women and their families could create unnecessary conflict and tension. As a participant stated,

> Yeah. And it's like, they don't understand that, that, you know, the world is changing and if I want to do something different than what they did, it's like, I think I'm better than them. I don't know how to explain it….They just don't know how to accept it, because the women in our family, they all tend to follow the same cycle. But it's like, I don't want to go through the same stuff they went through. It's like, I'm breaking the cycle and they don't know how to deal with it.

Thus, although participants listened to others and looked to them for mentoring, the research participants often reserved the right to decide differently based on what was best for themselves. One woman weighed and thought about what people said about labor and how it might apply to her. She reasoned that everyone is different and every pregnancy and birth is different. She wanted to keep her options open.

> Yeah, I've spoken with a few people at my job, some of the girls that I work with, and like she would say I went totally drug free, it was the best thing for me, and when I was going through my contractions what helped me was for everybody to just be quiet, don't talk, don't touch me, don't do anything. Well I'm a very extraverted person, I'm very outgoing. I need people. I need noise, you know. I need stuff going on in general, but perhaps during labor I may want that total quietness….You know, so, I think when it comes down to it I'll just have to see what works for me.

In addition to finding role models or mentors and talking with their own mothers who might be reliable or tolerated, women also took questions to their healthcare providers. Taking questions to healthcare providers was the third subcategory identified. All participants voiced that they had many questions about pregnancy and birthing for the physicians and nurses. Participants had mixed responses to their providers. Some women were very satisfied with the interactions with physicians and nurses. They felt care and information they received was appropriate and helpful. However, there were many other participants who were dissatisfied with care and information received. If they could, these women tried to work with the physicians or nurses to improve communication. When that did not work and questions were not answered, the moms had to decide to tolerate the situation or occasionally to change healthcare providers. Sometimes the unhappiness with care was related to perceived discriminatory care.

Many of the women were very happy with their interactions with care providers and were getting answers to their questions. Getting answers meant that participants approached their providers with questions about pregnancy and birthing. These women felt they received ample information and explanations to questions about their pregnancy. An example of such an encounter was discussed by the participant with early pregnancy problems who said:

> I would call my doctor, or really I would be speaking with his nurse….I would call her and ask questions, and it got to the point where I had her number memorized and she had my number memorized, and I would call her with more

> questions. The further along it got and the more…I was fitting in with the normal pregnancies that I had read about and heard about and everything, then our conversations tapered off.

Satisfaction with questions being answered was recounted by another participant who found her physician and his nurse both to be comforting as well as informative.

> And then I went to a little doctor, a little Caucasian doctor. I love him. I'm in love with this doctor. Not that he'd be my next baby's daddy but he, um, he was really like comforting. He talked to me. He talked about the baby, everything. So that plays a large role. And it's not racial but it's just like depending on how they treat you. And some places, some facilities treat you differently according to your economic status or your insurance.

Instead of getting answers, some of the women indicated they did not get questions answered in a satisfactory manner. When mothers did not get enough answers to their questions and concerns, they felt uneasy, sometimes resentful, and remained still questioning. Still questioning described participants' frustration at not feeling like their questions have been adequately addressed. In some cases, the participants relayed their concerns to the nurse when the physician was unresponsive. Looking to the nurse as one who would answer questions, a participant explained:

> And if I have a problem, like I'm close with the nurse, closer to the nurse than I am with my doctor. I know she will relate any problems that I have over to him if I call. Because that's normally who you're going to speak to because he's (doctor) out….He's really busy. Looks tired all the time. So, I can't wait until I'm off his hands. That, that's how he looks, like he's unhappy.

In other cases, it was the physician who helped address the mom's concerns when the nurse was difficult. When the nurse did not answer one mom's repeated calls to the office, an emergency room visit became necessary. The mom said:

> Like with mine I had to go to the emergency room. So I contemplated changing doctors but I liked the doctor. It was the nurse, she probably didn't get back to me. And I didn't want to, I liked the doctor, so I waited and, you know, luckily I haven't had, you know, to call him for anything like that again, so.

When physicians or nurses were unresponsive to participants' questions, the women had to weigh and consider whether or not they should advocate for themselves. This was a difficult thing to do and moms usually tolerated the uneasy relationship with healthcare providers, rather than change physicians. One mother explained the dilemma.

> …when I got to that point to where I felt like she (physician) wasn't talking to me, she wasn't taking out the time to speak to me, that's when it became this, it seemed like it was I don't have time for her questions type of behavior, and that's when I got into disagreement with her nurse. And it was this horrible, horrible, and it, she had changed nurses, and really it was the nurse that was helping her out that messed up everything and messed up the relationship. And then so we got fine and then she got her own nurse, and so now we're cool again.

Mothers who were very unhappy with the provider relationship looked for another physician. This happened to participants who felt they were getting inferior care. These women did not feel their physicians expressed a caring attitude. Participants felt physicians or their staff did not take sufficient time or provide ample explanations. This only happened to three mothers. One mother changed doctors twice before she was satisfied that her concerns were being met. She explained how her physicians did not seem to take time to address her questions adequately.

> Because I switched OB's three times. The first one, I don't like for you to run in and talk to me like you got something to do. You just got there. You're thirty minutes late. So, she came in, she's oh great. You're twenty weeks! Okay great. Oh yeah, no we won't do a sonogram for another month. Okay, bye. She walked out. I said, you know what? I'm going to leave her. So, I went to another doctor. She was seven foot tall with a voice like this (participant lowered and deepened her voice). And, uh, and, and this is a nice doctor. And she came in and she doesn't have children….Well, you're thirty weeks. Everything looks good. Blood pressure is fine. Okay, gotta go. Okay so she leave out….Well, it's amazing how you get a generic answer for some things. Because that's why I fired the other two OB's.

Besides complaining about inadequate time and inadequate explanations from medical staff, participants also sometimes felt they were being treated differently because of their race. This might be in the office setting or in the hospital. The differential

treatment closed off communication and moms again felt like they did not get sufficient answers to their questions. Again they had to weigh and consider what to do. Often they seemed resigned to the social context and tolerated this differential treatment. A trip to the hospital and being treated like "a minority" was recounted by a mom.

> But, um, she kept saying, the nurse kept saying in the labor and delivery because I was admitted into the hospital, your Medicaid or your Medicaid. She kept saying you have your Medicaid? Um, but, um, it did offend me because I am a minority. I said, ma'am, didn't I just tell you I have Blue Cross/Blue Shield? And I kept saying it. And I had a friend who was treated the same way….That experience right there and my experience just…told me I didn't want to go to that hospital. So that comes from like the medical provider.

When one mom had a seizure, passed out and fell, EMS (Emergency Medical Services) was called. The following is a discussion between the two sisters about their experience of that situation and the dismissive attitude of the EMS personnel.

> Mom #1: "Actually, it was probably a month ago my sister and I was at a Laundromat and I fell out. And I hit my head. When I woke up I was, you know, face down. And she called the EMS and he came. He even acted like, you know, I don't see anything wrong with you or whatever. And I was like, okay, well, at the time I was six months pregnant. I told him, I'm six months pregnant. Do you think I should…"
>
> Mom #2: "The moment he walked in, he hadn't even gotten all the way to her yet. The first thing he said was, she looks all right."
>
> Mom #1: "Yeah."
>
> Mom #2: "And you know, immediately like my blood, you know, I just watched my sister fall face down. And it was the first time I had actually seen that for myself. And I know that wasn't normal. So I felt like at least some kind of examination was in order. Look at the bare of her eyeballs or something. She just hit the floor. Just kind of an act of concern."

This story elicited a response from another participant who had gone to the hospital when she was "real sick." She described the way she felt her concerns had been dismissed by the nurses.

> But then my mom, she's like can I fill out a survey because I just don't feel we're being treated correctly and all this other stuff….But I mean, that's one way that I have felt I was treated wrongly. I was, you know, a black woman. I didn't even go there for a big problem. I went there because I was sick. I was having a cold, a bad cough, it was to the point where it was hurting. And they told me there's nothing they could do for me. Kind of like what you were saying, you were passing out, they can't tell you.

A number of mothers intimated that they felt they were treated differentially by their physician and wondered if it was a discriminating attitude that was being practiced. Others agreed with what one mom related:

> …you shouldn't even have to go into a debate with your doctor to get like information or to get a type of level of care, like I totally, I said I've been seeing you for ten years. And I don't think it's wrong for me to expect to get the type of level of care that you're going to give Sally Q or Jessie Johns. I don't think that's wrong of me to expect that, and if she can't do that then I can find someone else…And so I was even more offended by the whole you can leave type of attitude that I got from the nurse, so I don't know if it was racial.

When admitted to the hospital one mom had this to say:

> I don't feel like I've encountered any discrimination. Um, as a matter of fact I think it's been kind of the opposite. Well I guess it could be a form of discrimination. For example when I was admitted into labor and delivery and we thought that, you know, they were going to take the baby, the nurses would come in and make polite conversation, and they would say, oh, where do you work? I'd say I work for the Texas Board of Nursing. And I think they look at me and they see young, youngish, black, married. I wouldn't think that you work for the board of nursing. I wouldn't think that you work in the enforcement department specifically. And then when I finally tell them, the second one (nurse) her attitude definitely changed….Oh, you know, and all of a sudden, do you need any more juice, do you need any of this, do you need any of that? And it's just like ah-ha. Okay. I see what you're getting at.

Thus the category of recognizing the need to know involved seeking out role models or mentors who were most often women who had recently experienced pregnancy and birth. Mothers were sometimes mentors and were viewed as either reliable in imparting information, or if there were disagreement, tolerated. Questions and information were also fielded by healthcare providers who either adequately answered

questions or did not answer questions satisfactorily and so kept mothers still questioning. Mothers who were totally dissatisfied with those encounters changed healthcare providers. Throughout this process, mothers exhibited the ability to take in information and judge what would be to their best benefit.

Searching for information

The third category in the second process was searching for information. Many of the women did more than make contacts to acquire information and answers to questions already discussed. They readily sought out information through television programs, internet web sites, pamphlets, books, and journals in their quest for comprehensive information about pregnancy and birth. One mother captured the essence of this category when she said, "…you can never be too prepared." The following are comments made by moms about sources used to search for information.

> I'm a total internet junky, so that works just fine for me. But I still have books and stuff that they (doctor's office) recommended and things like that for information. Of course they gave me pamphlets and little booklets galore…and [recommended] this book, "What to Expect When You're Expecting."

> Parenting Magazine. That's the one I read the most of. And then there's this book, what's it called? "What to Expect when You're Pregnant." It takes you through each month. Like first through tenth. It's at least ten months. And I've been reading that. Those are the two books I read the most.

Internet sources were accessed by many moms. Examples included Baby Center and Google. These sites were helpful in not only offering information, but also in validating pregnancy experiences as compared with others. As one mom said:

> …and you click on the full article and you go to Google baby gaga dot com, and they have a full article about what's happening with you, what's happening with the baby, and they have pictures of moms who are at the same stage as you are.

Another mother added:

> I'm always on line, like if I have a question about something, I want to see what other people are saying, even like the Yahoo questions from random people. I want to see what they are saying. I want to see what the Mayo Clinic is saying. I live on line.

Participants differed in the energy they felt to pursue or research various topics. Working long hours left some mothers fatigued and unable to do much searching for answers. For example, one mother who had gained a lot of weight said:

> And I'm a very lethargic person when it comes to doing research and all of that. I watch T.V., like the baby shows and whatnot….It's not just one show that I watch, I watch Discovery Health also. When I watch the T.V. show, mainly I really just want to see how other women are reacting when they're in labor, you know, I'm curious.

Although many women early in pregnancy searched for sources of information, some waited until later. The third trimester seemed to be when most participants were intensely interested in the approaching end to pregnancy. One mom verbalized:

> I haven't really done much of anything except tour the hospital. I just got into my third trimester. And I've been reading a lot of parenting books and trying to tap into the mother gene because I just really don't like kids that much.

A wealth of information was shared by participants during the focus group sessions. Moms interacted with one another and received advice from each other about sources they had tapped. One mother shared a source she had accessed. Participants listened to what she had to say and considered whether or not they wanted to do likewise.

> Smart Moms is a program…So, I saw a billboard. And I was like, oh, let me check that out, you know. And they sent me a package in the mail with a backpack and all these kinds of manuals inside, you know, and just useful information. And then from there you go through that information and, and see what else you can use, you know, that they give you.

An area of great interest and discussion was about childbirth and prenatal classes. Many mothers weighed whether or not they should take such classes. Some mothers decided it was a good idea, others were undecided, and still others knew classes were not what they wanted. Those who thought classes were a good idea said, "So out of that

eighty dollars, it was worth it." This was echoed by a mom who said, "For me, the Lamaze Class was the same (valuable). I read a lot, so as soon as I found out I was pregnant, I had, you know, I had [to sign up]." Another mother stated that the value she saw in classes, was being supported by other pregnant women and learning from their experiences.

> I think nothing educates you more than listening to all the different possibilities as far as experiences go. Especially if you don't have a nice broad support system, you know, it helps to have yourself in a group of people who have that in common with you.

Moms who were undecided about childbirth classes said the following:

> The doctor said, but the doctor said, you know, they're going to tell you the truth and the classes help you, you know, and help the partner as well.

> I have to break out of, you know, me being lazy and getting enrolled in some classes, just so I can say, okay, I did do the classes or whatever. I do feel like, you know, I think I'm as prepared as anybody needs to be. But hearing from everybody else, then I feel kind of like no. And I don't want to go in there (labor and delivery) and regret. So no.

> And I will start taking Lamaze classes whenever my mom picks them up because she's the one who thinks I need them. I didn't think they were very necessary but she thinks they're important.

> And of course he's (husband) not home the whole month of January, and that's when the classes were, and I'm glad I didn't pay for them. Of course I could have gone by myself, but that wouldn't have made too much sense. So, you know to go by myself without having my wedding ring on, and then I don't know about the entire whole how many black people were in class, but I was like okay….So I called and they said yeah all the classes for February are booked.

Moms who were not interested in taking classes voiced these comments:

> I'm not real big on keeping classes. I've got a lot of support systems behind me. I've got a lot of family behind me. I've got ten women that think they're my mom. So I feel like I'm more than blessed when it comes to that area.

> You know, a long time ago you get the impression that women curse you out and throw things at the men when they are having babies. So, that is a valid point (to taking childbirth classes). But I'm too tired. I can't even clean the house.

One participant explained that she wanted to take classes but felt she would be uncomfortable in the class as the only "minority". She explained that, "There's a social perception reinforced by television commercials that black women don't know how to take care of themselves and their babies and so need to take prenatal classes." So, the mom did not feel comfortable taking a class in that environment. She went on to say:

> You know, you know that you know Shaniqua needs to take the class. She's over there putting too much milk in her baby milk, you know…in her formula… We need to somehow try to integrate these classes a little bit more, you know…. And the commercial is kinda like that really does put minorities in kinda bad light because it's like we're more worried about the baby shower and the baby shoes and then name and the hair…instead of what we need to do to have them grow right in our stomach, in our bellies. I was like um. I needed to take the class, but I'm going to go fail like this, I'm a drop out. I failed bad. I felt like I was a prenatal drop out.

In summary, the category of searching for information involved participants actively seeking out information about pregnancy and birthing. Multiple sources were accessed including women who had already experienced pregnancy and birth, but also written materials, television programs, the internet, and pregnancy. Women also weighed and considered whether or not they should attend childbirth preparation classes. However, attendance at classes took place in the third process when women were preparing for delivery.

Managing symptoms in pregnancy

The final category in the second process was managing symptoms in pregnancy. All women in the study discussed physical and emotional changes encountered at different times during the pregnancy. Because all these women, except one, were first time mothers, they had no experience in managing symptoms in pregnancy. Thus the women looked to others for treatments. As mentioned previously, other persons included their own mothers, role models, mentors, friends, physicians and nurses. The participants

listened to what they were told about how to manage the physical and emotional changes. Sometime the moms followed the advice of others while at other times they did not. Sometimes the moms had to choose between different treatments that were proposed. Again as before, they preferred what they saw as working best for themselves. One mother explained how she had disagreed with her doctor about some of the back pain treatments.

> I know she (doctor), I'm always having problems with my back, but she was saying she had support building exercises for my back. But I was like, it's not my lower back, it's my upper back. Actually I do need to go see my physical therapist. Then she (doctor) was saying maybe I need to apply heat and stuff. But she said that my back was, at least I agreed with her, hurting from all the weight I had gained.

Women complained about early pregnancy nausea. One mother found that she was unable to follow her doctor's advice of taking medicine. Instead, she decided to do what her sister advised.

> And so I took the medication and I was still throwing up and I'm throwing up stuff that I just bought, you know? So I was like, okay. I just stopped with the medication and found I was actually doing better doing it my sister's way, just quit depending….Drink some water, some crackers, whatever you've got to do. And my doctor was trying to get me to take (medication)…

A participant became "real sick with just cold and coughing, sneezing and everything." and called her physician's office for help. After a discussion with the nurse and physician about what to do, the woman decided to forgo all treatment.

> I called the nurse anyway and she's like, well, there's nothing that we can really prescribe for you….And so I was like, okay. But I went to see the doctor and she was like, well, there's nothing you can really take, but if you like I can prescribe just a, she said a Z-pack, which is an antibiotic to take. She's like, but it's your choice. I was like, well, I rode it out for a week and it was almost going away. So I was just like, I'll ride it out. But she did give me the option of the choice that you can get the antibiotic.

Having heartburn, a mother was given advice from friends and her doctor.

> The one thing I am hardheaded about obviously, because you know when you're pregnant you have bad heartburn. I had really really bad heartburn. But I love Tabasco sauce. And everybody tells me, you know that's bad. It's bad for the baby. I asked my doctor and she was like, well if you can stand the heartburn then you're okay. And so, you know, I use a lot of hot sauce, jalapeños all the time. The baby just kind of gets a taste for it. Somebody just come out eating jalapeños. Because that's what they're used to.

A couple of mothers complained about persistent nasal congestion during pregnancy. One participant looked to her own mother for a remedy.

> You and me, I had like really bad, I couldn't sleep because I was congested, and I suffered through that for like two weeks. And I was talking to my mom about that, and she was like well have you, are you drinking honey and lemon water? I was like no. Why would I do that, mom? I just don't know even how to take care of myself, you know.

Mood swings were discussed by several participants. Sometimes they noticed their families reacted negatively to their emotional changes. Women tried to hide their emotional ups and downs or gave up and tolerated their family's reactions. Several examples of comments follow.

> Mom #1: "I probably have mood swings but I try to keep mine in check just because everybody in my family was so convinced that I would turn into like Godzilla or something. They was like, oh, you going to be a witch."

> Mom #2: "…but as for my oldest sister, she's very, very happy for me, but she's the one that keeps going, you know, like you're very emotional."

> Mom #3: It's frustrating moving and some days I'm fine or one minute I'm fine to be sitting there and then I look depressed face. But there's nothing wrong with me, but to somebody else they'd think something is wrong with me just from my facial. It's weird."

In the category of managing pregnancy symptoms, participants not only sought out treatments for themselves and tried those treatments, but they also were seeking validation as to the normalcy of their condition. The subcategory of seeking validation was an attempt by participants to see themselves as having experiences similar to all other pregnant women.. They wanted to be reassured that what they were experiencing

was not problematic but rather part of a normal pregnancy. One mom explained that when she called the nurse or her best friend it was to validate normalcy of symptoms.

> I understand this is just a part of pregnancy. So I didn't call her (nurse) quite so much. And the only time now is when I really see something that concerns me, something I really haven't seen before. But usually before I call my doctor's office I'll ask my best friend, do you remember what it was like when you lost your mucus plug? Is this what it is supposed to be like?

Another participant wanted validation from her doctor about nausea in pregnancy.

> She (doctor) told me, okay, yeah, nausea is normal or whatever. But I was like, but I'm throwing up like four or five times throughout the day. Of course I'm complaining because this is new to me and I want to make sure nothing is wrong, getting dehydrated, whatever.

A trip to the emergency room surprised but pleased one woman when she found out that her symptoms were normal.

> So I ended up going to the emergency room just for them to tell me that is was my ligaments stretching. But, I mean, I had never heard anyone out of all the pregnancy complaints, I had never heard anyone complain about your stomach muscles being sore.

Participants voiced the difficulty of always having to decide if something was serious enough to warrant a trip to the doctor's office or the hospital. They were driven to check with as many people as possible to determine if what they were experiencing was normal or needed further attention. One woman voiced this dilemma.

> Right. And they (doctors and nurses) don't necessarily, I mean, you could be a complainer and go in there and be like I'm having pains. And this is your first pregnancy, that's what they expect for you to do so they're going to give you okay. Well you're just going to have that. You know, it's part of being pregnant. You know and I guess it's just being scared that something could go wrong.

The category of managing pregnancy symptoms required women to find out from others what treatments were available for their symptoms. Participants followed the treatments in some cases, looked for alternatives, or gave up and tolerated their

discomfort. While managing pregnancy symptoms, women also looked for validation that what was happening to them was not a cause for concern, but normal.

In summary, the second process included four categories: Changing life circumstances, recognizing the need to know, searching for information, and managing pregnancy symptoms. In each of these categories, mothers were bombarded with information from a variety of sources. Each time they weighed and considered the advice or information given. After thinking what was best for themselves, they accepted what they thought was paramount for their particular situation. They frequently voiced that they saw each of their pregnancies as special and different and so needed to consider the advice or course of action that made the most sense to them.

PREPARING FOR DELIVERY

The third process of preparing for delivery encompassed a number of categories. Serious attention was given to thoughts about labor, delivery and birth of their child. All women passed through the three categories of envisioning labor, marshalling resources, and anticipating the worst. The participants imagined what it would be like to be in labor, what their reaction would be, and who they wanted there with them. How each research participant went through this process depended on her personal experience, how she saw her strengths and weaknesses, and who she saw as her support systems.

Envisioning labor

Envisioning labor occurred off and on during the pregnancy. However, as women entered the third trimester and especially as they neared their due date, they began to imagine what it would be like to be in labor. As one participant put it, “Just because now it seems more real than it did before.” Sometimes this envisioning was triggered by discussion with others about labor. Taking a childbirth class or series of classes also

prompted thoughts about labor. Being admitted to the labor and delivery unit likewise generated visions of what it would be like to go through actual labor. There were women who thought a lot about being in labor and others who tried not to think much about it. Yet, even the participants who did not want to dwell on what it would be like to be in labor, had envisioned what options they might use.

The following comment is an example of a woman who envisioned labor, "I don't know what to expect from (labor)…I just figure they teach you how to breathe and that was it…So I've got to wait until I get there. Figure it out right then." A second woman observed, "…even though I've seen a lot of births and C-sections and stuff, it's different now because it's me actually. And I don't know how I'm going to react to what's going to happen." A third participant explained how she envisioned labor based on what others told her.

> Well, basically like what, what I want to do because, you know, once you get like to the hospital sometimes the tendency that they have to like rush you or put you on a timetable, basically. So a lot of people have been saying, um, to kind of like in the first part of labor, if everything's okay and you can deal with the contractions and stuff just stay at home as long as possible. You know, if you don't feel like the baby's coming, um, so that, you know, so you can be more relaxed and stuff, um, before you get to the hospital. Um, yeah so just try to stay at home, you know, as long as you can before the active part of labor.

Participants sometimes envisioned labor based on a previous visit to the hospital. A mother was admitted to the hospital for pain which later turned out to be ligament pain. She thought she was in labor and explained her experience.

> And I went to the hospital. And they had me on the monitor for two hours listening to the baby's heartbeat. I'm like, okay, it's beating. But I mean, I know they're doing it just to make sure but I was okay.

Another participant also was evaluated for labor in the hospital and said:

> Because I went to the hospital not too long ago. Thought I was having contractions and, um, I was like I was sitting in the room laying on the bed. I was

> like what if I had it, what if I had him now? Like what would I be like? I mean how would I take the pain, you know.

Another mother explained how she envisioned she would cope with labor, pushing, and birth. She voiced uncertainty about whether or not what she envisioned for herself would actually work.

> They're (nurses) going to tell me take a cleansing breath, and then on the next breath hold it, put your chin down to your chest….They're going to tell me, you know, pull your knee, get your hands behind your knees and pull them back and bear down and push in your bottom, and you know, they're going to tell me that kind of stuff…And as far as the breathing, I've seen women in labor and perhaps that method will work for me, perhaps not…Or having a focal point? I don't want to sit there and stare at a picture of my dog…I mean I'll have that with me just in case. I'll have something to focus on but when it actually comes down to it, that may not work for me at all, so.

Having the perfect pregnancy and delivery was the focus of one woman. She said she had always pictured what it would be like. Although she had an image of what she hoped for, she realized that the reality might be something much different.

> So, I'm right now, I'm just like okay, right now I'm at my what I always pictured my ideal pregnancy would be. If I could just hurry things along the next two weeks and have a perfect delivery, I'll be totally satisfied…I'll have the perfect delivery, I'll push him out, no problem, you know…and it just, you know, when it finally hits and it happens it's like well wait a minute. This isn't like what I expected.

During the focus group discussion a young mother volunteered that she envisioned labor based on what her mother had said. Still, she found it hard to think much about labor. She explained her dilemma in "getting her mind ready." She said:

> Girl, I don't think I can handle, um, birth…I try to get my mind ready…I don't know what to expect because this, this is my first time. And my mama be telling like okay, make sure you get the epidural. Do, this, do that. Makes sure she tell me stuff like that but I, I try to, I guess you could say I'm still in denial because I try not to think about it. I don't want to worry about it until it happens.

Envisioning labor, being prepared and having options during the birthing process were very important to one mother. She explained how her vision and that of her husband differed.

> Yeah. Yeah. I like to be prepared, like okay, if this situation happens then this is the possible scenario that we're facing. If this comes up then this is the possible outcome. But he's (husband) more like, well you know, if we get to the hospital and you're dilating, but the baby's not coming down and we have to have a C section, then we have to have a C section and I'll just call people and let them know, and we'll deal with it when it comes, when it happens, we'll deal with it then…. So I'll be like well you're just not prepared enough. You're not taking this as seriously as I am. He's like, no I am. I'm excited, and you know, I'm ready, but you never can tell what will happen. And I say precisely. That's why we need to have the options.

Getting an epidural was a major part of envisioning labor for one woman. She had planned out when she would take maternity leave so that she could be at home when labor started. That way she would not have to drive from her job to the house and back to the hospital. She explained her reasoning as follows:

> That's a big concern for me too is not being late to the hospital. Because I'm having a vaginal birth and I need an epidural. I want to make sure I don't miss it… and I don't want to try to come from South Austin to make it to my hospital up here in labor. So I was like I'm quitting work now so I'll be in my neighborhood. Whenever I go into labor I'll be there. My concern is not having to commute a long time. But my purpose was I need the medicine. I don't want to miss that shot.

Similarly, another mother envisioned a "natural" birth with her family at her side. Thus she planned to have an unmedicated birth but wanted to keep other options open.

> But I want the childbirth and I have support with it. The only reason why I would go ahead and opt for any medicine is because of my issues and not knowing what they are and if they tell me this is what I need to do, I'm with it. But that would be the only reason why I would do it. If I just really feel like it's necessary. But I don't think with the pain I'll be like, you know, give me some of this (medicine).

Besides having a mental picture of what labor would be like, participants voiced who they wanted to be with them in labor. Thus envisioning labor included envisioning

support persons. For some moms, they just wanted their husband or partner. Others were clear that they did not want the baby's father at their side and preferred family members or best friends. Often it was their own mother these women wanted. Although, there were some mothers who thought their own mother would not be able to tolerate seeing their daughter in pain. There were a variety of opinions about the number of people who should be present. Some wanted a lot of people and some wanted a few or just one person. For example, one mother said, "Yeah, I wouldn't want that many people there because like I don't want them to see my business."

Again, as in all other processes, each participant weighed and considered what she saw as best for herself. As one woman put it, "I kind of want it that way, just my husband, the doctor and nurse." Another participant wanted just her partner, "I want the father to be there. As long as he's there, I'm okay. Honestly, I don't think my mom is going to make it because they way in Dallas." Similarly three other moms stated who they anticipated being with them in labor.

> Mom #1: "Whoever's your coach or partner, husband, boyfriend, whatever. Whoever's going to be there with you [in labor]. You know, I feel like it's important for them to have that too (information about birth). And like I said, it's a bonding moment between you and your partner."
>
> Mom #2: "I think, I think I lucked out in that department, too, because, um to a certain extent my husband's been there, done that because I have, uh, a ten year old stepson… I mean I don't know what he's going to be like in the hospital…Like whatever mood he's in it comes off, rubs off on me. So I was like as long as you stay calm I stay calm. You panic, I panic….It's like act probably however he acts."
>
> Mom #3: "Even though I am carrying the child but you (baby's father) are a part of this. And it's important for you to know that, you know. And to know what your position is, you know….And you don't feel like you really don't have an obligation to do anything but stand there and hold my hand because there's more to it than that. It's really an emotional, you know, support that you are needing."

> Mom #4: "I don't want a lot of people in there because I don't want to hear everybody sit there say, just breathe. You'll be okay without them. I don't want to hear all that. So it's just going to be me and my husband."
>
> Mom #4: "That's weird. Um, you know, I kind of visualize my husband being there and then like my mom and my middle sister. But after my husband and I got to talking about it, because like my thing is like I'm not sure how he's going to be in labor…So when we talked about it he was like I want it to be just us, you know, and like our experience, our first child…And my mom told me she didn't want to be there because she doesn't think I can handle the pain. I'm going to show her."
>
> Mom # 5: "I don't think I want my mama to be there because she, like her facial expressions is like, I think like she's going to be, you know worried about me, her facial expression, she can't handle it any way…Because if she's in there I'll go crazy. Just going up watching her."
>
> Mom #6: "She (mom) doesn't want to be there for the labor and delivery. It's this whole I don't want to see my child in pain type of thing going on. So, that being said I'm going to have my friend who's hysterically excited about me being pregnant….So, I'm going to have her there. And, he (baby's father) may be there. I told him if he, if he's nonchalant at the wrong moment he will get put out…and that is why his mom isn't going to be there…Sometimes that nonchalant comes at the wrong moment.

A participant was wistful about not being able to look forward to having her mother with her in labor. She and her mother had had a tumultuous relationship over the years. This pregnant mom regretted not being able to count on her own mom.

> And so that's hard for me, because you want your mom to be there. You want them to be involved and I don't really think she's going to come to the hospital. I don't believe she's going to be there at all.

To restate, envisioning labor was necessary for each mother in the process of preparing for delivery. Some participants were idealistic in their visions of what labor would be like. Others had had brief hospital experiences and thus a glimpse of what it would be like to be in labor. Envisioning labor included not only seeing oneself in labor but also envisioning who would be there to provide emotional support.

Marshalling resources

The second category to emerge from the third process was marshalling resources. As part of the process of preparing for delivery, moms thought about all the resources they needed to make labor more tolerable or to prepare them for the birthing process. When asked, these moms referred to such things as exercise, stress reduction, and the taking of childbirth classes. While participants might have considered whether or not to take childbirth classes earlier in pregnancy, they did not do so until the third process. In speaking about her first pregnancy one of the participants stated, "I read a lot and went to a lot of classes. And I was just trying to prepare, actually know what to expect and how to deal with it." Suggestions for marshalling resources were made by other people or were gleaned from readings and watching childbirth programs. Although not a common strategy, prayer and a dependence upon spirituality were also mentioned by a few women. "My mom, my family is real religious. So thankfully they close to God. Keep praying. Prayer gets you through a lot. Sometimes you don't know what you're going to do. Pray." " My mom always tells me to look to God in all things."

Physical preparation was part of the category of marshalling resources for labor. As one woman put it, "the last couple of weeks especially before you have the baby is when it's really important to start doing that stuff (exercises) and walking and doing things that's going to make labor easier." A second woman said, "At work during the day. You know, I park in the back of the parking lot so I have no choice but to walk to and from (work)." A third participant said she didn't really like to walk but had forced herself to do so coming and going to school.

> Yeah. They tell me to make sure you don't be lazy and walk a lot. It'll make it (labor) easier. I have school at Huston-Tillotson. I have to walk up the hill and down….The only reason I walk is I have to go to school. If I didn't have, if I didn't have like a schedule with school and work and all that, I'd probably just be sitting at home eating.

Another woman responded to this comment by saying:

> I started walking, I mean I tried to before I got pregnant but I tried to step it up now especially if it's going to help make delivery easier. I don't walk with except my yeah, mom. We'll start walking in the afternoon after it gets cooler.

Specific exercises for labor were tried by a participant who explained their value.

> I try. I try to do that myself (walk). And then, um, but then I just do other exercises that are supposed to help, um, you know, strengthen your back and your hips. Like squatting and, um, pelvic thrusts, which actually if you do right before bed it feels good. I don't know it makes the baby happy and she like chills out for a while so I can go to sleep.

Besides exercising, a couple of participants planned on taking a birthing ball. As one of them said, "I hear that that may work." Another mother was planning on taking music with her. "…I'll have music there, you know. They told me I could bring whatever. So, I have a little jam box and my little CDs."

Marshalling resources for some mothers involved signing up and taking a birthing class. One mother stated, "I read a lot and I went to a lot of classes. And I was just trying to prepare, actually know what to expect and how to deal with it." Another mom added, "I have had one class. It wasn't Lamaze or anything, but just to go over what you should do to prepare for labor and during labor." Getting useful information was an additional plus. " It's uncensored, you know, it's all adults and you just, you know, enjoy yourself and receive very, very useful information as your…now, and I hope to continue to benefit from it in the future." Other pluses included learning how to be comfortable.

> And to, you know, yeah. Be comfortable. You know, that's mainly what I learned. And you can only truly do that if you know what's going on. If you know what to expect. You know, okay, it's normal for my contractions to start off sporadically and eventually shorten.

Sharing experiences in a class was also mentioned as a benefit to class attendance.

> It's helpful. Because you see the same people, you know, some of the same people you'll see, you know, going to these classes. It's good. You you, you

> know, just like here, you guys, you know, have talked about and shared your experiences with one another.

Besides a forum for sharing experiences, classes acted as a support group.

> Oh, yeah, because we're all in it together. We're all going to end up in the same spot. So we feel like, you know, you need some help, you know, getting up, you know, it's very supportive. It's like a support system away from home. You know you have that at home but then you get to this class and you're like, wow, I don't know this lady but hi, you're pregnant too. How you doing? You know, it automatically sparks, you know, you know, report, you know.

Several women saw classes as beneficial not only because classes covered suggestions for relaxing and coping in labor but also because the instructors validated what moms had been trying to tell their partners and husbands.

> … it (class) had a lot of different aspects to it. But anyway I did learn a lot. The best thing I liked about the class was our instructor was very open and honest, and she was very quick to say everybody is not the same, or you might experience this whereas a woman might experience this…but him (husband)…actually hearing it from another woman he was like oh….So that was the best reason to take the class was to educate him and let him hear it from someone else who is more credible than you know the wife.

Another participant interjected that she had tried to get her husband to prepare for birthing but he was resistant. "So when we took the class, the whole nesting thing he was like oh, that's real? So the class brought us another step closer to where our communication is even better than it was previously."

For one couple, "We were the only black couple in the class." The mother explained her discomfort with some of the comments made by other class participants.

> …but one of the young ladies said, you know, we had to go in and introduce ourselves, whatever, and she was like Alice, that's it, that's your name, that's it? And I was like well what would you expect it to be? Like…what do you want it to be? And she was like no, no, I'm just asking. And was like, yeah, just Alice. And it's like, you know what, don't even…That's one of those underlying stereotype things. I don't know what my name should have been for her. My husband's an engineer, so they were surprised to hear that. I'm a teacher. They were surprised to hear that. I was also asked what was my level of education….You try not to get all hot about it, but you're like… You try not to

> make it a race relation…but did you ask the red head up there what her level of education was or did you ask the blond over there is her name just Kristin, you know? So…

Still, this mother valued her childbirth class.

> We got all that from our class because our class was over four weeks and it was one day a week, and so it was very comprehensive, so we went over everything from that to, all the way through delivery. So we got the what to put in the bag list and everything. My husband is, you know, we got the when to go to the hospital. They gave us the 511 number like when the contractions are five minutes apart and they last for one minutes for one hour. When you get to that one hour, it's time to go. He's already practiced it. He's practiced timing it and like keeping track of the time…

Learning different positions in labor was seen as a benefit to taking a class.

> … we were able to get in those positions and practice with a partner and learn what kind of things we could do when we were by ourselves or even while we were in labor. Like should we have a whatchamacallit, one of those situations where the baby is not turned where it's supposed to be.

In summary, marshalling resources was a category in which women looked for ways to prepare for labor. Physical exercise, stress reduction and getting mentally ready, as well as attendance at childbirth classes, were all seen as resources in preparation for the delivery experience.

Anticipating the worst

The final category to emerge in the third process was anticipating the worst. As participants talked about getting ready for delivery, they often referred to the worst that could happen to them. Many women felt that if they prepared for the worst, then they would not be surprised by the outcome and would be able to better cope with any undue circumstance. Anticipating the worst involved three subcategories: Worst case scenario; acknowledging fear, pain, and panic; and avoiding the negative.

When women anticipated the worst that could happen to them, they imagined what might go wrong during labor or birth. "… I always think worst case scenario." A

mother had a family history of cardiomyopathy and even though she had been told her heart was normal, she worried about labor. "You know, am I going to have to worry about pushing and you know, going into labor and having a C Section? Can my heart deal with that? Will I have to have a C section?" Likewise concern about tearing in labor and needing forceps was acknowledged.

> …if I'm in labor and I'm pushing and there's a possibility I could tear, and I'm going, is he (doctor) going to talk to me about having an episiotomy or is he just going to do it?...Forceps, you know, the back end. Do we need to talk about this right now? It's like, well, you'll just have to wait and see what happens.

Being seven months pregnant, a mom was told that her baby was breech. She worried about it and told the other women she was hoping for a vaginal birth.

> Um, so my fear is that because I know that in the seventh month like my book says, that she should move into the fetal position. And, um, if that doesn't change then I think the way I prepare, of course, will be different because I'll be preparing my mind for a C-section, which I, I really don't want.

Worrying about pre-eclampsia and premature labor was a concern for one mother.

> The only thing I really thought about was the pre-eclampsia or whatever. There's that stuff you have to take, magnesium sulphate. That was the only big worry that I had was that and hoping that you don't go into labor early because there's no way they can stop it…I feel more prepared when I walk into the hospital. I know what to expect, what not to expect…we're not offered any surprises.

Acknowledging fear, pain and panic was a common subcategory for participants. As one woman said, "But for me, I may be a little more scared, and I, I'll freak out as some of the smallest things, so I'm going to want to go ahead of time (to the hospital), just in case you know." Another mother acknowledged fear, "I want to have the baby natural. But I'm kind of scared." Likewise a mother discussed with her husband her possible worst reactions. "So my husband has decided that he's going to purposely break his arm so that he'll have a cast so that I can hit it and scratch and scream and he'll be fine." The mother who had had a previous delivery said:

> …I did everything I could in my last pregnancy to educate myself because you know, there was a fear there….And I was in a lot of pain but I wanted to do it natural…I knew what to expect so I was able to endure the pain, I knew what to do to get through the pain.

Pain was a source of discussion. Participants acknowledged the pain but also sometimes tried to avoid talking too much about it. Women felt like many of their friends, family and co-workers focused on pain. The following are comments made. "I mean it just gets to me, too, because everybody always wants to talk about like how it hurts. And the pain, it's like I know that it's supposed to hurt. Can we talk about something else?" "It's like everybody talks about just how much the pain was." "Um, and the only reason I hadn't been watching the shows and stuff, our society really, people tend to focus on the pain. And all they talk about is the pain all the time." "I started out listening, tying to ask my mom and family member. But like you said they just focus on the pain. You don't want to hear it all the time."

Avoiding the negative was another strategy for anticipating the worst. One mom recommended against watching TV shows. "If that is all you are leaning on for education then you are going to be terrified because I don't see them showing anything that a pregnant woman should be looking at." Another mother explained that she avoided the negative stories told by others. "I don't like horror stories." Also not wanting to hear "horror stories" a different mom said:

> Um, uh, as far as labor and delivery's concerned, I won't let anyone tell me about it because I know every woman is different. Every woman's experience is different. So if somebody who's had a child starts telling me about it and starts telling horror stories, my friend this, my cousin this, my aunt that, I don't want to hear it. So that's the way I prepare myself but that's the attitude I've taken with a lot of stuff actually. I don't hear it. Like negative stuff.

Not wanting to hear about pain was important for one mom.

> I don't like anybody telling me how painful it's going to be. I think a lot of people psyche you out. Like, oh, it's going to hurt and yada-yada-yada. And by

> the time I get there I probably won't feel all that bad. Pain is pain. If you stub your toe it hurt too. You're going to cry about that too. So I don't like to hear about that. People walking up, oh, you're going to be in pain. I don't need you to tell me about that. Tell me something positive like, it's going to be beautiful. Tell me something nice or just don't tell me nothing at all. That's my only thing. I don't like to hear about that.

Not wanting to hear about possible problems with the epidural a third mom said,

> The things I've heard about having epidural or the spinal, I mean the after effects you can have problems, you know. And I guess some people don't know about that…And I was like, I don't want to know all the problems.

In summary, the third process was concerned with preparation for delivery. Participants engaged in envisioning how they thought labor would proceed for them and who would be there with them at the delivery. Women also marshaled resources by participating in physical exercise or childbirth classes. Prayer could also be an additional resource. A third category in the process of delivery preparation was anticipating the worst. Anticipating the worst scenario, acknowledging fear and pain and avoiding the negative were all ways used to prepare for delivery.

EXPERIENCING PERSONAL CHANGE

The processes used by study participants to prepare for delivery culminated in the final process of experiencing personal change. Personal change was not anticipated by the moms but happened as a result of the experience of pregnancy leading up to labor and delivery. The women felt changed by their experiences and the processes through which they had come. They came to a realization that their lives would be forever different than they had been before pregnancy. The first of these changes as expressed by the participants was letting go.

Letting go

The participants came to an understanding that they could not navigate pregnancy and prepare for birthing and parenthood without letting go. Letting go, the first category in this process, allowed them to save energy for activities deemed more essential than previously. Women were at times wistful, reminiscing about their past lives. Yet they knew that as hard as it was to give up the past, they had to let go in order to cope with the future. A participant explained how she came to the realization that she couldn't make her life perfect and that she was reordering her priorities.

> I think what it is it puts life into perspective and no matter what you do or how you look at things something is always going to be wrong in your life…there are some things that you may oh I want more of this or I want less of this or I wish I could change this, I wish I could change that. But then once you realize that your body is creating this miracle it's like, okay I don't need another pair of black loafers or I don't have to go to Chili's this week.

Being a woman who didn't like to get rid of anything in her house, a mom said she was having to rethink that strategy. She realized that she could no longer hold on to all her possessions and had to make room for the baby. Letting go, she explained was making her happier.

> One thing I can say is that I have had to let go of a lot of stuff, a lot of things that I kept harbored up and the whole pack rat. I have to hold things…And I'm just like, okay, well I'll get rid of, you know this…I'm letting go of everything….But I can honestly state that it's keeping me happier in a different sense in a different way.

One woman expressed that she knew that she needed to clean house but was tired from being seven months pregnant with a full time job. She said she didn't care that much anymore about being a fastidious housekeeper. She said she was letting go of housework and had decided to enlist the help of others.

> I was looking at my house and I said, why do I have so much furniture in here? Why haven't I got up and started wiping things down and cleaning up now? ..then right now my mind has changed from what it was maybe two weeks ago. And,

> um, I'm thinking about bringing in a whole bunch of family members and have them clean up my house.

The holiday season was stressful for a participant. She talked about how it was difficult to decide on which holiday to spend with whose relatives, hers or her husband's. She felt that the birth of her child would be a blessing because she could let go of that stress and just wait for relatives to come to her during the holidays.

> Speaking of holidays, that is one thing I am so looking forward to 'cause M. (husband) and I have been trying to juggle, we've been alternating the holidays. This year Thanksgiving was here, Christmas was here. So next year Christmas will be here, but you know, but you know, and it's like you know what, next year everything is at our house…But you know, next year we're not even going to have to be bothered with that, not even be worried about it. It (pregnancy) allows you to [do that].

The husband of one participant was very anxious about being able to get to the hospital in time for the delivery. She felt she could not take on his stress and had to let it go of the worry.

> And that's pretty much, you know, unfortunately how it looks, that I have to look at it. I have to let it go. I have to let it go. That's my motto right now, just got to let it go. So yeah.

Sometimes letting go meant letting go of an emotion which would normally be felt, for example in dealing with racism. A mom related frustration about treatment while buying a nursing bra. She explained that during pregnancy she had become much better at modulating strong emotions and letting them go.

> So, she (sales lady) says, um, well this is a good bra, but you know it is kind of expensive. And I wanted to say you know I'm not concerned about the price. I said I have to pay more for bras anyway because I have such a large cup. I'm not concerned about that…and as I'm looking at these bras I said well what about this one. Well, you don't want that one. I said why? She said 'cause it doesn't come in black. What do you mean it doesn't come in black? Well you're going to want a black bra. I'm like well why am I going to want a black bra? You know, I'm sitting there looking at her, and she's telling me that I need a black bra because of my skin color. And so she says these are the only three bras that come in black, so you might want to limit your search to these three. I was like this. You know,

> I'm trying to be nice, and I have this face like this…did you really just say that? And I'm really trying my hardest not to strangle you with this bra, but did you really just say what I think I just heard you say? …and so then another lady walks into the store…and she says to her what color bra do you want? We have brown and orange. Oh she gives a choice. I was so angry. She gets a choice? I didn't get a choice. And it was just odd. And I was like I don't need your help any more. I had to let her go, because had I continued to speak to her…I just had to leave because had I stayed…I can honestly say that recently I've been very good at holding in.

Letting go of financial worries and giving her concerns up to God was expressed by a participant.

> And that's that's what I'm doing. I'm just …that's what really scares me now, finances. I feel like, again, that God's not going to put something on me that I can't handle so I don't worry about that.

Thus letting go was the result of preparing for birth whereby moms had to reorder their priorities. This meant a change in behavior. Activities which had been important to them in the past now mattered much less. The women realized that they had less physical and emotional energy now during pregnancy and so could not do everything they had done in the past. They now had a new focus centered on getting through pregnancy and preparing for the birth of their child. Letting go also meant for some participants giving up certain emotions such as confrontation, or argument. These emotions required a great deal of energy. In the context of an environment of racism or discrimination, some moms felt they couldn't expend the additional emotionally draining task of speaking up about being treated differently than others. Besides, they reasoned, others might not understand their point of view.

Discovering inner strength

A second category in the fourth process that emerged from the data was discovering inner strength. Participants expressed that they had been changed by the experience of pregnancy and, in preparing for birth, they had discovered inner strength.

For example, one mother related a story where she was crossing a street slowly because of uterine cramping. A driver yelled at her and sarcastically asked if she might walk even slower.

> Mom #1: "That's the thing, you've got to be strong. Especially as a woman, and if you're a black woman on top of that. Just ignore it I guess. I know it hurts….I wave. Like how you doing? Can you walk any slower? I could, but what's that going to accomplish for you? Might as well just drive your car and let me walk where I walk at."

Another focus group participant validated her comments.

> Mom #2: I think she handled the situation like a woman. Well somebody else could have started something. She handled that situation real well.

In speaking about birthing, a participant expressed her feelings. "Okay, so, so, it's not that you know everything (about birthing). It's just that I feel like when it comes I'm going to be strong enough to get through it." This comment was validated by someone else who said, "I'm finding out I'm more capable of taking on more than I thought I was, you know…"Another mother explained how difficult experiences in pregnancy such as a trip to the emergency room had helped her realize she was stronger than she thought she was. She motivated herself by telling herself that she had come through difficult times in pregnancy and now she was stronger.

> …and it's okay, you're stronger than you think you are, you can push through this (labor) because you got through the trips to the ER…you got through that. You did well with that. You handled that.

Another mother expressed wanting to model strength for her daughter.

> And when I am talking about being strong it's because of what I want my little girl to see when she's growing up. I want her to be like, you know, my mommy has her education and she went to college and I want her to see a strong woman.

Strength could come from being a black woman, but it could also come from being naturally strong and being a woman.

> And I look at it too just not being the stereotypical strong black woman, just being strong period. If you don't do it by yourself, nobody is going to handle it for you. So you've got to take that stand with just being…I look at it as just being a woman. Do what you've got to do to be able to survive and just take care of your little ones.

In one focus group, there was discussion about the pressure of being perceived as a strong black woman. One mother voiced that putting on the appearance of being strong belied how she really felt when her relationship with the baby's father was in turmoil. "I practice and I voice great strength. But inside I was dying." This brought a response from a mom who validated the difficulties of always portraying strength.

> And like you said, you know, women who are being strong because they feel like they have to and putting out that strong black woman bearing the weight of the world thing. And I think that's something that we feel as black women in different points in our life no matter what the situation is. You go into a situation and people expect you as a black woman to be this kind of strength.

Discovering inner strength was voiced by others as well.

> Of course other people have gone through pregnancy, but it's not this pregnancy. This is mine, this is my first experience with these changes going on in my body. I've never had this before and it's like you really are stronger than you think you are…

> And yet at the same time now I'm starting to realize it's like well you know if the situation calls for it, there's no telling what I'm capable of. I, you know, if God forbid, if I'm in a mall or if I'm trapped somewhere and I can't get to the hospital, if there's ice on the ground or whatever and I have to deliver, you know, the baby, or if we have to deliver the baby without drugs, and even if I get to the hospital and I'm going so fast that I don't have time, I can't say no, I can't do it, I can't do it, and I won't do it, and you can't make me. I can't say that, because I am realizing I'm capable of doing more that I thought I was, and I know with this labor and delivery it could be the same way.

The discovering of inner strength was frequently discussed by participants. Many of the women felt that the experiences of pregnancy had forced them to look to their own inner resources to manage the future. Even those mothers who had a strong partner and family support recognized that there would be times when they had to rely solely on

themselves, when in labor, for example. While some participants questioned whether or not it was good for them to exhibit outward strength when they did not inwardly feel that way, still the general consensus was that women, especially black women were inwardly strong.

Bonding with other pregnant women

The third and final category to emerge from the processes of experiencing personal change, was bonding with other pregnant women. Bonding involved a realization that others before them had had similar but also unique experiences of pregnancy and birth. Thus, the participants felt they were part of a larger humanity that had for eons been going through exactly what they were going through. There was a sense of comfort in realizing that all pregnant women were part of a bigger story about pregnancy and birth. In a way, study participants were awed by being part of a special and select group of people. As one mom said, "Before I got pregnant, you know, I wasn't interested in babies or pregnant women or anything. So I didn't care. Now I'm just like, whoa, you know, and women do this." Similarly, a participant said:

> And it's like there's just this kind of bond between pregnant women. It's like hey, you got to do this. This is something we have to do. If our bodies can do this who are we to say no….Because I think we're a lot stronger than we give ourselves credit for.

Bonding sometimes occurred when taking a childbirth class. In response to whether or not she had bonded with other women in her class, a participant replied, "Yes, absolutely I have bonded with my other classmates." Having a common experience with which to relate, a mother stated:

> I think nothing educates you more than listening to all the different possibilities as far as experiences go. Especially if you don't have a nice broad support system, you know, it helps to have yourself in a group of people who have that in common with you.

Reflecting on women in the past and the nature of birthing, a mom said:

> Mom #1: "I mean, I don't know, from my understanding having a baby is supposed to be a natural thing. I was telling about all the women before, you know."
>
> Mom #2: "Before there was epidural?"
>
> Mom #1: "Right. And I just think that that is awesome that there are generations of women, you know, that is how it was done."

In summary, three categories emerged during the process of experiencing personal change. Women learned to let go of things that had seemed important to them prior to pregnancy. Pregnancy and getting ready for birth had taught them to conserve their energy and focus on different priorities. As they proceeded through pregnancy to birth, they discovered inner strength that helped them to withstand the unanticipated events and future uncertainties in labor. In so doing, they felt a bond with other pregnant women. The final testament to this bonding was the enthusiasm with which these women greeted the focus group sessions. All study participants, without exception, even when not participating in group discussion, listened intently to the dialogue and conversations of the other women. They seemed eager to connect with one another and share their experiences.

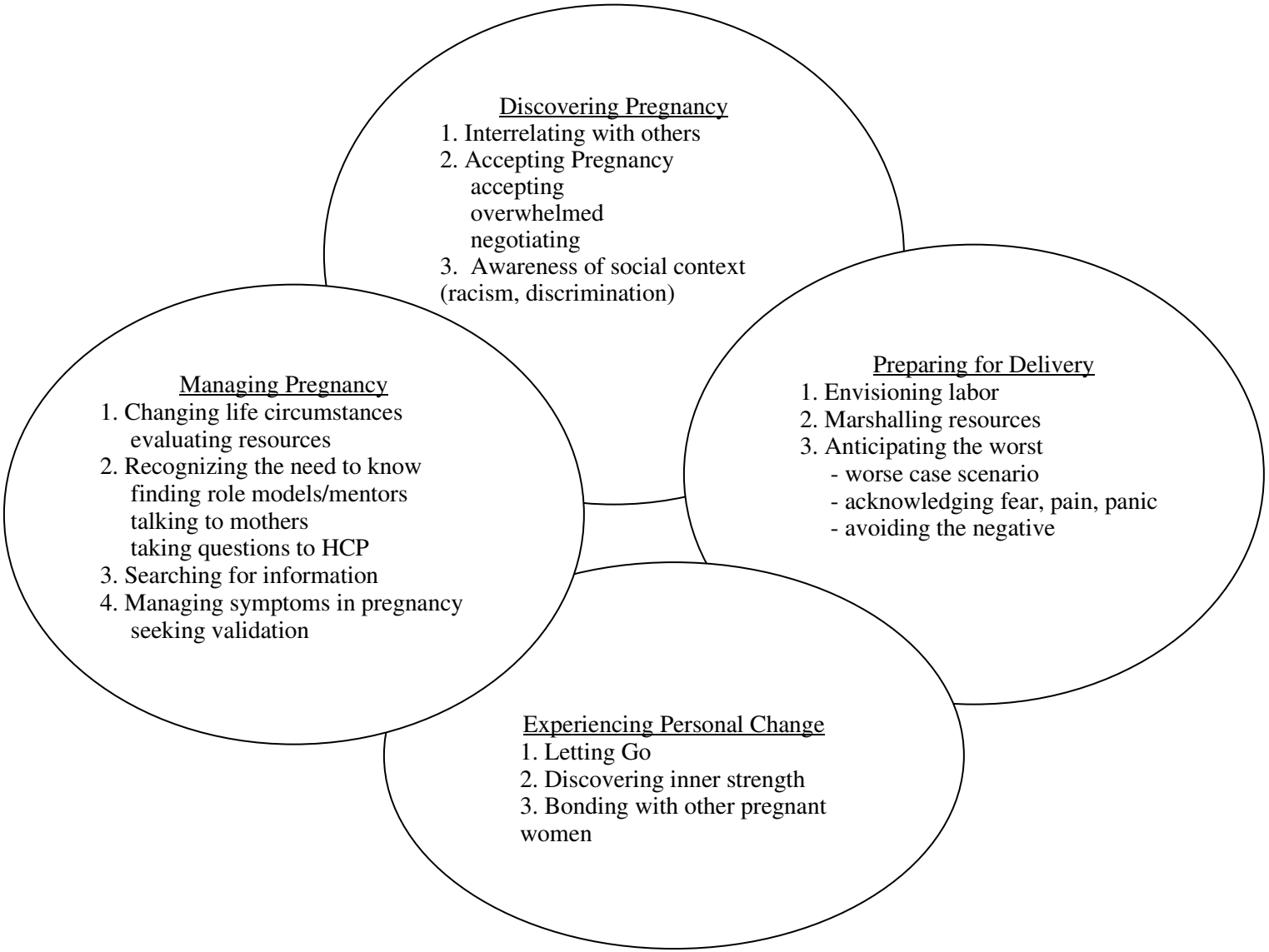
CONCLUSION

To summarize, pregnant urban black women traversed four major processes in their preparation for childbirth (see Figure 4.1). *Discovering pregnancy, managing pregnancy, preparing for delivery, and experiencing personal change* were the four processes which explained the theory of *weighing the impact on me*. Straus and Corbin (1998) state that although processes are often sequential, they do not have to be. This analysis revealed some relationship between the processes. However, additional study is

needed to delineate these relationships. For example, the first process of discovering pregnancy was the antecedent to the other processes. The process of discovering pregnancy likewise seemed necessary before women could move on to managing their pregnancies. Managing pregnancy was predicated on women accepting pregnancy as a result of positive relationships in their lives. Future study will help to substantiate and clarify these relationships.

The processes in managing pregnancy appeared mostly necessary before preparation for birthing could occur. Some aspects of managing pregnancy however,

Figure 4.1: Schematic Representation of the Processes used by Urban Black Women to Prepare for Childbirth: Weighing the Impact on Me



crossed over into the other processes. For example, pregnancy symptoms occurred throughout pregnancy and not just in managing pregnancy. Likewise, while looking for role models and mentors, getting questions answered, and searching for information about pregnancy and childbirth took place primarily during the managing pregnancy process, participants also engaged in these processes throughout discovering pregnancy and preparing for delivery.

Preparation for delivery should logically follow discovering pregnancy and managing pregnancy. The processes of managing pregnancy might be foundational to envisioning labor, marshalling resources, and anticipating the worst.

Finally, experiencing personal change represented activities that were ongoing during the entire pregnancy. Unlike the other three processes, experiencing personal change did not involve weighing what was best, but rather represented the impact felt during the other three processes. As women experienced different aspects of pregnancy whether early in pregnancy or later, they felt changed. Sometimes this was precipitated by an event such as a trip to the hospital or an encounter with a role model or mentor. However, experiencing personal change most often may represent the culmination of all the other processes through which the participants passed. Thus, additional study is needed.

This substantive theory of *weighing the impact on me* was clearly grounded in the data of the 22 pregnant black women who participated in this study. The discussion generated showed that while the women shared commonalities, each woman's experience was unique. Though each woman experienced the same processes, each woman made distinctive choices that suited her and made her journey of weighing the impact on me unique. The participants listened to the ideas and opinions around them yet each pregnant participant reached a different conclusion about how she wanted to handle her

particular situation. For example, some women chose to take the advice of relatives while others chose to defer to their physicians. Some pregnant moms might choose to make use of the internet while others valued books. Thus, it was clear that weighing the impact on me explained the personal aspect of the processes of childbirth preparation. Thus, each woman experienced the processes of weighing the impact on me by making personal choices about those aspects of pregnancy over which she had control.

Chapter 5: Summary, Conclusions, And Recommendations

The purpose of this chapter is to provide a discussion of the findings of the processes urban black women use in preparing for childbirth. Using the constant comparative analysis method advocated by Strauss and Corbin (1998), these findings were processes that emerged during data analysis, encapsulated in the grounded theory of *weighing the impact on me*. Also in this chapter are comparisons between the results of this grounded theory and those of other childbirth preparation studies in the literature. Finally, recommendations for nursing practice and future research are suggested.

OVERVIEW OF THE STUDY

The aim of this qualitative study was to identify the ways in which urban pregnant black women prepare for childbirth. The study design involved gathering data from five focus groups (n=20). Two participants elected to have individual interviews because they could not be present during a rescheduling of their focus group. The total sample size of 22 pregnant black women in the last four months of pregnancy was recruited from a variety of community settings. The research participants ranged in age from 19 to 34 years of age. Group discussions were led by a black moderator at a community clinic while the individual interviews were undertaken by the white researcher. Analysis of data was performed using open coding, axial coding and selective coding (Strauss & Corbin, 1998). The use of selective coding led to the identification of interrelated categories culminating in the grounded theory of weighing the impact on me.

SUMMARY OF FINDINGS

Women engaged in deciding each step of the way what they considered to be the best course of action for themselves in their journey through pregnancy leading up to the

birth of their child. Weighing the impact on me explained these processes urban black women used to prepare for childbirth. These processes were further subdivided into categories through which the women passed. The first of these was the process of discovering pregnancy. During this time, women engaged in interrelating with others, partners, spouses, and family. The quality of relationships with others directly influenced the process of accepting pregnancy. Some moms were accepting of pregnancy while others were negotiating with themselves or overwhelmed at the prospect of being pregnant. During this time there was an awareness of the social context in which pregnancy was happening. For most mothers, the support from family and friends outweighed the negative aspects of living in an environment of racism and discrimination. Some mothers reacted to the negative social context while others did not.

In the second process, pregnant moms engaged in managing pregnancy. During this process, moms weighed their changing life circumstances which might include, for example, change of residence, change of job status and resolving unfinished business. Mothers found it necessary to evaluate resources. Resources were family, friends, and others in the social environment who could provide financial and moral support or who might be a source of stress for pregnant moms. Mothers weighed whether or not they wanted their partners and spouses at their side or more peripherally involved on the side. Also during this process was the category of recognizing the need to know. This encompassed making decisions about information that might or might not be useful to them during pregnancy. Thus moms engaged in finding role models and mentors, often family members or friends with previous experience, who could share advice and information. Role models and mentors were judged to be reliable when advice and information was deemed useful. If not perceived as helpful, role models and mentors were tolerated. Healthcare providers from whom mothers were getting answers or left

still questioning also played a role in this process of managing pregnancy. When the relationship was unsatisfactory, moms looked for another physician. Third in the second process was searching for answers, through the accessing of written materials, the media, and formalized classes. The fourth and final category in the second process was managing symptoms in pregnancy, when mothers looked for treatments and were seeking validation that their symptoms were normal.

The third process was preparing for delivery. The first category in the third process was envisioning labor during which women imagined what it would be like to give birth and who would be with them. The second category was marshalling resources for birthing, for example, physical exercise and participating in childbirth classes. The final category was anticipating the worst. This involved imagining the worst case scenario as a means of coping with the unknown. Also a part of this category was acknowledging the fear, pain, and panic that might occur during labor and birth. Finally, women talked about avoiding the negative as part of their way of anticipating the worst.

The fourth process experienced by the research participants was represented by three categories and reflected the other three processes through which these women had passed. The first category was the experience of letting go as women acknowledged the need to prioritize their lives differently in preparing for birthing and the future. The second category was discovering inner strength as women realized they were more capable of tolerating adverse circumstances than they thought they were. The final category was that of bonding with other pregnant women as women came to understand they were part of a much larger story – that of all women who had been pregnant and given birth. The findings of this study are not unique to pregnant black women and closely resemble findings of other studies of pregnant women reported in the literature.

DISCUSSION

Conceptual framework

Findings from this study support work done by previous theorists about processes pregnant women use in their journey through pregnancy. For example, Rubin (1984), in her work on maternal role attainment, proposed that as part of the task of safe passage, pregnant women seek knowledge about what to expect in coping with pregnancy and childbirth. This study supports the notion that urban black women, like other women, do likewise. They engage in processes in preparation for childbirth, possibly no different than other women. Each pregnant black woman was searching for answers as best suited her needs. Some looked to role models or mentors. Others looked to friends, family, physicians, nurses, or the media. Besides the search for knowledge, this study demonstrated that women processed the information received. The women in this study weighed the source of the information received and the information itself. Some women needed a lot of information from different sources while others did not. The women then determined whether or not the knowledge and information was of use to them in their particular situation. Thus, some women accepted what their mothers told them, while others preferred information from physicians. For each woman, the process reflected her own needs as she saw her pregnancy and approaching birth.

Lederman (1984) discusses women's need to prepare for childbirth and motherhood by imagining themselves in those situations. According to Lederman, this is done through fantasy and dreams and the use of role models, primarily their own mothers. Women in this study also imagined themselves in labor and birth by envisioning labor, what it would be like and who would be with them. Women in this study used role models or mentors, although not necessarily their own mothers. However, women in this study did not seem to engage in "conflict resolution" of psychological tension in

overcoming fears about labor as purported by Lederman. Rather, women in this study marshaled resources and prepared themselves physically and mentally for the events of labor. They also anticipated the worst that could happen as a way of coping a priori with adverse events that might occur. Sometimes anticipating the worst meant avoiding the negative, including discussion of pain and "horror" stories. The consequence was that the pregnant women mostly saw themselves as strong and capable of coping with approaching labor and birth. They also saw themselves as situated among all women both past and present who must endure the passage from pregnancy to labor and finally from labor to birth.

In Becoming a Mother, Mercer (2004) discusses little about preparation for labor and birth other than seeking and maintaining family support. In the current study, women were actively engaged in relationships. Sometimes these relationships were in flux, with certain persons receding into the background while others became more central. Husbands and partners were central for some women and were at their side or if not, on the side. Others participants preferred mothers or close friends. Thus, similar to Mercer, women might seek support often from the family. Social contacts could also be a source of support and information. Again, each pregnant woman was the judge of what she perceived as working best for her. The support of a close friend might be just as important as the support of a mother or a husband. Mercer notes that family may likewise be a source of stress. This was true for this study's participants as a few of the women related how they wished they had a better relationship with their mother. Occasionally, the pregnant moms would also voice that extended family dynamics were at times very stressful.

Rubin (1984), Lederman (1984), and Mercer (2004) all emphasize the role of mothers in helping pregnant women prepare for childbirth. In this study, many of the

women had good relationships with their mothers and looked to them for support and information, seeing them as reliable. However, perhaps because of the growth of excellent sources of information in the media such as books, journals, television (TV), formal classes and the internet, many women also looked beyond their mothers for help in childbirth preparation. Today's management of pregnancy is much more medically complex than it was perhaps in the past. There are many more tests, procedures, and new standards of care than in the past. Medical management of labor is more common than in the past. Therefore, mothers need more detailed and specific information than that provided by their own mothers. Also, pregnant women now often look to friends who have recently experienced pregnancy as sources of support and current information about childbirth preparation. Finally, some of the mothers in this study did not look to their own mothers for help but rather tolerated them. Again, validation of information came from multiple sources within and without the family and within and without the healthcare environment. The processes through which the women moved depended on the relationships they had as well as their own intrinsic personalities and personal needs. Weighing who to look to for support and information, how much information was necessary, and the reliability of the information were individualized by each pregnant study participant.

Acquisition of knowledge

Previous studies have pointed out the importance pregnant women attach to obtaining information about pregnancy, labor and delivery. This includes importance of sources of information, amount of information and reliability of information. Women of all income levels (Johnson-Robledo, 1998) seek information for childbirth preparation. Knowledge may be informal as gleaned from family, women who have previous experience, or other social contacts. Similarly, knowledge may be attained through more

formal sources such as healthcare providers, written and visual media, or scheduled classes (Davis-Floyd, 2003; Declercq, Sakala, Corry, & Applebaum, 2006; Savage, 2006; Svensson, Barclay, & Cooke, 2006; Sawyer, 1999). Svensson, Barclay, and Cooke (2006) and Savage (2006) in particular, point out that pregnant mothers often receive conflicting information and consequently look for multiple sources for validation. Savage (2006) also reported that in her study, pregnant women often felt that some birthing information was being withheld and that this was another reason to seek multiple sources of information about birthing.

The current study echoes what previous researchers have found in other pregnant populations. Formal and informal sources of information were accessed by most of this study's volunteer women. There were many personal reasons given for choosing one source over another. Some mothers were accustomed to using the internet and as one mother put it "addicted" to surfing the internet. Other mothers did not have ready access to the internet and preferred watching TV programs. However, a few mothers felt that watching TV did not paint a realistic picture of what to expect in labor and so chose to attend childbirth classes. Attending childbirth classes was seen by still other mothers as necessary for acquiring current and relevant information about birthing within a hospital setting. For all mothers, validating information from formal and informal sources was important, especially information that was conflicting.

Convenience was a third reason for source of information used. For example, several of the mothers were in school and so with little free time looked to friends or family who had recently experienced pregnancy and birth for information. Mostly nurses, but some physicians were also considered sources of information about managing pregnancy, and preparing for birthing. Written materials such as pamphlets, books, and journals were likewise sources accessed by the study participants. One mother joined the

local chapter of a postpartum support group called "Mocha Moms." Even though she had not yet delivered, she said that she received information about a pregnancy book and informal information about pregnancy and birthing from that group.

Childbirth preparation classes

A previous study has found that it was primarily white, middle class women who participated in childbirth classes (Lu et al, 2003). Of those women, only 11% perceived classes as a routine part of pregnancy. More recently, the number of women attending such classes had declined to about half of all pregnant moms. The trends have shifted, though since black women were significantly more likely to take childbirth classes than white women (Declercq, Sakala, Corry, & Applebaum, 2006). Regardless of socioeconomic status, these women had varied attendance at childbirth classes. Mothers with limited financial means sought out classes offered on a sliding scale. Middle class mothers were more likely to take classes offered by local hospitals.

Participants in this study, voiced great interest in and engaged in discussion about childbirth classes. Opinions about taking childbirth classes were mixed. For some mothers, classes were seen as an integral part of prenatal care. Armstrong (2000) found that black women saw childbirth classes as an essential part of prenatal care. In this study, one mom said that she felt hospitals should offer free classes because they are so necessary for pregnant moms. Some mothers took classes on the recommendation of their care providers. Other moms initiated taking classes on their own. A few mothers wished they had taken classes but found their schedule conflicted with the times the classes were offered or classes were already fully booked. Still other mothers saw classes as unnecessary because they felt they already had adequate and reliable information about birthing.

Whether or not childbirth classes were welcoming of black women was a point of discussion in this research study. Mothers who attended classes with a diverse membership stated they felt comfortable taking the classes. Pregnant mothers who attended classes where they were the only black individuals sometimes felt welcomed and sometimes felt they were singled out as different. Other mothers voiced that they would have taken classes but were worried about being stereotyped as being black and ignorant. Berman (2006) found that respondents wanted childbirth classes but felt they should be taught by someone from each woman's culture. Women in the current study did not voice the need for an all black group membership nor for needing a black teacher, rather emphasis was on being accepted as being just like everyone else.

Social Environment

Social support: Acquisition of information is not the only important aspect of preparation for birthing. According to Mann, Abercrombie, Dejoseph, Norbeck and Smith (1999), the need for social support of black women may be great during pregnancy and birthing, especially when the surrounding environment is stressful. The authors note that emotional support from other women can be an asset in pregnancy. As discussed earlier, in this study, relationships with others was a consistent thread through out the processes of preparing for childbirth. For example, interrelating with others was a process important in discovering pregnancy as women determined their response to the news they were pregnant. Close relationships with the father of the baby meant participants had a greater likelihood of acceptance of pregnancy. Support from family in early pregnancy helped women who did not have good support from partners move from negotiating to accepting pregnancy. The one mother who was overwhelmed by pregnancy spoke of estrangement from the baby's father and poor support from her family. Peacock et al. (2002) found that support networks especially partners and female relatives were

influential in the way black women coped with the discovery and acceptance of pregnancy. Others in the literature have also emphasized the worth of such support (Chatters, Taylor, Lincoln and Schroepfer, 2002; Herman, 2006; Johnson & Staples, 2005; Kavanaugh & Hershberger, 2005; McAdoo, 2007; Mullings et al. 2007; Scannapieco & Jackson, 1996).

In the second process of managing pregnancy, moms again evaluated, among other things, their relationships with partners, family, and their larger circle of friends and acquaintances. They looked to these persons for financial and emotional support as well as using them as sources of information. This has also been reported in the literature. Melender (2002) found that social support was used by pregnant women to cope with fears and uncertainty in pregnancy. Blake and Darling (2000) found strong bonds of love and support within the extended family and church environment with the black community they studied.

Finally, during the process of preparing for delivery pregnant mothers in envisioning labor thought about who they needed with them. These were persons who were reliable and dependable and would help mothers through labor and birth. Therefore, it was apparent in this study that supportive close relationships with partners or spouses, family, and best friends was necessary for moms to feel satisfied about pregnancy and preparation for delivery. Raines and Morgan (2000) found that black women more than white women valued the presence of their partner, spouse, mother, sister, or other female relative during labor and delivery.

Group support: Davis-Floyd (2003) reports that close bonds with other women help create a community of shared experiences where information can be exchanged and where support can be received. She gives baby showers as an example of an event in which this occurs. Childbirth preparation classes may also be a place where this happens

(Armstrong, 2000; Nichols & Humenick, 2000; Nolan 1997; Svensson, Barclay, & Cooke, 2006).

Pregnant black women in this study gave examples of women who had been supportive of them in their families, among friends, at church, and in the workplace. What was also apparent was that the focus groups themselves functioned as a support group. During the group discussion, women talked freely of their experiences. There was much nodding of heads and verbal expressions of agreement as women were talking. Women asked for, or involuntarily received advice about concerns they had. At times it was hard to keep the discussion focused on the topic at hand because the women became so engrossed in relating their own personal stories, sometimes only tangentially related to pregnancy and childbirth preparation. The moderator also sometimes shared her own story or gave advice if she thought it was warranted. Thus, these women shared their joys, hopes, fears, trials and tribulations with one another and received back affirmation of these emotions and experiences. Banks-Wallace (2000) advises that such use of group discussion is a successful strategy for doing research with black women, as it helps to foster a sense of community. This process was evident in this study's use of focus groups as often, after the sessions had ended, the women stayed to converse with one another about topics related to pregnancy.

Bonding: Besides the sense of support the research participants in this study received through the group process, they also received validation of their bonding with other pregnant women. The research participants often referred to other women they knew who had been pregnant and given birth. While there was awareness that each pregnancy and birth were unique to each woman, there was additionally reference to the commonality of the experience. The sharing of experiences and the giving of advice seemed to strengthen the sense of bonding the women felt with one another. Although

the women were advised before starting the focus groups that they could elect to leave at any time, none did. As mentioned previously, some women stayed after the focus groups to continue their conversations with one another. A couple of women exchanged phone numbers and planned to meet again. Women bonding with one another has been a common theme throughout much of the research reported by Davis-Floyd (2003).

Healthcare providers: As part of their social environment, the pregnant moms in this study talked about their relationships with their healthcare providers. Not surprising was the range of opinions. Some mothers felt totally supported by the nurses and physicians with whom they came in contact. Others stated that they were frustrated by the lack of interaction with their providers. Several of the moms shared that they felt their concerns had been dismissed. They were uncertain whether or not this was due to racist attitudes by their providers. A few women changed providers hoping to find a more concerned medical staff. A few moms chose to stay with their healthcare providers although they felt they had been labeled with black stereotypes such as sexual promiscuity or ignorance. They reasoned it was too difficult and too late to change providers. This finding is similar to one found by Vonderheid, Montgomery, and Norr (2003) whose research participants indicated that healthcare providers did not adequately address their concerns during pregnancy. Handler, Rosenberg, Raube and Lynons (2003) also found that black women of all socioeconomic levels rated the importance of prenatal care very highly. Yet, there was dissatisfaction with care, especially by middle income women.

Experiences of racism: At least half of the women in this study reported personal experiences of perceived racism within and without the healthcare settings during their pregnancy. The stories told were about contacts with individuals: in the hospital, both in the labor and delivery suites and the emergency room; from emergency personnel; in

private physician's offices, both nurses and physicians; in childbirth classes; while shopping; and from the general public. Besides these personal experiences, all women discussed in general, situations in which they knew racism or discrimination might occur. Some reflected on experiences they had had in the past during school or with the general public. Stories were also related about families or friends who had experienced discrimination especially within the healthcare system. For example, one mother discussed how her sister had been diagnosed with a sexually transmitted disease although this diagnosis did not match the symptoms. The physician had presumed that the woman had multiple sexual partners even though the woman had said she was monogamous. It was not until the woman was treated by a black physician that the correct diagnosis of uterine fibroids was made.

The findings in this study confirm what numerous publications have reported: That some blacks experience unequal treatment within the healthcare system (Bach, Phan, Schrag, Tate, & Hargraves, 2004; Baicker, Chandra, Skilnner, & Wennberg, 2004; Bettancourt, & Maina, 2004; Collins, David, Handler, Wall, & Andes, 2004; Hogan & Ferré 2004; Mann, Abercrombie, Dejoseph, Norbeck, & Smith, 1999; Satcher et al., 2005; Sawyer, 1999; Smedly, Stith, & Nelson, 2003; Smiley, 2006; Smith, 2005; Stancil, Hertz-Picciotto, Schramm, & Watt-Morse, 2000; Taylor, 2005; Williams & Collins, 2001). Most significant was the publication by the Institute of Medicine (Smedly et al.) entitled "Unequal treatment: Confronting racial and ethnic disparities in healthcare," which documented the unequal medical treatment of blacks. Included in this report was a study which demonstrated that interactions between physicians and white patients was different than between physicians and black patients.

The findings of this study also confirm that black women live in a world that treats them differently even when they are not pregnant. Racist and discriminatory

attitudes towards blacks have been published by numerous authors (Brown et al., 2003; Collins, 2004; hooks, 1995; Jackson, Phillips, Hogue, & Curry-Owens, 2001; Johnson & Staples, 2005; Jones & Shorter-Gooden, 2003; Massey & Denton, 2003; McAdoo, 2007; Moradi & Subich, 2003; Porter & Barbee, 2004; Smelser, Wilson, & Mitchell, 2001; St. Jean & Feagein, 1998; Taylor, 1998, 1999). Pregnant black women in this study not only had to cope with the physical and emotional changes in pregnancy, but they also had to constantly cope with racism within and without the healthcare system. Mothers in this study were clearly distressed by their experiences of racism. Sometimes the mothers tried, but were unsuccessful in bringing attention to the differential treatment. Mostly they engaged in letting go as a means of coping. Letting go allowed them to forgo confrontation and save energy for other priorities in preparing for childbirth. Dole et al. (2004) found that pregnant black women reported a greater number of negative life events than whites. Those with high levels of perceived racial or gender discrimination were more likely to experience premature birth. Coping styles included avoidance, detachment, acceptance, or talking about problems. Letting go in this study of pregnant urban black women is similar to Dole et al.'s findings of acceptance. When prompted, however, women in this study were also willing to talk about the problem of racism.

Whether or not letting go was truly a part of coping with prejudicial and discriminatory experiences needs further research. It is possible that study participants did not let go of emotions stirred by encounters with racism. Instead they may have internalized these negative encounters in the form of stress. This stress may have been experienced by pregnant participants frequently, and be difficult to talk about openly. Lu and Halfon (2003) argue that birth disparities between blacks and whites can be explained by lifetime exposure to stress before and during pregnancy for black women. The birth outcomes for this study's participants is unknown. Following pregnant black

women post delivery in future studies may give some answers as to the relationship between racism, stress, and pregnancy outcomes. Also important would be to follow women with complicated pregnancies, for they may be the ones that experience multiple forms of stress stemming from SES, gender inequity, and racism.

Personal characteristics

The findings of this study did not elucidate the influence of personal characteristics in the process of childbirth preparation as has been reported in other studies (Bechelmayr, 1995; Handler, Rosenberg, Raube, & Lyons, 2003; Johnson-Robledo, 1998; Raines and Morgan, 2000). However, the results of this research did show that in this group of urban pregnant black women, each woman approached pregnancy and birthing by making individual choices. No two women made the exact same choices. Although all women went through the same processes, each pregnant mother made her own choices. The decisions made reflected a variety of factors. These contributing factors were apparent as women related their stories and included: past experience, support systems, influence of others, belief system, availability of resources, physical limitations, emotional state, financial resources and competing priorities. Undoubtedly there were other contributing factors which were not apparent and not discussed. The message these women gave was that pregnancy was a special time for them and that the decisions each pregnant mother made were unique to what she saw as benefiting her the most. The culmination of the processes was the theory that emerged, *weighing the impact on me*.

The theory of weighing the impact on me, demonstrates that the black women in this study were not monolithic in their lifestyles and life choices. During pregnancy, these moms, like other ethnic and racial groups, made individual choices. Afrocentric culture and perspective may have played a role in the lives of these women, but it was not

an overriding factor. The bigger influence in these women's lives seemed to be the relationships they had with partners, spouses, family, friends, acquaintances, healthcare providers and the social environment around them. Unique to this group of pregnant participants were social experiences of racism and discrimination. Each mother coped with these encounters in her own way. Whether or not and how these experiences may have influenced birth outcomes is a topic for future research.

LIMITATIONS OF THE STUDY

Recruitment

Limitations of this study are several. The first limitation concerns recruitment of participants. Recruitment of eligible women was challenging. Radio advertising was successful, although many women did not meet the study's criteria. Advertisement through two internet sites yielded a large response, but only one mother met the study's criteria. Church staff were acquiescent in posting flyers, but it did not appear that this was a successful strategy. Many churches stated that they simply did not have pregnant women in their congregations or that there were few such women. One large church stated that they had many pregnant women. However, in repeated visits to that campus, it was determined that most of the pregnant women were not first time mothers. Likewise recruitment through hair salons and nail parlors was unsuccessful. The process which yielded the most participants was through radio ads and through snowball sampling. Women, as they learned about the study, contacted others to participate. This technique also was responsible for recruiting several women from physician's offices. At least three women were also recruited through childbirth classes. One woman volunteered to participate after hearing about the study through the postpartum group Mocha Moms.

Barriers to recruitment may have been several. Venues other than those used should have been considered which were more convenient and more attractive to participants. Also, the researcher being white may have been an impediment to recruitment. Several people asked the primary investigator (PI) if the purpose was to discover differences between blacks and whites. The PI felt the necessity to reassure individuals in recruitment venues that this was not the case and that living in an environment of racism was of interest. The question of comparison between black and white was also asked in two focus groups. Again, the PI felt the necessity of addressing this issue prior to beginning each focus group session. This may have contaminated the results. Of note, however, is that during the recruitment process, the PI had many long discussions with individuals in the black community about experiences of racism and in particular racism in healthcare. This finding validated that racism and healthcare is an issue for some individuals in this black urban population.

During recruitment, the PI came to understand that for some in the black community, the University does not have a good reputation. While the exact reasons for this were unclear, it seemed to be related to the University not being responsive to the needs of the black community. This again may have hindered recruitment and participation in this research study.

An additional problem with recruitment was the restrictive criteria for participation. Not only was it difficult to find first time mothers, but it was even more difficult to find mothers in the last trimester of pregnancy who had not experienced problems during pregnancy. Unclear is whether the pool of urban pregnant black women is small or whether the recruitment techniques needed to be revised. Perhaps the benefits of participation in this research were not made real to potential recruits. Several individuals in the black community who were connected through churches were also

unsuccessful in helping to find research participants. The study design should have included contacting and use of individuals within the African American community to assist with recruitment. Then the effort might have been more successful.

The net result of problems with recruitment was that the number of women recruited was less than anticipated. Furthermore, the researcher had hoped to have a large sample of middle class mothers reflecting the national demographics. Instead 55 percent of the women stated that their income was adequate for their daily needs. Research results might have been different had the sample represented a larger number of middle class mothers. The term used for income on the demographic form was "adequacy" Better would have been a range of possible incomes, in identifying participants' SES.

Results of this study may also have been altered by not including participants who had complicated pregnancies. Women with complications and thus potentially adverse perinatal outcomes may have been the women who experienced the most stress, in the form of racism. Their voices were not heard.

Collecting data

Limitations of the study extended to the focus groups as well. While the intent was to have three to five focus groups with six to eight women in each group, this did not prove to be possible. Only one of the focus groups had seven women. The rest had from two to five participants. The problem was primarily that it was difficult to recruit enough women for each group. Perhaps the women did not see the real benefit of participation in this research. In addition, there were scheduling problems. When adequate numbers were scheduled for a focus group, some women did not show up. While the focus groups were held even with small numbers of women, the discussion might have been more limited than had the groups been larger. An additional problem was that a couple of the women

participated very little in the discussion. As a result of these limitations, the findings of this research apply only to those who participated.

Presence of primary investigator

Two individual interviews were conducted by the PI in the absence of the moderator. The presence of the white researcher may have inhibited the participants from full disclosure. For example, in one individual interview, the participant seemed reluctant to discuss issues around race. After much probing, she admitted to experiences of racism but did not have any specific stories of such encounters. This discussion might have been more forthcoming in the presence of a black interviewer. Conversely the PI may have been biased in looking for racism where there was none or approaching the topic of bias in a manner that made participants uncomfortable.

During focus groups, the PI was also present. The moderator and PI discussed whether or not the presence of the PI would inhibit dialogue around issues of race. The PI elected not to sit at the oval table where the discussions took place, but instead to sit unobtrusively at one end of the room. Again, the presence of the white PI may have restrained discussion. Participants did not volunteer information about whether or not the PI seemed biased or inattentive to their stories. However, it would have been helpful to gather this information through anonymous means.

Finally, one research participant inadvertently included was multiparous. Although she clearly remembered her first pregnancy and spoke at length about it, she may have contaminated the results by her presence. In addition, she brought her preschooler with her and was at times somewhat distracted by him. The PI elected to take the child outside to play. The mother seemed initially unsure about this arrangement and came to check on him a couple of times before she was satisfied with this

arrangement. The impact of these disruptions on the group discussion is unknown but may have altered the course of the discourse.

The moderator

The moderator's presence was valuable in probing participant's responses, redirecting the discussion, and summarizing the dialogue's major points. However, at times, the moderator recounted stories of her experiences as well. She also occasionally gave advice. Whether this was helpful in giving her validity in the eyes of the participants or somehow contaminated the results is not known.

Validity and reliability of results

The original intent of the proposed research was to build in validity and reliability of research results by asking for two to three women from each session to give feedback about focus group synopses. As planned, these were mailed or emailed to all who volunteered for this activity. However, out of 12 mailings, there were only two responses, both affirming that the synopses were correct and not wanting to make changes or add comments. Mailings done by email were returned with an auto reply indicating the women were on leave. This was a disappointment. Although the PI and moderator debriefed after each session, and the moderator gave feedback about each synopsis before it was mailed, the results would have been strengthened by more feedback from the participants themselves. It is presumed that this problem was in part because of the length of time it took to transcribe audio tapes, write the synopses and mail them. Both women who responded had delivered by the time the mailing reached them. This was probably true for most of the other women. Having delivered or being close to their delivery date, the priority of giving feedback was probably very small. Still more of an effort should have been made to contact the women postpartum.

In summary, the small number of overall participants, the generally few numbers of women in each focus group, the presence of the white PI, the impact of disruptions, the at times subjective participation by the moderator, the biases of the PI, and the negligible member checking that occurred, together may have influenced the results of this research.

IMPLICATIONS

The results of this research have implications for healthcare providers of pregnant black women. First, it is important to note that pregnant black women are not all of one mind in their approach to pregnancy and birthing. Like any other group of women, they come from a variety of social, cultural, educational, religious, and experiential backgrounds and reserve the right to make individual choices. Each woman is unique and engages in weighing what is best for her. Some mothers will need a lot of information about pregnancy and childbirth preparation while others will not. Some mothers will be satisfied with information from their close relatives and friends while others may prefer to refer to their physicians or media resources. Some women will attend childbirth classes while others will not. Some women will question the advice given from healthcare providers while others may not. Some women may need a lot of emotional support from families. Others may prefer the closeness of their partners or spouse, while still others will want all the support they can get. These findings may be similar for all groups of pregnant women.

The second implication of this study is that healthcare providers, as a group, reflect the social environment in which they live. This means that attitudes and behaviors are shaped by society's view with respect to black populations, and in particular black women. Black women are often portrayed by society as poor, ignorant, sexually promiscuous, and uninvolved in their pregnancies (Banks-Wallace, 2000; hooks, 1995, 2000; Hudson-Weems, 2004; Roberts 1997; Taylor, 1999. Thus, healthcare providers

would benefit from becoming self conscious about the attitudes and behaviors brought to encounters with pregnant black women. Continuing education for physicians, nurses, and allied health professionals can help educate healthcare providers about common misconceptions and how to overcome stereotypes. Too often this effort has been directed toward understanding the African American culture rather than focusing on the provider's attitudes and behavior which impact the provider client relationship.

Third, special attention needs to be made to the provider client interaction. Many women in this study complained that they were not afforded adequate time, explanations, or involvement in and about their care. This may be true for all groups of pregnant women and not just pregnant black women. However, providing opportunity for dialogue is particularly crucial for black women because they are more likely than other groups to experience disparities in pregnancy outcomes. They are also more likely to experience multiple stresses as a result of prevalent racism adding to pregnancy burden. The unequal treatment experienced by some of the study's participants may have added to the normal physical and psychological stress of pregnancy, putting these women at risk for preterm delivery and other adverse pregnancy outcomes. It is thus especially important that adequate time be given by healthcare providers for discussion about premature labor and birth and other pregnancy complications in this at risk group of women.

Finally, because this group of women was difficult to recruit, it is important that further research be done to replicate the results and test the theory. Do for example other women of diverse racial and ethnic backgrounds use the same processes? Does SES within race have implications for the amount of stress experienced and thus contribute to poor pregnancy outcomes? Beyond replication, other research is needed to examine in more depth the specific nature of racism within the healthcare environment and ways to

alleviate this troublesome finding. A research design which uses several encounters with participants, even postpartum might allow for more richness of data. Nurses would benefit greatly from such research as they are the healthcare provider who usually has the most contact with clients. Especially productive would be a mixed methods approach to enrich and enhance findings of a qualitative approach.

Other research might focus on looking at the relevance of group support and bonding with respect to preparation for childbirth and attendance at childbirth classes. How for example, do support groups compare with childbirth classes in preparing women for birthing? Also, how does information obtained through the internet compare with other types of childbirth information?

CONCLUSION

Pregnant urban black women's voices are extremely important in helping to determine how to narrow the perinatal health disparities between blacks and whites. The use of focus groups, especially with groups of six to eight women with similar interests, while difficult to achieve, can produce rich qualitative data. Still, racism is a difficult topic to probe and must be approached sensitively and with forethought.

Pregnant black women in a southwestern urban setting use certain processes to move through pregnancy in preparation for childbirth. Each woman's story of what happened in her pregnancy and how she prepared for the birth of her child was different. The differences do not reflect different processes or outcomes but the choices made during that journey. Nurses can only help pregnant black women if there is awareness of the normality of these processes; achievement of good pregnancy outcomes is supported; and most importantly that nurses become conscious of ways in which they may be behaving in a racist or discriminatory manner. For it is repeated encounters of a racist or

discriminatory nature which add undue stress to pregnant black women's lives and prevents them from getting the quality care they want, and to which they are entitled.

Appendix A: Radio Script

Are you an American born black woman who is pregnant?

A study is being conducted at The University of Texas at Austin School of Nursing to examine how black women prepare for birthing. The information gained will help nurses provide better care to pregnant black women and may improve pregnancy outcomes.

You can earn $60 for participating in this study.

The study requires you to attend a 2 hour small group discussion about your experiences in preparing for birth. The group will meet at a Community Wellness Clinic for women.

If you are at least 7 months into your first pregnancy, at least 21 years old, and an American born black woman then you are needed for the study. If you are interested in the study, please call Chris at 694-5592.

If you are interested in earning $60 please call the UT nurse researchers at 694-5592.

Appendix B: Recruitment Flyer

Pregnant women invited:

Your opinion is needed in a study of pregnancy experiences of black women!

You are invited to be part of a 2 hour discussion group if you are at least 7 months into your first pregnancy, at least 21 years old, and an American-born Black woman.

Compensation for your time: $60

For details call (512) 694-5592

Chris Abbyad, MSN, RN
Women's Health Nurse Practitioner and Doctoral Student
The University of Texas at Austin School of Nursing
Email: c.abbyad@mail.utexas.edu

Appendix C: Telephone Screening Script

- Thank you for your interest in my study about black women's experiences in preparing for childbirth. Is this an okay time to talk to you? My research examines how black women prepare for birthing of their child. This research will help nurses to understand the ways in which they need to be more aware of the concerns of pregnant black women. It will also help nurses improve care delivered to pregnant black women and, hopefully, improve pregnancy outcomes.
- Before I describe the study details, I need to ask you a few questions to make sure you can be in this study (Refer to Appendix C).
- My name is Chris Abbyad. I am a registered nurse, finishing a PhD in nursing, and I teach at The University of Texas at Austin School of Nursing. I am a white nurse and I have worked in maternity nursing for 33 years. Last year in a similar study 12 black nurses discussed how they saw black women prepare for birth. They helped me understand preparation for birthing and the unique experiences of black women.
- If you agree to be part of this study you will
- Be part of a discussion group of 6-8 pregnant black women.
- The group leader is a black women and an experienced discussion leader who also has been pregnant in the past.
- For research purposes, the discussion will be taped but your name will not be used. We will call you a name you make up.
- We will meet at The University of Texas at Austin Family Wellness Center, for two hours, at an agreed upon time.

- At the end of the discussion, I will ask you to fill out a short form about yourself. Your name will not be on the form, only the one that you made up. Before you leave, I will pay you $60.
- If you decide to be in this study,
- I will mail you a packet of information which will include a cover letter and a meeting reminder with the date, time and place for the group discussion.
- The packet will also include a copy of the study consent form for you to read. Please don't sign the consent until you arrive for the discussion group. The consent form will be signed before the start of the discussion group.
- You may change your mind and drop out of the study at any time.
- If you come to the discussion group you may say as little or as much as you like. I value your opinion.
- I appreciate your consideration and look forward to meeting you. Do you have any questions?

Appendix D: Screening/Eligibility Tool

Age_____

Race/Ethnicity self identification_____

Country of birth_____

First pregnancy?_____

At least 7 months pregnant?_____

Receiving prenatal care?_____

Complications during pregnancy?_____

Eligible for study participation? Yes No

Contact information:

Name_____

Mailing address_____

Telephone number_____

Available times:

Appendix E: Cover Letter

Dear _____,

Thank you for agreeing to participate in this study. As I mentioned in our phone conversation, people in this study are American born pregnant black women in their first pregnancy, at least 21 years old and getting prenatal care.

I have been a maternity nurse for 33 years. I am now a doctoral student in nursing, getting my PhD. My research is looking at how black women prepare for birthing of their child. This research will help nurses to understand the ways in which they need to be more aware of the concerns of pregnant black women. Last year in a similar study 12 black nurses discussed how they saw black women prepare for birth. They helped me understand preparation for birthing and the unique experiences of black women.

As a participant in this study, you will be part of a group of 6-8 pregnant black women. The group, called a focus group, will meet one time for about 90 minutes. The group discussion will be led by a black woman who has done this before and who has been pregnant before. For research purposes, the discussion will be audio taped but you name will not be used, only one that you make up. At the end of the discussion I will ask you to fill out a short form about yourself. Again, your name will not be on the form, only the name you made up. The total time you will spend being a part of this study is 2 hours. Before you leave, I will pay you $60.

The meeting place for the discussion group will be The University of Texas at Austin Family Wellness Center. Directions to the center as well as a reminder of your group meeting time, is included in this packet.

Also in this packet is a consent form. Please read it but **do not sign** it before coming to the meeting. Please bring it with you when you come for the group discussion. I will answer any questions and then have you sign it when you come for the focus group. If needed you may me with **any** questions at (512) 694-5592

After deciding to be in this study, you may change your mind and drop out of the study at any time. If you come to the group you may say as little or as much as you like. I value your opinion. I appreciate your consideration and look forward to meeting you.

Sincerely,

Chris Abbyad, MSN, RN, Women's Health Nurse Practitioner
Doctoral student, UT Austin School of Nursing

Appendix F: Postcard

Dear _____ ,

Thank you for agreeing to be in this study.

The discussion group that you will be in will meet

On _____(date)

At _____(time)

At The University of Texas at Austin Family Wellness Center (place).
The University of Texas at Austin Family Wellness Center is located at 2901 North I-35, DEV Building , Suite 101.
It is on the East side of I-35, along the access road, across from St. David's Medical Center.

Driving directions:
From the South
Take I 35 North
Exit 236 toward 32nd St.
End at 2901 N I H 35 on the right had side.

From the North
Take I 35 South
Exit 235 A toward M.L.K. Blvd.
Turn slightly left onto I-35 N
End at 2901 N I H 35 on the right had side.

Please do not hesitate to call me if you have any questions.

Chris Abbyad
Telephone: 512-694-5592

Appendix G: Consent Form

IRB# _____

Informed Consent to Participate in Research
The University of Texas at Austin

You are being asked to participate in a research study. This form provides you with information about the study. The Researcher, Chris Abbyad, a doctoral student in nursing, will also describe this study to you and answer all of your questions. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part. Your participation is entirely voluntary and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

Title of Research Study: Processes used by urban black women to prepare for childbirth: A grounded theory study

Principal Investigator(s)
Chris Abbyad, MSN, RN, Women's Health Nurse Practitioner (512) 232-4702
Sharon Dormire, PhD, RN (512) 471-9088

Funding Source: None

What is the purpose of this study?
The purpose of this study is to examine how pregnant black women prepare for childbirth. This will also provide direction for ways in which nurses might be more sensitive to the needs of this population. Information gained will help nurses provide better care to pregnant black women and may ultimately improve pregnancy outcomes.

What will be done if you take part in this research study?

- Volunteers in this study will meet in groups of 6 to 8 women as a focus group for discussion lasting about 2 hours. The group discussion will focus on unique experiences in preparing for childbirth as pregnant black women.
- Discussion will be taped recorded for later analysis.
- As part of the discussion, you will be asked about your experiences with pregnancy and preparation for childbirth.
- You will also be asked to complete a short form about things like your age, education, and marital status. Your name will not be used, only a made up name you choose for yourself.
- At the completion of the discussion we will ask for volunteers who would agree to read a typed summary of the discussion (mailed to them) and give us feedback about the summary.

- You will also be asked if you would like to have the research results mailed to you when the study is completed.

- We will also ask for volunteers to give feedback regarding the study results.

What are the possible discomforts and risks?
There are no anticipated risks to you and your baby. Because you are pregnant, you may experience physical discomfort from sitting for a two hour period. However, you have the opportunity to walk around if you need to. Also, you may experience some emotional responses to the discussion. You may be uncomfortable with some of the responses of others. You may refuse to answer any question or withdraw from the study at any time. If you should require emotional support as a result of the research experience, you will be encouraged to see your primary provider. If you have any questions or concerns about risks, you may call the Principal Investigator at any time.

What are the possible benefits to you or to others?
You may feel a variety of emotions through sharing your experiences with the researcher or other women in a focus group. You may be comforted by discovering that your experience is similar to that of other women. You may also enjoy learning about pregnancy and birthing from other women in the discussion group.

Your participation will help make nurses more aware of the needs of pregnant black women as they prepare for birthing. You may also experience satisfaction by contributing to improving care for pregnant black women in the future.

If you choose to take part in this study, will it cost you anything?
There are no costs for participating in this study other than 2 hours of your time.

Will you receive compensation for your participation in this study?
You will receive $60 to compensate you for participation.

What if you are injured because of the study?
It is highly unlikely that you will be physically or psychologically injured as a result of this study. However, if that occurs, you will be encouraged to see your primary provider. In the event of a medical emergency during the group discussion, 911 emergency services will be contacted. Likewise, should there be disclosure of abuse, you will be provided with emergency social services information and assisted if requested.

If you do not want to take part in this study what other options are available to you?
Participation in this study is entirely voluntary. You are free to refuse to be in the study, and your refusal will not influence your current or future relationship with The University of Texas at Austin.

How can you withdraw from this research study and who should you call if you have questions?
You may withdraw from the study at any time by simply saying you wish to end your participation. In that case please contact Chris Abbyad at the number below.

If you wish to stop your participation in this research study for any reason, you should contact:

Chris Abbyad, MSN, RN, Women's Health Nurse Practitioner (512) 694-5592
Sharon Dormire, PhD, RN (512) 471-7944

You are free to withdraw your consent and stop participation in this research study at any time without penalty or loss of benefits for which you may be entitled. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

In addition, if you have questions about your rights as a research participant, please contact Jody L. Jensen, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 232-4383.

How will your privacy and confidentiality of your research records be protected?
Authorized persons from The University of Texas at Austin and the Institutional Review Board have the legal right to review your research records and will protect the confidentiality of those records to the extent permitted by law. Otherwise your research records will not be released without your consent unless required by law or a court order.

If the results of this research are published or presented at scientific meetings, your identity will not be disclosed. As this study will involve the use of tape recordings, the following apply:

1. The interviews or sessions will be audio taped.
2. The cassettes will be coded so that no personal identifying information is visible.
3. You will be asked to choose a made up name for yourself.
4. The cassettes will be kept in a locked file cabinet in the investigator's office.
5. The cassettes will be heard and viewed only for research purposes by the investigator and her associates (a transcription service).
6. All documents will be kept locked in the researcher's office.
7. The cassettes *may* be reviewed for additional analyses at a later date but will be erased at the conclusion of the study.

Will the researchers benefit from your participation in this study?
Yes, acquisition of knowledge. Also, publications may be produced to share findings of the study but no identifying information will be used.

Signatures:

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

_____/Chris Abbyad_____
Signature and printed name of person obtaining consent Date

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

Printed Name of Subject Date

Signature of Subject Date

Appendix H: Interview Guide

The following information is intended as a guide and not as a script to be read verbatim. All group discussions will proceed as dictated by the needs of each session. However, the guide will serve to list the important elements that need to be covered in most sessions. Following self-disclosure, questions will proceed from the general to the more specific. Often probes will be used to provide more detail or clarity to a statement, to summarize what has already been said, or to elicit feedback from the participant(s).

Self-disclosure will include the researcher's nursing experience working with childbearing populations. It will include a statement of understanding of the many ways in which women in general approach the birthing experience. There will also be acknowledgement of the failure of previous research to give adequate voice to black women's experiences, experiences that reflect the social environment in which they live.

My name is Chris Abbyad. I want to thank you for coming today to be a part of this study. As you know I am interested in finding out about how black women prepare for the birthing experience. The information from this study will help nurses to be more sensitive to the needs and concerns of pregnant black women. As you know, this a voluntary activity and you may feel free to leave at any time, and to participate as little or as much as you wish. You will be paid whether or not you stay for the whole session. The session will last approximately two hours. You will be paid $60 at that time.

I want to tell you a little about myself. I have been a nurse for 33 years. I know from my experiences that women prepare for birth in a number of ways. There is no reason to think that black women prepare any differently from other women except that black women live in a society which may treat them as different from other women. Research in the past has often not listened to the voices of black women. So that is why I

am coming to you today. I want to hear what you have to say. The session will be taped. No real names will appear ever, only the made up name you choose for yourself. Once the research is finished, I will destroy all tapes and paperwork. Do you have any questions, or thoughts? What fictitious name would you like to choose?

TR will be the moderator. She will introduce herself then she will ask the questions and I am going to listen. You may see me taking notes as thoughts come to my mind or as I describe the situation here. Do you have any questions?

Questions

1. In general, what has been your experience with pregnancy?
2. How are you doing with this pregnancy? What has made your pregnancy especially happy/sad?
3. Have you started preparing for labor? Tell me about what you are doing.
4. Are there certain people important to you in preparing for labor?
5. How are you preparing for the birth of your baby?
6. What types of situations do you think might affect preparing for labor? Have you had any problems with discrimination?
7. Have you thought about attending a class? Has anyone talked to you about it? What are some of the reasons you might choose/or not choose to attend a class? (Do you think being black in an all white class could be a challenge?)
8. How do you get information about labor and birth?
9. Is there anything else that you feel is important that we have left out of this discussion?

Sample Probes

Can you tell me more about that? Has anyone else had a similar experience?

Appendix I: Demographic Form

Instructions: Please fill in the blank or place a check mark for the following questions.

Made up name _____

1. Your age_____

2. Since finding out that you are pregnant, how many visits have you made to your doctor? _____

3. Are you?

_____married

_____separated

_____single with a partner

_____single without a partner

_____widowed

_____divorced

_____other

5. How many years of schooling have you completed? (circle one)

High School Grades: 8 9 10 11 12

College 1 2 3 4 Graduate School 1 2 3 4 5 6

6. Would you say your income is enough to meet your everyday needs? _____

7. Are you employed? _____

Appendix J: Feedback on Focus Group Session

Thank you for agreeing to give feedback on the focus group discussion that you were a part of. Your comments are very much appreciated.

Please read the attached summary and write in answers to the following 4 questions. When you are finished please mail this form in the enclosed envelope provided for you.

1. Do you think this summary gives an accurate idea of what was discussed?

_____

_____

_____

2. Do you think this summary leaves out any important information?

_____

_____

_____

3. What changes do you think should be made to this summary?

_____

_____

_____

4. Is there anything else you would like to say?

_____

_____

_____

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