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How Do Black Nulliparous Women Cognitively Construct Birth?

Marianne F. Moore
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HOW DO BLACK NULLIPAROUS WOMEN COGNITIVELY CONSTRUCT BIRTH?
DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN NURSING

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON
SCHOOL OF NURSING

BY
MARIANNE F. MOORE MSN, CNM

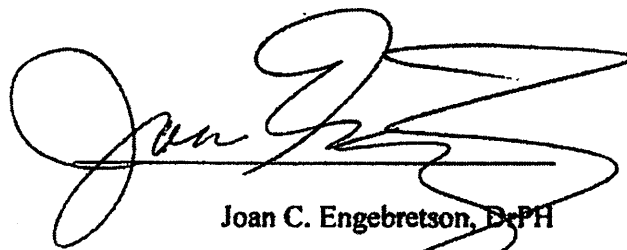
May, 2014

The University of Texas Health Science Center at Houston
School of Nursing
Houston, Texas

December 6, 2013
Date

To the Dean for the School of Nursing,

I am submitting a dissertation written by Marianne F. Moore and entitled "How Do Black Nulliparous Women Construct Birth?". I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing.


Joan C. Engebretson, DrPH
Committee Chair

We have read this dissertation and recommend its acceptance:

Ainda Gustafson
XXS (Rebecca Davis-Floyd)
Carol Rogers

Accepted: Patricia L. Starck
Dean for the School of Nursing

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To all of the women of color that I have known, worked with or served; may we all see true equality in our lifetimes.

Finally, the candidate would like to acknowledge the love and support of her daughters, her family, and most of all, of her husband Steven. This dissertation exists because of their understanding.

Marianne Moore CNM, RN

How Do Black Nulliparous Women Construct Birth?

May 2014

Abstract

A focused ethnography was conducted to determine the cognitive constructions about birth described by nulliparous Black women in an urban area of the Southwestern US; also, during postpartum, how do these women reconcile expectations with the actual birth? Semi-structured interviews were conducted before birth and after birth.

Women, 16 or older, 17 - 33 weeks carrying a singleton fetus and without anomalies or problems like pre-gestational diabetes, NYHA Cardiac Class III/IV, cancer, renal failure, or sickle cell anemia that eliminated vaginal birth were sequentially recruited and sampled in an affiliated ultrasound clinic. Women scheduled for an anatomy scan were approached.

Eleven women enrolled. Participants were 17 to 30 years old, with 11 to 22 years of schooling. Gestational age at enrollment was 17+5 to 31+5 weeks. Two women were college graduates. Four women were employed, and all used Medicaid to pay for care. Seven women received SNAP and/or WIC benefits. Three of the 4 employed women received this assistance. Three women did not have their mother in their lives. The sample was purposefully analyzed for age, education and maternal presence, and a natural spread of ages and situations was found, making purposeful sampling unnecessary.

Initial interviews lasted 12.5 to 41 minutes. Post-delivery interviews lasted 24 to 54 minutes, and occurred 13 to 25 days postpartum. The researcher transcribed all interviews, and used Atlas.ti to assist in analysis and organization.

Women described views of birth that grew from ideas shared with them by their own mothers. Themes included “birth is painful” which was the predominant view, followed by “birth damages you and/or the baby” Two women identified, “birth changes you.” Ideas obtained from friends, other family members, the media and the popular culture, as well as their care providers were evaluated in light of these maternal ideas. Women also evaluated their own births using these maternal ideas. Beyond describing birth as their mothers did, women concluded that birth was essentially unknown to them, and they had limited expectations about what would happen during the birth.

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How Do Black Nulliparous Women Construct Birth?

Chapter I

INTRODUCTION

Black infants are almost twice as likely to be born too small, too soon, or to die in the period around delivery (Murphy, Xu, & Kochanek, 2013; Martin et al., 2013). The 2011 infant mortality rate for Black infants in the United States (US) was 11.63/1000, while the rate for all infants was 6.15/1000 (Martin et al., 2013). In 2011, 16.77% of Black babies were preterm, vs. 11.73% of all US babies (Martin et al., 2013). Low-risk Black mothers are 30% more likely to deliver preterm when compared to White mothers with similar risk (Whitehead & Helms, 2010). Black mothers (6% under 17) are more likely to be under the age of 17 in Texas than any other racial group (White, 2.2% under 17) with the exception of Hispanics, at 6.7% under 17 (Texas Department of State Health Services, 2010). In 2007, the most recently reported year, Black women in the US (27.5/100,000 live births) were more likely to die than White women (10.0/100,000 live births) as a result of childbirth as well (Xu, Kochanek, Murphy, & Tejada-Vera, 2010; Berg, Callaghan, Syverson, & Henderson, 2010). In Texas, Black women also were more likely than White women to die (53.9 vs. 27.0/100,000 live births) in 2010 (Texas Department of State Health Services, 2013).

Historically birth took place in the woman's home or in a place set apart for birth, and a woman was accompanied by persons known to her (Davis-Floyd, 2003). Birth has been seen as a dangerous time which may either bring new life to the family, or take life away, and which exposes private areas like sexuality to the culture at large. Birth presents an opportunity to create a strong cultural imprint upon both the woman and her infant,

and the memories of the event can persist for many years (Simkin, 1991). Phenomena such as these are always surrounded by a series of beliefs and practices, or rituals, intended to protect both the persons involved and the culture itself (Jordan, 1993; Davis-Floyd, 2003). This ritualizing leads both women and birth providers within a particular culture to feel that the culturally correct way is the only way that birth can be “right”, which creates culturally constructed expectations or anticipations of birth. Meeting these culturally specified expectations preserves cultural identity and makes the woman feel safe as she births (Davis-Floyd, 2003).

Beginning in the early years of the twentieth century, various trends moved birth away from the home, and into the hospital, including the desire to be more technologically advanced, a belief in the superiority of the safety of hospital birth, and active efforts to discredit midwives as birth providers (Davis-Floyd, 2003). Physicians working in hospitals had access to intravenous fluids, forceps, and, as they developed, antibiotics, all of which improved the safety of birth and decreased both infant and maternal mortality. The application of these and newer technologies in the care of women with higher obstetrical risk, and to their infants, has improved the safety of birth for many women and infants.

Women often hope for a birth with minimal intervention that results in a healthy child (Howell-White, 1997). Technology in the form of medical and surgical intervention continues to mark many births in the US. Rates for many birth-related medical procedures have increased since 1997, when induction was employed in 18.4% of deliveries, electronic fetal monitoring was used in 83% of deliveries, and the Cesarean section rate in the US for all Cesareans was 20.8% (Ventura, Martin, Curtin, & Mathews,

1999). A recent telephone survey of 1573 women in the United States, who had delivered a baby in the last year found that 97% experienced electronic fetal monitoring (Declercq, Sakala, Corry, & Applebaum, 2006). A subsequent survey, completed in 2013 found that 62% were given intravenous fluids, 50% had labor induction or augmentation attempted, and 67% used regional anesthesia (Declercq, Sakala, Corry, Applebaum & Herrlich, 2013). These measures are commonly employed to manage childbirth and decrease morbidity and mortality (Declercq, & Chalmers, 2008; Declercq et al., 2006; Declercq et al., 2013; Michelson, Carr, & Easterling, 2008). Cesarean section rates in the US continued to increase (MacDorman, Menacker, & Declercq, 2008) and the final data for the US in 2011 indicates a rate of 32.8%, which includes both primary (1st) and repeat Cesarean sections (Martin et al., 2013).

This extensive use of technology in the US has not led to universal improvements in perinatal outcomes (MacDorman, Menacker, et al., 2008; MacDorman, Declercq, Menacker, & Malloy, 2008; Martin et al., 2013). The use of elective induction is increasing (Declercq et al., 2013; Moleti, 2009), and in nulliparous women can double the rate of primary Cesarean section (Michelson et al., 2008). Despite being the least likely to be electively induced in comparison to White or Hispanic women, Black women were most likely to experience a primary Cesarean section (MacDorman, Menacker, et al., 2008). Medically-indicated induction in Black women irrespective of parity leads to higher rates of Cesarean birth (Wilson, Effken, & Butler, 2010). All of the reasons for these disparate outcomes are not clear, and the reality of these experiences may create different ideas about birth in the Black community, leading to differing constructions about birth.

Experience, knowledge and context shape cognitive constructions and they are influenced by both societal values and the woman's core beliefs and values (Bergeron, 2007, Gibbins & Thomson, 2001). These constructions are used to create meaning for personal and cultural experience, and shape expectations, and they may also be understood as living hypotheses that people use to navigate through their lives (Walker & Winter, 2007). Constructions may be formed related to aspects of the childbirth experience, and women will then evaluate choices and actions using these constructions. Women make choices on a daily basis based on these constructions about pregnancy and childbirth, and these daily self-care choices have a profound effect on their health and the health of their fetus. The childbearing constructions of nulliparous women (women who have not delivered a pregnancy beyond 20 weeks) are often incongruous with their actual birth experiences. Women spend time postpartum revising these constructions to make sense of their birth experience, and to make sense of what it means to have become a mother (Dahlen, Barclay, & Homer, 2010a; Gibbins & Thomson, 2001; Hogue & Bremner, 2005; Walker & Winter, 2007). Congruence between expectations and actual experience in labor was found to lead to positive self-evaluation after delivery for the mother, as well as an improved mother-baby relationship (Beaton & Gupton, 1990). Healthcare providers hope to improve women's state of mental health after birth by setting up realistic constructions, or expectations that women can actually meet, thus avoiding cognitive dissonance (Beaton & Gupton, 1990).

Most published studies about expectations of pregnant women, sampled White women, most often those who were taking part in childbirth education classes (Dahlen, Barclay, & Homer, 2010b; Dahlen et al., 2010a; Fenwick, Gamble, Nathan, Bayes, &

Hauck, 2009; Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; Kingdon et al., 2009; Morhason-Bello et al., 2008). The lack of published research using participants who are Black women raises the question of whether their constructions differ from what is found in the research, due to their markedly different perinatal outcomes and life experiences overall. Our knowledge about childbirth constructions developed by Black women is limited, and we can only speculate on the role these constructions may play in the pregnancies of these women. Understanding these constructions may enable providers to offer care and education that is more relevant to the needs of Black women. The purpose of this focused ethnographic study is to examine the cognitive constructions regarding the birth expectations of nulliparous pregnant Black women living in a large urban city in the southwestern US.

Aims

1. Describe how nulliparous Black women living in southeastern Texas cognitively construct their expectations of birth
2. Describe how nulliparous Black women living in southeastern Texas reconcile their expectations of birth with their actual experiences, during the postpartum period.

Research Questions

1. What are the cognitive constructions about birth articulated by nulliparous Black women living in an urban area of the Southwestern US?
2. During the postpartum period, how do nulliparous Black women living in a large urban city in the Southwestern US reconcile their expectations with their actual childbirth experience?

Chapter II

REVIEW OF THE LITERATURE

Birth in the United States has undergone and continues to undergo tremendous changes in recent years. Cesarean section rates have increased by 60% since 1996 (Martin et al., 2012), and rates of other labor and birth intervention are increased. Young women who give birth in 2013 in the United States are facing choices and options that were not available for their mothers, and the pace of change means that choices and options can easily change from one pregnancy in a woman's life to the next.

Birth in the US

Most infants in the US are delivered by physicians in hospitals, and in 2011, the US Cesarean section rate was 32.8% (Martin et al., 2013). Non-Hispanic Black women in 2011 had the highest Cesarean section rates at 35.5% (Martin et al., 2013). The primary Cesarean section rate nationwide is now 23.5% using reporting from more detailed birth certificates (National Center for Health Statistics, 2012). The rate of primary Cesarean section remains high, even among low-risk mothers (MacDorman, Menacker, et al., 2008; MacDorman, Declercq, et al., 2008). There are many reasons why Cesarean rates are elevated. Common explanations include fear of litigation, maternal diseases like diabetes and pre-eclampsia, and increases in multiple gestation (twins and higher order multiple births). Additionally, elective induction is increasing (Declercq et al., 2013; Moleti, 2009) and elective induction of nulliparous women, in some research, results in Cesarean rates of 40%, if reproductive physiologic changes that indicate cervical readiness for birth are not present (called an "unfavorable cervix") (Michelson et al.,

2008). Other sources (Nguyen et al., 2010) note that epidural use increases risk of Cesarean for nulliparous women (2.4 relative risk; 95% CI: 1.5- 3.7).

In populations with unfavorable cervixes, induction of labor causes women to experience a long and painful labor. The elevated levels of pain and lack of progression lead to early and frequent use of pain medication, and often results in failure to progress, failure to descend, or fetal distress, which demoralizes and frightens women and their partners. This scenario may increase the likelihood that women who plan to labor and deliver without pain medication will need epidural anesthesia to cope with labor pain. Although these women may deliver vaginally, they display less satisfaction with the overall experience of birth (Kannan, Jamison, & Datta, 2001; Kjaergaard, Foldgast, & Dykes, 2007). Some of these women are not able to deliver vaginally; a nulliparous woman, who has not delivered a baby, faces a one to two in five chance of delivering her infant surgically in the US (MacDorman, Menacker, et al., 2008; MacDorman, Declercq, et al., 2008). These types of experiences may be difficult to reconcile with a construct that values participatory vaginal birth, or even one that has at its center a relatively pain-free experience (Davis-Floyd, 2003; Goldberg, 2002; Kannan, et al., 2001).

Women come to the birthing process feeling varying amounts of fear (Eriksson, Westman, & Hamberg, 2005; Fenwick et al., 2009; Morhason-Bello et al., 2008). One response to fear in Western society involves turning to medicine as a way to minimize risk and increase safety, a process called medicalization. Medicalization is defined as an expansion of medicine into the realms of everyday existence (Metzl & Herzig, 2007; Rose, 2007). It situates physical processes on a scale from normal to pathological (Bergeron, 2007). With the increase in Cesarean section, it would seem that more

pregnancies and labors are called “pathological”, and require intervention. The language of obstetrics is built on medicalization, and represents an attempt on the part of women, providers, and society to control a process that is essentially female, powerful and unpredictable (Davis-Floyd, 2003; Goldberg, 2002). The rapid addition of technology to obstetrical care means that the experiences of a woman’s mother and older female relatives may not be as relevant to young Black women as they create constructions around birth, and it is not clear if the disconnect between what Black mothers desire (Brubaker, 2007; Raines & Morgan, 2000) and what most Black mothers experience is problematic.

Cesarean section

Cesarean section is major abdominal surgery. Williams’ Obstetrics (Cunningham et al., 2010) notes that maternal mortality has been shown in studies to be doubled with Cesarean section, and various types of morbidity in mothers also increase with Cesarean delivery. Infection, hemorrhage, and thromboembolism are all more common with Cesarean section, and re-hospitalization is twice as likely. Bladder and ureteral injury can occur during the surgery, and costs for Cesarean section and related hospital care are approximately double the costs for a vaginal delivery. Neonatal mortality is 2.4 times higher for the babies who are delivered by Cesarean section, even when the pregnancy is classed as “low-risk” (MacDorman, Declercq, et al., 2008). Prior Cesarean section in Black mothers is linked to higher risk of subsequent stillbirth (Salihu et al., 2006; Rowland Hogue & Silver, 2011). Cesarean section has been linked to increased risk for abnormal attachment of the placenta (accreta, percreta and increta) in subsequent

pregnancies (Cunningham et al., 2010), which is linked to increased postpartum hemorrhage.

As a result of a recent (July, 2004) policy statement by the American College of Obstetricians and Gynecologists (ACOG Practice bulletin 54, 2004) regarding trial of labor in subsequent pregnancies, a Cesarean section permanently altered a woman's reproductive life during the past 9 years. ACOG recommended that surgery be "immediately" available when a mother with a prior Cesarean section attempts a subsequent vaginal birth (ACOG Practice bulletin 54, 2004). This recommendation led many practices and hospitals to either refuse to allow a trial of labor, or stringently restrict them. As a result, mothers in many areas were required to have all their subsequent deliveries by Cesarean section after a primary Cesarean delivery, due to the inability or unwillingness of hospitals to have appropriate staff on hand to meet the requirements of this policy statement. In 2006, rates of repeat Cesarean section were about 92%; due, in part, to these restrictive policies (Martin et al., 2009). High rates of repeat Cesarean section mean that a woman may not experience a desired (and safer, in many respects) vaginal birth with any of her subsequent pregnancies, and it is unclear what effect repeat Cesarean section has on expectations around birth.

In 2010, the National Institutes of Health (NIH) convened a consensus conference to examine the issue of vaginal birth after cesarean (VBAC). This NIH conference released revised recommendations, based on an extensive literature review (National institutes of health, 2010; Guise et al., 2010). The NIH recommendations included encouraging a trial of labor for many pregnant women who have had one prior low transverse Cesarean section, and the NIH encouraged ACOG to reconsider its'

“immediately available” recommendation as it was found to restrict availability of VBAC. A revised practice bulletin was issued in August of 2010 (ACOG Practice bulletin 115, 2010) supporting the NIH recommendations. Despite this change in guidelines, not every hospital offers VBAC, and many women still cannot access a trial of labor after Cesarean.

Constructions around Childbirth

Cultural constructions related to childbearing allow a woman to organize ideas, thoughts and impressions in a coherent manner regarding pregnancy and birth. These constructions frame expectations. These constructions, or expectations, reflect or determine what the woman considers desirable, preferable, possible or undesirable in terms of the outcomes of her birth experience and the meaning she attaches to it. Most women expect some discontinuity between expectations and the actual experience; in fact, the ongoing knowledge acquisition allows concurrent adjustment of the expectations on the part of individual women. Women’s choices about method of birth have been found to often change as the pregnancy progresses (Davis-Floyd, 2003). Women in one qualitative study also spontaneously stated that they realized that while for them, vaginal birth was preferable, they needed to “keep an open mind” in the face of the reality that a Cesarean birth might be necessary (Kingdon et al., 2009). Expectations are built on and evaluated in light of experienced reality. Some women initially choose Cesarean delivery, and then decide vaginal birth is what they desire. Expectations and perceived risk affect choice of provider (Howell-White, 1997).

Nulliparous women (women who have not delivered a pregnancy past 20 weeks gestation) are novices in birth who have limited personal information to utilize in creating

expectations about childbirth (Dahlen et al., 2010b). They are largely dependent on information received from women they know, providers, and the popular media, which penetrates all sectors of health care. Studies have shown that a lack of experience does not keep women from having detailed expectations of what birth will be like (Beaton & Gupton, 1990). Nulliparous women approaching birth value personal and infant safety, pain relief, physical and emotional support and professional assistance during postpartum (Dahlen et al., 2010a; Declercq & Chalmers, 2008; Eriksson et al., 2005; Nilsson & Lundgren, 2009).

Birth in the US has moved away from the popular sector, and further into the professional sector. This change in place of birth creates situations in which persons involved in a birth may not share the same culture or have the same values. They are often strangers prior to the birth, and lose contact after the birth is completed. Ethnographic study can help clarify the needs and priorities of the women being cared for in these situations.

Providers and patients have expectations for the behaviors and attitudes of themselves as well as for others in birth. Constructions related to childbirth can include prescribed and taboo behaviors on the part of mothers, fathers and healthcare providers. Routine provider and/or patient behaviors in one culture may be taboo in another culture (Semenic, Callister, & Feldman, 2004; Morhason-Bellow, Olayemi, Ojengbede, Adedokun, Okuyemi, & Orji, 2008; Reid & Taylor, 2007; Brathwaite & Williams, 2004; David, Aslan, Siedentopf, & Kentenich, 2009; Berry, 1999; Jambunathan & Stewart, 1995; Wiklund, Aden, Hogberg, Wikman, & Dahlgren, 2000; Liamputtong-Rice &

Naksook, 1998). When cultures differ, anticipations of behavior can differ, and may not match experienced behavior.

The birth of a child is a significant event in both the newborn and mother's life. Women look to their own mothers, family members, friends, healthcare providers and the society at large to develop expectations around the experience of pregnancy and birth (Davis-Floyd, 2003). While they may have knowledge of their own bodies, they often have difficulty dealing with the realities of pregnancy and the physical changes it can cause in a woman's body. These physical changes probably cause some of the first adjustments of expectations undertaken by the pregnant woman, such as adjusting to the fatigue of early pregnancy, or changes in body image. The first experience of pregnancy and birth, owing to the vulnerability of the woman in this constantly changing and new experience, leaves many lasting impressions and sets the direction of her trajectory as a mother (Davis-Floyd, 2003).

The expectations that a woman develops prior to birth are found to have some correlation to satisfaction both with herself as a woman and mother, and with the birth itself (Hodnett, 2002). Creating satisfaction with the birth and with the self can be facilitated by utilizing the information gained to improve anticipatory guidance and prenatal education. A recent review of the literature revealed that current antenatal curriculums do not have consistently positive effects on women (Gagnon & Sandall, 2009). In this review, antenatal classes were not found to increase knowledge, promote a sense of control, or consistently increase rates of breastfeeding or vaginal birth; consistent effects on pain or anxiety are not found.

Since most women in the majority of studies around birth were White, and taking part in childbirth education classes, our knowledge about childbirth expectations for many minority mothers may be limited (Dahlen et al., 2010b; Dahlen et al., 2010a; Fenwick et al., 2009; Houghton et al., 2008; Kingdon et al., 2009; Morhason-Bello et al., 2008; Williams, Lago, Lainchbury, & Eagar, 2010).

Responses to Birth from the Folk/Popular Culture

In the folk sector, these obstetric realities have led to increased visibility of childbirth outside of the hospital and an increase in attention paid to professional or direct-entry midwives (so named because they come directly to midwifery, not through the status of registered nurse, as a certified nurse midwife does). Concern about the rising Cesarean rates and rising rates of intervention led to the release of a movie in 2007 about out of hospital birth, called “The Business of Being Born”. Both direct-entry and certified nurse midwives deliver babies at home or in free-standing birth centers, but certified nurse midwives, who are classified as advanced practice nurses in most parts of the US, are seen as more closely aligned with the professional sector, as 96% of their births took place in a hospital in 2010 (Martin et al., 2012). In the South, Black women for years were delivered by direct-entry midwives, many of whom had excellent outcomes. These midwives were highly respected in their communities and some were still delivering babies in the 1980s in the South (Roberts & Reeb, 1994; Robinson, 1984; Fraser, 1998).

In the Listening to Mothers III online survey of 2400 women who gave birth between July 2011 and June 2012, 82% of all mothers reported using a laptop or desktop to access the Internet as a source of information about their pregnancy and birth. Sixty-six percent of first-time mothers used pregnancy or childbirth websites, and 56% has

installed informational applications, or “apps” on their smartphones to get information (Declercq et al., 2013). There are articles for providers about setting up websites and using social networking sites such as Facebook, MySpace or Twitter to communicate with patients (Craig, 2009). These sites can be used for posting practical information, such as inclement weather closings of practices, as well as education for patients on lifestyle or diseases. Some pregnant women are already being regularly contacted by the professional sector of health care, through the use of social media. Women indicated that 31% of providers used E-mail to communicate with them as patients (Declercq et al., 2013). In many major cities, women regularly see billboards and other advertisements from personal injury attorneys who specialize in medical malpractice. Birth, once a private and even taboo subject (Davis-Floyd, 2003) can now be seen on television and even on the Internet, since people can now post video of their own deliveries on sites like You Tube. As of March 27, 2011 a search for “birth” on You Tube yielded 318,000 results. These events suggest the growth of alternative information sources regarding pregnancy, but it is unclear what effect, if any, they have on the expectations of Black mothers.

Birth in the US for Black Women

Black women in the US often have worse pregnancy outcomes than the population of the United States as a whole (Heron et al., 2010; Martin et al., 2013). Black babies in the US suffer disproportionately higher morbidity and mortality when compared to the population as a whole (Martin et al., 2013). In the US in 2010, Black babies were 1.9 times more likely to die, and 1.4 times more likely to be born premature than the US population as a whole (Murphy et al., 2013; Martin et al., 2012); even more distressing is

the fact that Black mothers in the US are twice as likely to die in childbirth. Per the CDC in 2007, the US had a maternal mortality rate of 12.7/100,000 live births for all mothers; for Black women it is 26.5 /100,000 (Xu et al., 2010). Black women are also more likely than White women to deliver a baby while they are still teenagers. The US rates of adolescent birth decreased in 2011; the rates for all races combined was 31.3 births per 1000 young women aged 15-19; for non-Hispanic Blacks the rate was 47.3 births per 1000 women aged 15-19. The only racial group with a higher rate of teen birth in 2011 was Hispanic women of Mexican descent, with a rate of 49.6/1000; the rate for White adolescents stood at 21/1000 for that same year (Martin et al., 2013). When the state of Texas is considered for the year 2010 (most recent data), births to all young women 17 years of age and under comprise 4.3% of all births for which mother's age was reported for race/ethnic group; births to Black teens account for 5% of these births, and Hispanic teen births account for 6.2% of all such births (Texas Department of State Health Services, 2013b).

Prenatal and intrapartum care is provided to women to improve safety and prevent negative outcomes, such as low birth weight, premature birth, untreated diabetes, hypertension, pre-eclampsia, arrested or prolonged labor, or fetal distress (Cunningham et al., 2010). A retrospective study done in Illinois found that American-born Blacks had almost twice as many low-birth weight babies (13.2% of babies were low birth weight) as African-born Black women (7.1% of babies were low birth weight) delivering in Illinois during the same period of time, so this weight discrepancy is not likely to be related to inherent racial variation (David & Collins, 1997).

The most recent data related to first trimester prenatal care described 33 states in 2010 (Martin et al., 2012; National Center for Health Statistics, 2012); the percentage of Black women getting prenatal care in the first trimester dropped; but while the percentages for Black (62.5%) and Hispanic (67.6%) women are below the national average of 73.1%, they are not dissimilar enough to allow for an increased rate of preterm birth among Black women, when Hispanic births are compared to Black births. In 2010, 11.79% of all live births were preterm births to Hispanic women, while 17.2% of all live births were preterm births to Black women (Martin et al., 2012). Smoking is implicated in poor blood flow to the fetus, yet interestingly, Black women (10.6%) were less likely to smoke than all US women (13.2%) or White women (18.1%), but Black infants were more likely to die (11.63/1000) than the national average of 6.15/1000 (Martin et al., 2012).

The presence of such marked disparity in perinatal outcomes suggests that there may be some breakdown or lack in the care that is provided to Black women, or that the standard prenatal care does not prevent these types of outcomes as effectively for this population. Studies completed well into the 1990s demonstrated that even for Black women belonging to the United States military, who are well insured and for whom access to care is not a problem, rates for first trimester prenatal care were lower and the rates for low birth weight, fetal and neonatal mortality were higher than those of White servicewomen (Sylvia et al., 2001).

Poor outcomes for Black mothers, even in a population with accessible care, suggest the presence of other causes for morbidity. Research suggests the presence of chronic stress in Black women (Hogue & Bremner, 2005; Rosenthal & Lobel, 2011;

Love, David, Rankin, & Collins, 2010) related to racism and often exacerbated by poverty and related co-morbidity. Stress has also been found to interact with neighborhood factors such as low levels of education, high levels of poverty, and household crowding to increase rates of both preterm birth and low birth weight (Nkansah-Amankra, Luchok, Hussey, Watkins, & Liu, 2010). Stress, low social capital, income inequality, segregation and isolation are linked to increased infant mortality in Blacks (McFarland & Smith, 2011; Nkansah-Amankra, Dhawain, Hussey, & Luchok, 2010).

When a person repeatedly perceives herself as experiencing the behavior that she sees as racist, she becomes hypervigilant and experiences a state of hyperarousal (Nilsson & Lundgren, 2009). This hyperarousal is physically stressful for the person to experience. Depression has been reported to be more prevalent in pregnant Black women, and has been linked to preterm delivery and low birth weight in this population (Field et al., 2009; Nilsson & Lundgren, 2009). Rates of depression in foreign-born pregnant Black women were similar compared to US-born pregnant Black women, but foreign-born Black women were more likely to report their mental health as good when compared to Black women born in the US (Elo & Culhane, 2010). The authors hypothesize that foreign-born Black women have had less exposure to the stress of experiencing what is perceived as racist behavior.

In terms of morbidity, preterm birth is associated with many adverse outcomes, depending on the degree of prematurity and subsequent care issues. Recent studies (Swamy, Ostbye, & Skjaerven, 2008) note that for these children, increased morbidity and a higher risk of death persists throughout childhood, and those born preterm may

experience trouble themselves as adults in carrying children to full-term, as well as bearing those children. Low birth weight has been linked to type II diabetes and hypertension in adulthood, related to insulin resistance and weight gain (Barker, 2006). Decreases in renal size and number of glomeruli can lead to hypertension, coronary heart disease, and stroke (Jang, Jo, Lee, Kim, & Lee, 2010)

Conceptual Framework

Kleinman (1980) describes healthcare as having three distinct sectors: the popular sector, the professional sector, and the folk sector. The popular sector includes the individual, the family and friends, and community or culturally-mediated beliefs. Health care begins for individuals in this sector, either with self-recognition or recognition by others of illness. The professional sector encompasses what most professionals in the US think of as “healthcare”- nurses, doctors and hospitals, for example. Nurse midwives are likely to be considered part of this sector, but occupy a more marginal position within it than other practitioners. The Western model of professional healthcare is reductionist and tends to approach problems as essentially compatible with technical solutions. The folk sector here in the US would include complementary and alternative practitioners, as well as lay healers, direct-entry or licensed midwives, or other people respected inside their communities as healers. The culture of the folk sector is generally more holistic, acknowledging spiritual components in health problems and often giving as much, or more attention to the family around the person who is identified as ill.

Kleinman (1980) sees health care as always beginning in the popular sector, and progressing to either the folk sector or professional sector depending on the values of the culture surrounding the person and situation. Electronic media, including television,

movies, the Internet, and social media, as well as “self-help” books and authors, and popular daytime talk-show hosts often act as a facilitator of communication, bringing large amounts of mixed information to people. It is likely that this mix of information is being used in novel, ingenious and sometimes flawed ways to create cognitive constructions around the nature of pregnancy and birth. These cognitive constructions would be utilized by a woman to create expectations, make basic healthcare decisions, and to navigate within the three sectors to obtain needed information or care. Since most of the research regarding birth experiences, expectations, constructions and beliefs has been done using White women as participants, our view of how the sectors of health care operate in the Black community may have significant gaps, which therefore means that providers do not completely understand the care-providing and care-seeking behaviors of nulliparous Black women.

In conclusion, Black women come to delivery with additional stress and depression, possibly as a result of the effects of racism here in the US (Field et al., 2009; Hogue & Bremner, 2005; Nilsson & Lundgren, 2009). We know very little about the birth constructions of women who are not White. In the last 10 years, there have been significant changes in the way that the professional sector manages pregnancy and birth (Declercq & Chalmers, 2008; Declercq et al., 2006), an expansion of the folk sector into the care of pregnant and birthing women, and a virtual explosion of information in the media, on the Internet, and available via social networking sites (Craig, 2009; Hall & Irvine, 2009). These changes may have an impact on the ways that all women construct expectations about birth. Understanding the constructions that Black women utilize to “make sense” of pregnancy and birth might enable providers to give meaningful

information, comprehend patient priorities, and support positive and life-affirming constructions with our care. Depression was found to be present in 56% of urban Black mothers recently studied in the first postpartum year (Chaudron et al., 2010). Helping a woman to have what she considers “a good birth” may even contribute to positive expectations for subsequent births and improve the woman’s overall mental health.

Chapter III

METHODS

Research Design and Methods

Design.

The researcher pursued a focused ethnography aimed at understanding the cognitive constructions of Black nulliparous women regarding birth. Ethnography is traditionally employed to look at cultures or groups, and childbirth is definitely affected by the culture that it takes place in (Davis-Floyd, 2003). Focused ethnography can be used to understand the shared experience of a group (Richards & Morse, 2007). In order to describe the beliefs, priorities and expectations of these women, Black nulliparous women obtaining care at a central ultrasound clinic were approached. Semi-structured and digitally recorded interviews were conducted both at the time of the initial gestational dating and anatomy ultrasound, and again two to three weeks after the birth. The transcribed data was analyzed for themes and constructions.

Since the researcher is also a CNM, practicing the midwifery model, there are limits to the degree of a naturally-occurring etic view. Green and Thorogood (2009) note that it has been successfully argued that in ethnographic research conducted by nurses or other health care providers, their professional expertise can enhance the types of questions and the understanding of the medical culture. The researcher might argue that previous experience as a labor and delivery nurse, a childbirth educator, and education and experience as a midwife, helps in knowing “what to ask about”, based on an understanding of childbirth in the US.

The researcher has worked inside and outside of hospitals for over 30 years. Hospital/inpatient experience, coupled with the researchers' professional education gives an emic perspective. Much of the time was spent with those who are poor, disadvantaged, and often African-American. The researcher has worked with African-American men and women in New Jersey, Nebraska, California, and Texas. Time spent in settings outside of the hospital providing care to patients created a naturally-occurring etic perspective on the medical system, since nurses working in the community are seen as functioning separately from the hospitals that serve these men and women. Time has been spent with laboring and postpartum women of varied backgrounds both inside and outside the hospital, working as a nurse and as a midwife, for the past 15 years. Moving from nursing to midwifery brought a different understanding of how patients interact with the health care system. This change has again created a more etic viewpoint of the culture of nursing and the health care system. The researcher's natural curiosity about how people deal with health and illness, and why they do what they do, has made clinical experience an extended fieldwork. Conversely, careful bracketing of personal beliefs, frequent conversations with the dissertation chair and debriefing were very helpful in the maintenance of the equipoise required to position the researcher to better understand the emic or the perspective of the informants.

Sample.

Black women residing in an urban area in southeastern Texas who were nulliparous, between 17 weeks and 33+6 weeks gestation and obtaining care at a central academically-affiliated ultrasound clinic were recruited at the time of their gestational dating and anatomy scan. These parameters were designed to allow sampling of women

with both early and late entry to prenatal care. Early entry is generally regarded as prior to 12 weeks; late entry is defined as > 13 weeks and later in pregnancy (Gabbe, Niebyl, & Simpson, 2005). Women scheduled between 17-20 weeks gestation for an anatomy scan are more likely to have entered care earlier in pregnancy than those being scanned later in the second and early third trimesters. Gestational age at the first interview ranged from 17+5 weeks to 31+5 weeks of pregnancy. Participants identified their racial group as Black (non-Hispanic), were at least 16 years of age and able to read, write and speak English, and were carrying singleton pregnancies. Women carrying a fetus with a major anomaly were excluded, as well as women with pre-existing pathology such as pre-gestational diabetes, cardiac disease with a New York Heart Association class of III or IV, cancer, renal failure, or sickle cell anemia (not trait). Women with a fetus in breech presentation would not have been excluded from the sample, but none were enrolled. Women who were scheduled for Cesarean section were not the primary focus of this research. Qualitative researchers deliberately select participants who will provide the study with rich data (Richards & Morse, 2007). Black nulliparous women were the primary focus of the study.

Women who met the study criteria were sequentially sampled as they arrived at the ultrasound clinic. The sample was examined in terms of age, education, and the presence of absence of the participant's mother. After analysis it was determined that the sample provided variation in maternal age, educational status, presence/absence of the mother, and socioeconomic status in family of origin, though all participants were using Medicaid at the time of the interviews. Ongoing analysis of initial interviews was done, and sampling ceased when redundancy of the prenatal data occurred. The researcher was

hearing the same responses from women at participant number eight, but continued to interview and redundancy in responses was seen, despite trying different probes. Prenatal saturation occurred at 11 participants. Despite frequent attempts to obtain postpartum interviews with all participants, the researcher was only able to talk to 4 of the 11 participants after delivery. One participant lost her baby at 36 weeks gestation, and the remaining 6 participants had non-working contact information, made and broke appointments or were lost to follow-up in other ways.

Setting.

Women were approached in a central clinic located within an academic health science center in a large urban Southwestern city that provides obstetric ultrasound to both patients of University of Texas private physicians and patients who are publically insured and seen by University of Texas obstetric residents. The ultrasound clinic performs over 100 scans every month to examine fetal anatomy and provide or confirm gestational age per month, with half of the patients being Black.

Recruitment.

The researcher was able to develop relationships with clinic staff, including the receptionists and the ultrasound technicians, and the staff assisted with recruiting patients. The list of ultrasound patients for the day was reviewed, and through access to the records, women who might be Black/African-American and nulliparous were identified. The researcher gave these names to the front desk if they were less pressed for time, but also watched the sign-in sheet to assist in enrolling these patients. When patients who might be eligible were finished with the required clinic paperwork and were ready to be seen, the researcher would approach them in the waiting room. The researcher

introduced herself and briefly explained the study. Initially clinic front desk staff were to hand out the recruitment flyers, but it was determined that their job responsibilities made this task too burdensome and would have slowed the pace of the clinic.

It was made clear that participation was not a requirement to receive care. Patients were left with a flyer describing the research study (see Appendix B) and told that the researcher would check in with them once they entered an ultrasound room, to see if they were interested. The researcher returned to the clinic area. Patients often had to wait 20-30 minutes to be scanned, so they had some time in the waiting area to consider the possibility of participation, and talk to their family members in relative privacy.

Data Collection

The initial interviews took place in a private space within the immediate area, or in an area in the same building. Informants were not interested in making arrangements to meet at their home, or at another neutral location to complete the entire interview, or to finish an interrupted interview. Mothers agreed to be interviewed twice: (a) between 17 weeks and 33+6 weeks gestation when they presented for their anatomy, growth and dating scan, and (b) two to three weeks after the birth. In order to both maintain contact with the mother, and verify contact information, the researcher attempted to make a phone call to each participant between 35 and 36 weeks. Additionally, hospital census lists were surveyed for consented study participants, and the following items were collected from the delivery record: delivery date, delivery method, baby's gender, baby's weight, and gestational age by the new Ballard exam (see Appendix D). Post-delivery interviews were completed at the client's home, or in the private interview space in the clinic building depending on the client's preferences.

Interviews began by discussing and offering the consent form, the contact information form and the demographic form. Informants received a copy of the consent for their own records. A separate consent also was signed to allow for access to records at the hospital where most informants delivered their babies. Consent was followed by the interview which began with a “grand tour” question about what the informant thought would happen at birth, and the interview was conversational in nature and loosely structured to allow data to reveal itself in the interaction (see Appendix A). All participants verbally stated that they had signed a consent form at the start of the interview. This initial probe always required, as Spradley (1979) describes, expansion of the question since different women understood the question in different ways. Some of the listed items were intended as probes and were not to be used if the data revealed itself during the conversationally-styled interview. Preparing a complete interview guide, even if it is never used, helps the researcher anticipate a wide variety of participant responses and narrative directions (Clinchy, 2003). Unfortunately, during the 36 week phone call, it was discovered that one mother suffered a stillbirth; the researcher offered to talk to her about it when the participant felt able and left contact information with her again, but did not hear from that young woman.

Interviews were digitally recorded and immediately transcribed by the researcher. Field notes were made immediately after each interview to allow for prompt recording of participant’s appearance, affect and impressions of non-verbal communications. During the interviews, the researcher periodically re-stated or re-framed the participant’s ideas to validate the data. A reflective journal was kept throughout data collection and analysis, to allow for ongoing comments and perceptions, allowing the exposure of any biases and

the recording of insights. The field notes, transcripts that become text and the reflective journal created a clear trail which can be audited. Interpretation is seen as an iterative process, in which ongoing analysis shifts and refines the researcher's focus as the study proceeds (Crabtree & Miller, 1999). The multiple interviews of mothers aided in full description of the cognitive constructions of nulliparous women regarding birth. There was no need to contact these women via telephone after their interviews were completed as there was no need to clarify participants' viewpoints, clarify any interview data or clarify themes that emerged during analysis, and thus, no subsequent interviews were scheduled,.

The researcher collected demographic data at the first interview that included age, number of years of school completed, employment, marital status, height and weight prior to pregnancy, weight at last prenatal appointment, and the presence of WIC, TANF, Medicaid and/or Food Stamps (called SNAP), as a proxy for SES (see Appendix D). In Texas, these forms of assistance are based on the Federal poverty guidelines. The Women, Infants, and Children (WIC) assists with food and formula, and is awarded to those who make 185% of the Federal poverty guideline, or \$28,694.00 or less per year for a mother and baby (Texas Department of State Health Services, 2013). Medicaid may be awarded to a pregnant woman earning \$21,264.00 per year if she has no other children; CHIP perinatal coverage could be extended up to an income of \$22,980.00 per year in that situation (Texas Medicaid/Medicare, 2013). Temporary Assistance for Needy Families (TANF) is provided as income for those who qualify, based on Federal poverty guidelines; a household of one parent and one child receives \$240.00 per month (Texas Health and Human Services Commission, 2013). The Supplemental Nutrition Assistance

Program (SNAP), formerly known as food stamps, is awarded to assist in buying groceries and food. Applicants can have up to \$2,000.00 in assets, a house and one car that they drive for work or need to transport a child or disabled household member. For a mother and infant with a monthly gross household income of \$1,681.00 or less it provides a maximum amount of \$347.00 per month in benefits (United States Department of Agriculture, Food and Nutrition Services, 2013). The goal of collecting these demographic data was to provide a relevant description of the study sample. The information was updated, with maternal weight at delivery, infant gestational age, infant weight and method of delivery added at the second interview. The form used for collection of these data is found in Appendix D.

The researcher personally transcribed the interviews using computer software that came with the digital recorder. This software allows the user to adjust the speed and volume of the recording, making transcription easier. Transcribing personally created thorough engagement with the data as it unfolded for the second time. It presented plenty of opportunities to consider better ways to approach subjects, as well as reconsider initial thoughts about subject responses.

Analysis

All transcribed interviews were saved as both a Word file and a text file. The text files were entered into Atlas.ti (Version 7) for analysis. Transcribed data were examined for themes, or codable moments. Initially the researcher labeled what looked like significant or meaningful phrases, and these phrases were organized and labeled utilizing Atlas.ti software. The software was used to facilitate identification of these pieces of data, and these named pieces were used to document and check for key themes. The goal of

thematic analysis is comparison of data from interview texts. The researcher asks what is unique about each piece of data, as well as what is similar to other data. Peer debriefing was conducted by the dissertation chair on an ongoing basis, as data analysis and synthesis was undertaken to increase rigor and researcher objectivity.

As themes were developed, they were re-evaluated in light of newly transcribed text as well. Thematic content analysis (Green & Thorogood, 2009) was used to thoroughly describe the constructions developed by nulliparous Black women about birth. The researcher first utilized data across cases, due to the delay between initial interviews and postpartum interviews. Subsequent analysis was completed within each case by comparing the data before and after the birth. Analysis of the participant's expectations of birth and their reconciliation of expectations with the birth event was completed to explore the cognitive constructions that are formed after birth. Analysis was completed by the investigator with direction from the dissertation chair. Descriptive statistics were applied to limited demographic information, some of which was obtained from the women and some from the delivery record (Appendix D). Work began with code families in Atlas.ti, and initial ideas were developed about birth as pain, damage to the mother and/or baby, and the role of mothers, family and friends in the upcoming birth. The researcher will make a copy of the findings available, should participants request one.

Payment

Participants who completed the first interview were paid \$10.00 in the form of a VISA gift card that was given after completion of the interview. An additional payment of \$25.00 in the form of a VISA gift card was given to the informants after the

completion of the second interview, for a total payment of \$35.00. Initial interview gift cards were purchased by the researcher, and gift cards for the second interview were paid for by a grant from the local chapter of Sigma Theta Tau International. These VISA gift cards can be used anywhere that a VISA card is accepted.

Human Subjects Protection

Protection of Human Subjects.

Consent was obtained from all participants at the time of enrollment and one participant was, in fact, under 18 years of age and was not accompanied by a parent (Appendix C). Pregnant teenagers are considered emancipated and may give consent in matters related to their pregnancies. Mothers who were 16 years of age and older were eligible for enrollment in the study and their enrollment was cleared by the IRB. The participant who was under age 18 was given a copy of the consent form as an information sheet for her parents to read (Appendix C). Demographic information and transcribed interviews are retained in a de-identified form as encrypted data files on a password-protected, secure portable data drive, the Iron Key. These devices will destroy their data if 10 unsuccessful attempts are made to open the device. Contact information, including at least two emergency contacts for each participant, was collected and kept locked in a separate location within the investigator's office to facilitate completion of the phone contact and second interview. Contact information will remain identified until the study is completed, and will then be destroyed. Audio files, which are digital in nature, will be retained on the secure Iron Key. After all analysis of the data is completed, audio files will be destroyed. Any use of the participant's first name was removed from transcribed texts and subsequent reports.

Potential Risks.

Since there is no intervention, and the questions asked of the women are simply designed to elicit their own ideas and shared cultural beliefs, risk should be reduced.

Risk Reduction.

Post-delivery interviews might potentially cause participants to contemplate births that are less than satisfactory. During post-partum interviews, the names of at least two counselors who accept Medicaid and/or provide care on a sliding-fee scale basis, with contact information printed on business cards, was provided to all participants, in case participants find that the process is distressing in any way. If a participant became severely distressed during the interview, the researcher had made plans to remain with the participant until she composes herself or until a friend or family member arrives. Participants who might have been a danger to themselves would have been referred for emergency psychiatric services as appropriate to the setting where the interview takes place. Fortunately, the researcher was not aware of any participants who became seriously distressed after interviews.

Potential Benefits.

Discussing birth, even traumatic birth, in detail can help women to reconcile expectations with actual experiences, which some women find beneficial. Delineating birth expectations may prompt some women to bring questions to their providers, if they should realize that there are gaps in their knowledge.

Inclusion of Women and Minorities.

Women of child-bearing age who are Black were included in this study. Adult male patients were excluded from this study because inclusion of these individuals would

be inappropriate with respect to pregnancy. The research questions were only relevant to one adult gender. Infants of both genders were included.

Targeted/Planned Enrollment.

The ultrasound clinic identified in the proposal completes at least 100 dating and anatomy scans each month, and approximately half of the patient population is Black. Prenatal data saturation occurred after 11 interviews. Postpartum interviews were planned, but only 4 of the 11 participants were available for interviews

Inclusion of Children.

Children of 16 through 17 years of age (under age 18) were permitted to be approached for this study. In Texas, pregnant children are considered to be emancipated in regards to matters concerning their pregnancy or subsequent children, and may provide consent independently. If a child had arrived accompanied by a parent, and the child was agreeable to including the parent in the consent discussion, the researcher would have spoken to both the child and her parent, and accepted consent from both parties.

Pilot Work

Two pilot interviews were completed. The researcher was able to develop relationships with clinic staff, including the receptionists and the ultrasound technicians, and the staff aided the researcher in recruiting patients. Sequential sampling of the ultrasound clinic patients provided variation in age (30 and 19), education (college and high school) and socioeconomic status (not employed and small business owner), as well as providing women with and without a mother present. Interviews were transcribed, and basic reflexive analysis was initiated. Transcription was followed by reading, and initial

classification of themes using Atlas-ti was made. Field notes and a study log were kept. Discussion of the results with the dissertation chair, as well as debriefing occurred.

Initial analysis identified themes that included pain, uncertainty, anxiety, and some fear. One participant spoke about wanting the nurses and doctors to stay with her, and to keep her informed about what was going on. The younger participant responded to multiple probes regarding conversations about birth by indicating that she had not had such discussions, and spoke of avoiding conversations with people about labor or birth, saying that she “keeps walkin’” to avoid these conversations- she said that just did not want them right now.

One probe that was particularly productive, even for the younger participant, concerned dreaming about the birth. Dreaming about labor and birth is common in pregnancy, with 38% of dreams in one study being related to pregnancy, the birth or the baby (Backe, 2004) and a vivid dream life in pregnancy is often reported by mothers. Dreams reported by the more educated participant included concerns about the location of labor onset, and fears of being unable to deliver the baby without surgical intervention. The younger participant reported a dream about the birth in which she found herself holding the baby but did not dream about physical labor at all. This participant reported some watching of television shows about labor and birth, but then said she did not watch television all that much.

It was difficult to draw conclusions in the pilot study about the first research question after two interviews. The researcher identified differences between individual prenatal cognitive constructions of nulliparous Black women with varying backgrounds, but two interviews were not sufficient to fully describe these constructions, or to describe

the cultural context of these ideas. At the suggestion of a committee member, the researcher began to offer to buy a drink and/or snack for participants to create a more relaxed atmosphere during the interviews. Completion of the subsequent 9 interviews yielded redundancy in the data. Telephone follow-up and postpartum interviews added depth and breadth to the understanding of these constructions, as well as providing information related to the second research question.

Chapter IV

ANALYSIS OF THE DATA

Between March of 2011 and March of 2012 the researcher was able to complete initial interviews with 11 participants, and obtain postpartum interviews with 4 of them during that time. The researcher collected basic demographic information during initial enrollment and after delivery, as described under methods, using either the hospital records for the participants, or by directly questioning the participant if they reported having delivered at another hospital.

Description of the Sample

The participants ranged in age from 17 to 30 years of age, and had completed between 11 and 22 years of schooling (See Table 1; Appendix E). Two were college graduates and 2 others had some college education. Despite being educated, only 3 of the women were employed, and all were using Medicaid to pay for their medical care during pregnancy. Seven of the 11 women were also receiving benefits for food-either from the SNAP program or from WIC (Women, Infants, and Children). One of the employed women was not receiving this additional assistance, but the other employed women were receiving aid from both of these programs. The gestational age of the pregnancies at the time of the first interview ranged from 17+5 weeks to 31+5 weeks.

The researcher was able to obtain prepregnant weights and heights for 10 of the 11 participants with demographic information. One of the women only disclosed her height. BMI for those 10 women was calculated with this data, using the formula found in the Institute of Medicine's (IOM) 2009 guidelines on weight gain in pregnancy (Rasmussen & Yaktine, 2009). Five of these 10 women had what is considered a normal

pre-pregnant BMI, or Body Mass Index, between 18.5 and 24.9. The other 5 women ranged from overweight (25-29.9 BMI) to obese (30 and higher BMI). The researcher obtained delivery weights on 8 of the 10 women, along with basic information about the birth. None of the 8 women had gained the recommended amount of weight; 3 gained less weight and 5 of the women gained more weight than is recommended.

Two of the 10 mothers delivered the infants by Cesarean section. Eight delivered vaginally, and one mother delivered at another hospital and could not be contacted, despite repeated phone calls and text messages, so the researcher was unable to find out her delivery method.

Newborn weights for 8 of the 11 babies were obtained, and they ranged from 5 pounds, 12 ounces (2630 grams) to 8 pounds, 12 ounces (3963 grams). This sample was comparable to the United States population in terms of newborn size at birth (National Center for Health Statistics, 2012). Three of the infants were delivered prematurely, between 36 weeks and 36 weeks, 5 days gestation. One delivery occurred at 41+6 weeks.

One surprising finding was the fact that 3 of the 11 young women had lost their mothers. This was not expected, since the oldest participant was 30 years old-even an older mother of 35-40 would then be 65-70 years old. The causes of the deaths or the absence of these participants' mother are not known. One of these young women reported that her mother left when she was 2 or 3 years old, and she was raised by her father. Another woman whose mother was deceased stated during the initial interview that she did not want to talk to anyone about birth, and she was then not available for the postpartum interview despite numerous attempts to meet. The third young woman was supported by her maternal grandmother, and had access to information about her

mother's births. Flat affect and limited verbal interaction were described in the field notes in more than one participant. Some participants identified few sources of support and limited social interaction in their lives.

Initial interviews were between 12.5 and 41 minutes long. One participant was contradictory in her answers and did not respond to any probes. Throughout the interview process, the initial grand tour question was subtly altered, based on queries to previous participants that seemed to elicit more information- for instance, women were sometimes more open in discussing what they were curious about, what they were interested in, or in describing how the birth might process. Some women persisted in focusing on the time period after the baby was delivered, or returned repeatedly to the pain of labor. Participants described events that they remembered well with depth and detail, but if there was no detail to discuss, said very little. Asking participants, "What do you think will happen when you have your baby?" usually resulted in blank stares, embarrassed laughter, and sometimes long silences.

In reviewing field notes, about 50% of the women who were approached agreed to be interviewed. Most who declined cited time or other appointments as a reason. Some women who were approached had asked to contact the researcher for a later interview. These women were given contact information but none of them followed up with the researcher.

Three of the postpartum interviews occurred between 13-25 days postpartum; the fourth one was completed, with the consent of the dissertation chair, via E-mail at the request of the participant. The postpartum personal interviews occurred either at the participants' home or in the interview space inside the clinic building.

Table 1

Demographics

Age	30	19	18	25	26	25	21	22	18	17	24
Years school	18	13	12	11	22	14.5	12		12	11	13.5
Working now	Yes	No	No	Yes	No	Yes-FT	No	No	No	No	Yes-FT
Student?	FT	No	No	PT	No	No	No	No	No	FT	No
Height	66"	61"	68"	62"	66"	69.5"	64"	62"	64"	66"	64"
Pre-pregnant weight	150	UNK	130	146	150	160	190	213	160	130	165
BMI/ Rec wt. gain	24.3/ 25-35		19.8/ 25-35	27.1/ 15-25	24.3/ 15-25	23.1/ 25-35	32.7/ <15	39.5/ <15	27.5/ 15-25	21.1/ 25-35	28/ 15-25
Gest age at Interview	24	19+2	25+6	31+5	20	31+4	20	17+5	21	20+1	23+4
Assistance WIC-W Medicaid-M SNAP-S	M	M	W,M,S	W,M,S	M	W, M	M, S	M	M, S	W,M,S	W, M
Wt Gained?	13		20	40	31	20	36+	11+	58	56	30
Gestational age-dates	38+2	36+5	41+6	37+2	39+2	39	40+5	36	39+2	36	39+5
Gestational age- exam	40			38+		40			39	35	40
Weight of baby	6# 1 2755		7# 3181	6#12 3050	6# 11 3039	7#4 3290		fetal demise	6#14 3132	5 # 12 2630	8# 12 3963
Gender M/F	F	M	M	F	F	F		F	M	F	F
Delivery method	SVD	SVD	SVD	SVD	CS	SVD	UNK	SVD	CS	SVD	SVD

The postpartum interviews tended to be longer and more relaxed than the initial interviews; most likely this was related to the researcher being known to the participant, as well as being able to plan ahead for interview time. Postpartum interviews were anywhere from 24 to 54 minutes long.

Findings

Anticipations of Birth

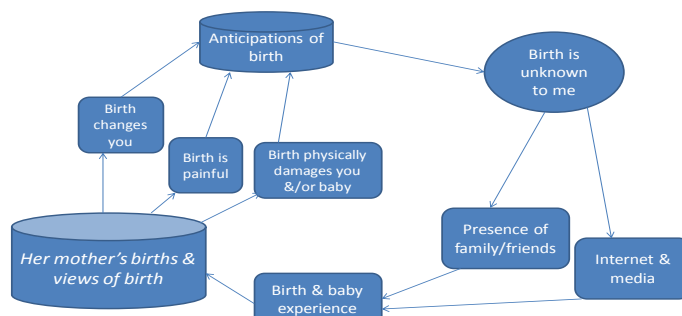


Figure 1. Conceptual Model of the Findings; constructs come from the woman's mother and return to those views.

In the following paragraphs, participants are identified numerically, and those participants whose views are noted are cited. The relationship between the woman's mother, her basic expectations and the role of other outside persons acting as sources of information, such as family, friends and providers was contemplated.

In this study, women formed their initial constructs about birth from their own mother's views. These ideas could be summed up as falling into three basic themes: birth is painful, birth physically damages you and/or the baby, or birth changes you. A fairly direct relationship between what women told the researcher about their mothers' views and their own expectations first came to light when some of the participants did not volunteer that their primary thought about labor was pain. This relationship became more evident when an expanded demographic sheet was developed to make some sense of the data. The researcher noted that women who responded initially with a minority view that birth meant profound changes in responsibility had identified this idea about birth as their mothers' viewpoint. When an entry for the views of the women's mother was added to

the demographic chart, the relationship between the woman's expectations and her mothers' ideas was seen. The views of a woman's mother formed the basis for the woman's anticipations or cognitive constructions about birth. This construct might be added to or altered by the experiences of seeing other births, talking to family and friends, or later by experiencing birth, but the narrative is built on what the pregnant woman carries from her own mother, as seen in the circular nature of the model. When women considered these initial constructions about birth, most concluded that birth was essentially unknown to them. This construct of not knowing what birth was led women to want varying combinations of family and friends to be present, and to utilize the Internet and media, but this information is evaluated in the light of her mother's experiences and expectations.

Her Mothers' Births and Views of Birth.

When women talked about their mothers' experiences, they described a wide variety of births. Some of the young women interviewed knew some detail about their mother's births (030801, 031501, 063001, 021601, 022301, 042201), and they described the context of the birth, time frames, or discussions between their mothers and physicians. One young woman saw her own mother deliver her youngest child, who is the participant's brother (031501). Other young women offered very little (030401, 062301, 072101), or nothing (011901, 031701) about their mother's births. Overall, according to the participants, mothers described their own births as hard and painful when they offered information, so it is possible that some of the reticence is related to a desire to avoid reliving unpleasant memories. This makes one wonder about the actual circumstances of the delivery. Some of the participants offered questions to the researcher at the end of the

interview; since the interview was completed the researcher generally answered these questions- and they were universally questions about the care that the participant or a friend of the participant had received from other providers in the area. These women were concerned that the care that was given may have been substandard.

Women talked about how their mothers had unwanted Cesarean sections, which one woman's mother got through by being given general anesthesia. The participant (021601) described her mother as saying, “‘Put me to sleep, cause I don’t want to see it,’ she’s like, ‘I see my baby when I wake up.’ ” Comments like, “Just from my mother, growin’ up, listening to her, I always been scared of delivering” (063001) were made. This participant went on to say that her mother told her to get medication, because it “hurts really bad”. Another participant (030801) discussed not having many questions for her provider, because her mother gave her information. One participant (063001) described her mother’s breech delivery in which the provider turned the baby during labor. Her mother did not describe exactly what happened, but the participant said her mother, “said that was tough, because, of course they had to turn her around. She never lets my sister forget that (short laugh). I think that may have been her hardest delivery”. Women discussed having mothers who described difficult or painful births; one women’s mother (022301) was reported to have temporarily been on crutches after her delivery, and the participant was not clear about why that happened. Some of the emotions connected to these stories came through in the inflections used by the participants-the pain, the fear and sometimes the defeat that their mothers felt echoed in their voices.

Other participants stated that they were not told much about their mother’s births- just that it hurt (030401) and they needed an IV and an epidural to get through the

experience. Two of the three participants who lost their mothers (011901, 031701) could not give the researcher any information regarding birth or even accounts of their own birth. One participant who was motherless got her information about birth in general from overhearing her father (011901) and from health class. She did not indicate that there were any older females involved in her life. She chose to talk to friends to get information about birth. The other participant (031701) had indicated that her mother had died, but did not offer any additional information related to her mother's births. She told me that there were older female relatives in her life, but she did not offer that she talked to them. Interestingly, she said that she would get her questions answered by her oldest sister, who had not had children yet. She identified that she had two other sisters who had experienced pregnancy and/or birth, but was not using them as sources of information. She was not very communicative, and did not offer a reason why she chose not to utilize these sisters with experience for information. She was watching popular television shows, like "Baby Story", about birth. This participant was extremely challenging, offering very little information in response to various probes. A third participant whose mother had died was living with her maternal grandmother, and able to have multiple discussions with her grandmother about her mother's births.

Talking to mothers did not alleviate fears or concerns; one participant (063001) said "she didn't calm my fears at all, she just re-iterated what everyone else said-that it is painful...". One participant (030801) also listened to her mother's directions about activities to avoid so that she could protect the baby from difficulties like having the umbilical cord wrapped around the baby's neck. Participants interviewed by this researcher, when asked about discussions with their mothers about birth described talks

advising against having sex, or discussions of other young women's pregnancies as a negative thing.

Participants described that some of their mothers were unhappy about the daughter's pregnancies; one of the participants (031501) interviewed in this study reported that her mother wanted her to finish school before having a baby. Mothers were described as accompanying young women to appointments; one woman who was interviewed for this study (022301) brought her mother for her ultrasound appointment. Lack of respect on the part of providers for the pregnant woman's mother is viewed unfavorably and was described negatively by one of the young women (021601) interviewed for this study.

Birth is Painful.

Birth is painful had a range of descriptors. Phrases like, "a lot of pain" (030801, 042201), "well, if I don't get an epidural I heard it's like, crucial, the contractions" (031501), or "heavy cramping...like menstrual cramping pains" (030401), "menstrual cramps but, like.....30 times worse" (031501) were used. One woman said her mother was coming to the labor but would not stay for the delivery, since her mother "cannot watch me go through that kind of pain" (021601). Participants said, "they say it hurts like hell...that's all I know" (011901), and "some people describe it as, something's ripping you apart" (021601). One participant (022301) never mentioned pain, so finally the researcher asked her if she had thought about the labor pain much. Her reply was, "Yes, I think about it all the time...". Other ideas included "(pain is) really bad" (042201) and "excruciatingly painful" (063001). Cesarean section was identified as causing "a lotta pain" (022301) afterwards.

Birth Physically Damages You or the Baby.

Birth physically damages you or the baby was exemplified by ideas like, “if I have a C-section I won’t be able to wear any more...bikinis...” (031501). Women described the C-section as having to be “cut” (031501, 021601). Others worried about stretch marks (030801), and two women described fears about the baby being hurt by having the cord around the neck (072101, 030801). Two mothers specifically worried about birth defects- one (062301) felt her anemia might cause a defect in her baby, and the other (063001) had personal experience seeing babies in the NICU related to her nursing education that caused fears. This participant also said, “I’m wondering about my body. Will my stomach ever go back down to the old size? Will the-well, if I have a C-section will the scar prevent me from getting back in shape?” (063001). One woman (011901) described her vagina as “somewhere I don’t want it to come (from)”. Another spoke of “splittin’ or cuttin’” (062301), and described the experience of seeing another family member’s birth as, “It looked scary...(giggles)...I guess because her stuff opened so wide” (062301). Women discussed fear, anxiety, and mental states that verged on panic-“I don’t know, I, I...my mind goes everywhere” (063001).

Birth Changes You.

A small minority of the women in this study, when asked some version of “what will happen when you have the baby/give birth/deliver the baby?” spontaneously volunteered the idea that birth changes you, that it “makes you become a woman, after you can take that type of pain” (030401), or that it is “an experience like none other” (063001). Three women, when the interview initially opened with the general idea of what they were expecting when they had their babies, immediately began discussing

financial changes (031501, 072101) after birth or the need to physically prepare (022301) for the arrival of the baby- for them, the birth itself was more of a mid-way event or a “way station” between pregnancy and parenting.

Birth and Baby Experience.

Women described varying levels of personal experience with birth. The researcher noticed that among the women who participated in the study, women who had a living mother (8 of the 11 participants) were more likely to have seen a close friend or family member-even their own mother-actually deliver a baby (5 of the 8 participants, versus none of the women without a living mother). More than one young woman told the researcher stories of mothers who were disappointed that they were pregnant (031501, 072101), admonishing them that a baby was a lot of work. One (031501) also said that whenever her mother discussed other girls who got pregnant, it was implied that getting pregnant prior to marriage was not desirable. She said that her mother told her that if she engaged in sexual activity prior to marriage, she and the young man would “get stuck” and that someone would have to call the ambulance to separate them.

One woman (072101) had been in the surgical suite with her sister during her Cesarean section, and also had personally seen a vaginal delivery of a friend. Two of the participants specifically discussed attending someone’s birth, and stated during the postpartum interview that there were younger women in their lives, nieces or young cousins that had either come to their labor or came to stay with them after the delivery. One participant (062301) noted that this younger relative was like a “stepsister” and wanted to be with her, so she admitted, “I try to torture her a little bit” by making her get up and fix formula in the middle of the night for the participant’s baby. The other

(063001) noted that she and a younger cousin had gotten close, so she specifically wanted to “share (the birth) with her because I know when I witnessed MY sister give birth, it turned me off from havin’ kids for years”.

Other women saw younger siblings (030501) nieces or nephews (022301, 062301, 063001, 072101) or the children of friends (072101) delivered. Two participants stayed with older siblings post-delivery to help (022301, 062301), which, based on comments made by participants in the postpartum interview, may possibly serve to discourage early childbearing. None of the women who had seen an actual birth felt it was significantly different than what their mothers led them to expect, and none said that seeing the birth made them want to have children sooner. Participants shared that seeing the birth served to encourage them to delay having a baby of their own.

In the interviews done prior to birth, personal experiences with the births of other women were measured by maternally dependent anticipations and not seen as more valuable than what a woman had been told by her mother, since women who had seen other births still built on their mothers’ viewpoint, even when a sister made different choices. One participant (022301) noted that one of her sisters had no medication for her birth, but the others had an epidural. According to this participant’s description, her mother was very matter-of-fact in describing birth, calling her last delivery with the participant a “regular delivery” despite needing crutches to get around after the birth. The participant was afraid of the pain but thought she would just sit around and “probably just cry” but does not say she will want an epidural. Other participants were advised by their mothers to get an epidural (030401, 030801, 042201) and they told the researcher that was what they planned to do. One participant (072101) acknowledged her mother’s view

and experience, and planned on taking Lamaze classes, but thought she would want pain medication, even though she said that her mother did not support that idea for her nor for her sister who previously delivered, but she was an exception among the woman interviewed. In the four postpartum interviews, women weighed their birth much like other deliveries the woman has experienced-by the criteria she learned from her own mother.

Discussions about having a baby varied for the participants. Discussions were not reported (030401, 031701, 042201) for some young women. One of these women (042201) was able to get specific questions answered about having a baby, but she did not realize that she was pregnant until her 5th month-despite previously regular cycles that were absent for the first 5 months of the pregnancy. Some of the participants overheard family discussions about having a baby but had no formal discussions about the process (011901, 022301, 030801, 062301, 063001). One of these young women made a mental connection between what she overheard about having a baby around 8 or 9 years of age, and the material that she was exposed to in her high school health class. Her mother was not present in her life, and she said when her father sat down during high school to have what she called “the talk” he was relieved to realize that she had figured out where babies came from.

Two participants (031501, 072101) recalled very explicit messages about not engaging in sexual activity before marriage. While these participants were beyond their teen years, neither was married at the time of their interviews. The messages may have delayed sexual debut. One participant (031501) described her mother’s deliberate education regarding all aspects of reproduction- she “brought out books” and discussed

menarche and procreation so that the participant was well-educated, but this experience was an exception. This young woman said her mother wanted her to get good information and felt providing it herself was the best way to insure that it happened.

Birth is Unknown to Me.

It was difficult for many of the informants to clearly describe the birth that they expected. These constructs or anticipations of pain, damage, or change were accompanied by facial expressions that conveyed fear. During interviews women used terms like “cut” to describe both vaginal and cesarean delivery, and there was a lack of understanding of terms like “vaginal” to describe birth. Difficulties with basic health care literacy make communication between participant and provider very difficult-literally each may use the same term but mean two different things, or the provider may use a term that the participant does not understand at all. Some women verbalized knowledge that birth is different for different women, saying “Everybody have different ways of havin’ they baby, so, I really don’t know yet” (062301), “people describe it, you know, in different ways, so I really don’t know what to expect” (021601), and “everybody has their own experiences” (072101). Most of the participants concluded that birth was unknown to them. When I asked women what they thought would happen or what they expected to happen in birth, I heard “I don’t know” (031701, 011901) and a lot of variations of the phrase, such as “really don’t know” (062301), and “I’m not sure” (030401).

Dreaming about the birth was common in the reports of these participants. Only 2 of the 11 participants reported no dreams about birth. Five participants reported dreaming of quick (030401, 021601, 031501) or easy (042201, 022301) births. One of these participants also dreamed of having a Cesarean birth (030401) that resulted in a baby she

did not recognize. One mother dreamed she was holding her baby, without any hint of labor. Some mothers, when asked about dreams immediately began discussing pain (011901) and one (062301) replied, “Yeah, I- I’d really like to have her. I don’t like muscle spasms- I have muscle spasms in my back- I don’t like that,” when asked if she was dreaming about the baby. She went on to talk about her physical problems in the pregnancy. A participant who was anticipating major life changes as a result of the birth dreamed she was having twin babies, interestingly enough. Discussions of these dreams had few details about the labor, consistent with the overall construct of “not knowing” that participants arrived at.

Along with a feeling of not understanding birth, there was a feeling from many of these young women that they really could not evaluate their providers. Asking participants to describe what a good doctor looks like, or what they would like in a doctor also yielded similar phrases like, “um...I don’t know-he’s doin’ what he’s supposed to do?” (011901) and “Um...I haven’t a clue-I haven’t a clue” (030801). Participants who had ideas about what made a good provider said that they wanted courtesy to themselves and their family, information, honesty, and delivery of the baby. These women used phrases like, “hopefully deliver the baby and help me” (030401); “tell me exactly like, what I’m supposed to expect” (030401); “just bein’ there to help, and make sure everything’s OK” (042201); “I mean, they tell you. Don’t beat around the bush about stuff wrong or nothin’ like that” (062301); and “bedside manner...matters the most to me, because if you’re a doctor, or you’re a nurse-you have the education, you know, you have the knowledge, but how do you treat people?” (063001). Some asked many questions of their doctors (042201, 011901, and 022301) but getting participants

questions answered did not cause them to feel knowledgeable about what was happening, or feel prepared for the birth.

Another participant initially was a bit hesitant. She described her physician as, “my doctor’s very brief” (021601), and went on to say that she was glad she could do Internet research to get information. When the researcher asked her if she wished her doctor was a little “more chatty”, it was as if the floodgates opened, and she discussed wanting a doctor to be more talkative, more informative. “He’ll say what’s goin’ on but he won’t explain it. He won’t break it down for me, and I’ll be confused, I’ll go home, and I’ll be so-you know-so worried about my baby, and I-it just-it was unbearable, sittin’ there with like, what’s goin’ on-what’s goin’ on, and he-didn’t even try to tell me much more.” She went on to say that she wished doctors were happier to be there, “walk in like you ready to be there-you WANT to be there. Don’t come in, you know, just-you know, people say they doin’ it just for the money. Don’t do it for that-do it because you genuinely CARE about that patient.” She was also unhappy that this doctor had been rude to her mother and her friend, and that the clinic seemed to be perpetually late. She felt that her time was just as valuable as the provider’s time, and that the way that the clinic was run added to this problem, saying “if you gonna be late, you know, don’t have, you know, your waitin’ room full of people-and don’t schedule a whole bunch of people at the same time”.

One participant (042201), who told me that she had done a lot of reading about birth, was very clear about what good care looked like, but she used phrases like “to be very nice to ‘em,” when asked about what she was expecting from doctors and nurses- “just to be nice, and patient,”. When the researcher asked her, to clarify, “and you expect

that if you treat the healthcare providers nicely, they'll answer your questions", she replied, "Everything'll go kinda quicker", and added that it was not good to yell at them because you were frustrated, "and you're goin' through stuff-so better to just be nice to them...and they help you out better".

Presence of Family/Friends.

There was also a desire to have the physical presence and support of family and friends, based on their construct of birth and the construct that birth was unknown to them. One mother noted that the people in the room are there "trying to make sure I'm comfortable....and makin' sure I get what I need. Like if I'm feelin' contractions, or somethin', ask the nurse, could they give me some medicine..." (022301); another woman noted that there would be "a lot of my family there," and when I asked what they would be doing, the woman said, "Just there for moral support I guess...(laughs) I don't know" (030401).

Mothers and grandmothers (for one girl whose mother was deceased) come to "hold my hand and like to help kinda coach me through it, cause she had kids before and this is my first one" (042201). Participants (022301, 063001, 072101) described births that they had been at as having anywhere from 5 to 13 people in the room, and as one woman said, "I guess everybody that's in the room is the people that should be in there" (030401). Two women mentioned not wanting their mothers- one noted, however, that since her mother lived close that she would most likely end up needing her help (063001), and that is what happened. She had expressed concern that her mother would "probably try to tell the doctor what to do and that would make me embarrassed or upset". The other woman (072101) did not mention having her mother at the birth in her

communication after delivery. Her concern about having her mother related to the fact that her mother did not have pain medication for her own deliveries, and the participant very much wanted medication for pain- she was concerned that her mother might interfere with her plan, and she said that her mother had been eating food in front of her laboring sister, who was not allowed to eat.

Internet and media information.

Some of the participants also used the Internet to deal with their perceived lack of knowledge about birth. Many searched for specific pieces of information during their pregnancies. Some did not use the Internet at all (062301, 011901). Some mentioned using downloadable applications to provide week-by-week pregnancy highlights (031501), while others used the Internet and sites like babycenter.com, Google (030401), parenting.com (021601) and Ask.com (030801) to find definitions of specific words, or information about specific topics. One woman described her Internet use as “I’ll probably type that (term) in-Cesarean- and then they have like-varieties of different topics, and I just read over ‘em....if it’s talkin’ ‘bout the same thing, then I know, it’s accurate” (022301). One woman read pregnancy blogs, first person writings that often include birth experiences (063001). Some would branch out from the results they obtained, using suggested sites to get more information, and others searched only one site for answers. Some of the women watched television shows (022301, 030401) like “Baby Story” (031701, 011901) or “16 and Pregnant” (030801,063001) to see births, though one woman who had seen two births personally (072101) noted that the television shows did not really give you a good sense of time passing or of what the event is really like”; “when you’re actually in the room, you’re like, in a daze-you’re just- you can’t believe

that it's happening right there before your eyes, it's kinda surreal in a way". This participant also noted that these shows rarely showed placental delivery: "they don't show you when you have to like, pull out the sack" (072101). Other women found the "hollerin'" (011901) and verbal outbursts of women on these shows to be frightening to them.

Actual birth experience.

The second research question asked how women reconciled their actual birth experiences with their expectations or constructs. As discussed, only four (4) postpartum interviews could be arranged. The other seven women did not respond to multiple contacts, or made and broke appointments, so their postpartum interviews could not be completed.

Women evaluated the birth experience in terms of what they had been expecting. Birth was experienced as being "more or less" what was expected. Evaluating birth in these terms may be the beginnings of developing competence as a mother. Those who expected pain discussed the experience after the fact in those terms. One participant (042201) found the intravenous needles to be more painful than the birth, but said that this was because she was given an epidural. She said that she felt the contractions were terribly painful and wanted the epidural "5 minutes" after contractions started. She reported being given a transfusion prior to having her labor artificially induced. She thought the hardest thing about having a baby was getting up at night, but felt that the baby taught her to be mature. She said she would discourage a friend or sister from having a baby.

A second participant (063001) found birth to be intensely painful, but not as bad as she imagined it would be; she said that the epidural was not as bad as she feared it would be. She described herself as “screaming” at home with contractions, because she had been sent home earlier in the day from the hospital. She did not want to go back to the hospital too soon. She also found that the Cesarean section that she had was not as difficult to recover from as she had feared. Overall, the experience was totally different than she imagined it would be-not as bad, and it did not make her think she would not have more children, though she wants to wait for another baby until her situation is more settled.

A third participant (062301) was prenatally concerned about “splittin” and in her postpartum interview discussed her birth in terms of how damaged her perineum was. Interestingly, as the interview went on her description of the baby’s weight and head circumference kept increasing, as she repeatedly described the damage that birth had caused. This participant had described extensive experience with newborns within her family circle, and said that she wanted to experience birth for herself; during the postpartum interview she initially said there would be no more babies, but towards the end she allowed that there might be another one “in 10 years or so”.

The fourth participant (072101), who expected pain, felt that it was manageable. Her description of her induced labor was straightforward, and she accepted that due to severe scoliosis, she could not receive an epidural-she opted for intravenous medication instead. She found the urge to push to be very overwhelming, but the contractions seemed very manageable with breathing techniques. Labor was faster than she was expecting it to

be. This participant said she would encourage a friend or sister to take a class, read a lot and try not to listen to what everyone says, since everyone's experience is different.

The young women in this study who were interviewed after delivery described birth as a life-changing experience that matured them, usually for the better. During postpartum they described feeling calmer (063001), and more focused, since they have more responsibilities, cannot act like a child anymore, or "just be there only for yourself" (042201). This participant (042201) also noted, "It teaches you to be mature". The hardest things for these young women were getting up at night for feedings and learning to breastfeed, but there were not any comments from participants that indicated being surprised about the changes in their lives.

Once these four women experienced their own deliveries, the experience was weighed much like other deliveries the woman has experienced-by the criteria she learned from her own mother. One woman (062301) described expecting to be "split" open, and said delivery had "ripped her up"- but the delivery record noted a more superficial first degree laceration that was repaired, and her baby weighed 6 pounds, 12 ounces. Three of the participants had been expecting pain, and they described their labors in terms of pain; most found it to be less painful than they expected, or noted that certain aspects, like the intravenous lines or the contractions were more painful than the birth. One woman found the Cesarean section to be less painful than she was expecting it to be.

It is worth noting that none of the women interviewed postpartum described the friends and family in the room in any detail. In discussing their births there is a focus on the woman and her baby, and the nurses and physicians who are providing care to her. The researcher did specifically ask the women who was in the room during the birth, and

in prenatal interviews these people were expected to provide support. However, when the woman presented the story of her birth, it was focused on herself and the baby. Mention of the others in the room is almost tangential-for example, the partner (063001) is mentioned because he is holding the baby.

Chapter V

SUMMARY OF THE STUDY

Summary

1. What are the cognitive constructions about birth articulated by nulliparous Black women living in an urban area of the Southwestern US?
2. During the postpartum period, how do nulliparous Black women living in a large urban city in the Southwestern US reconcile their expectations with their actual childbirth experience?

Semi-structured interviews were conducted both prior to birth and in the postpartum period and designed to identify how nulliparous African-American women in a major Southwestern city in the United States construct their expectations regarding birth, as well as how they reconcile those constructs with their actual experiences. Eligible women were identified using the clinic schedule and the electronic health record, and were approached as they arrived at the clinic. Eleven women agreed to participate; another 11 were approached but declined, usually due to time constraints. Initial interviews ranged in length from 12.5 minutes to 41 minutes. Post-delivery interviews ranged from 24 minutes to 54 minutes, and occurred between 13 days postpartum to 25 days postpartum. All interviews were transcribed by the researcher and analyzed using Atlas.ti (Version 7)

Women described views of birth that grew from ideas given to them by their own mothers. Ideas obtained from friends, other family members, the media and the popular culture, as well as their care providers were evaluated in light of these maternal ideas. Beyond seeing birth in the way that their mothers did, women concluded that birth was

essentially unknown to them, and had few concrete expectations for themselves or care providers during the experience.

Discussion

The participants interviewed for this study began constructing labor expectations from their mother's experience. These beginning constructions fell into three groups- predominantly, women expected pain; a much smaller number expected pain, but their main focus was perineal damage or damage to the baby; a third group saw the experience of birth, including the pain as a life-changing event. The experience of seeing birth personally or actually giving birth was filtered through these initial constructs.

Ultimately, when women began to listen to what other women said and try to imagine their own birth, they concluded that birth was unknown to them. This "unknown" quality made it difficult for women to evaluate their providers, their care, or the statements of friends and family about birth. This "unknown" quality also may play a part in having many people present at the birth- women are not sure how it will proceed and are not sure what they may need, so more people can mean more support and help. Women collected information from their providers, the Internet, media, books and the rest of their family and friends, evaluated it in light of the ideas gleaned from their mothers, but still concluded for the most part that they did not know what to expect.

Women who self-identify as Black or African-American are part of a racial minority group in the United States. Much of the research concerning anticipations or expectations of birth utilized participants who were largely White and partnered. There are few studies that focus on minority participants. Brubaker (2007) produced one of the few qualitative studies focused on the experience of pregnancy and birth in African-

American teens. According to Brubaker (2007), many mothers of young Black women feel responsible for avoiding commonly held stereotypes of Black mothers as irresponsible and immoral. Mothers of young African-American teens are described in the literature as having to be responsible for the teens' moral and sexual behavior. The mothers of the young women that Brubaker (2007) interviewed often avoided specific discussions about sex and sexuality, and saw the provision of contraception as permission to have sex. Of the 8 mothers who were discussed by the participants in this study, only one (021601) sat down with her daughter, who was 8 years old at the time, and "brought out the books and started explaining everything [about menses and pregnancy] to me". This participant said that her mother wanted to be sure that the participant learned correct information. This parental behavior was rarely seen in the study participants. Other participants described being close to their mothers but either described no discussion of reproductive function, or limited warnings about delaying sexual behavior until marriage.

This sense of responsibility also may lead to the practice of having young girls observe birth, which was described by two participants as a deterrent to sexual activity. As a clinician, the researcher has often observed younger women present in the deliveries of African-American women. The delivering woman will typically describe some version of "she is here to see what this is like" as a means to discourage the young girl from pregnancy at a young age. Since the experience of observing a birth was only reported by women in this study who had living mothers, it led the researcher to question if the pregnant woman's mother may act as a "go-between" in providing access to the birth for other, younger women in the family. It is also possible that description of the mother's own births are avoided, as they are seen as a form of giving permission to daughters to

pursue pregnancy for themselves, and so mothers avoid discussion of the situation with their daughters. Some of the mothers that Brubaker (2007) described were unhappy about their daughter's pregnancies, as were some of these participant's mothers. It is also unclear how an initial experience of birth that is designed to be a deterrent affects later perceptions during pregnancy and a woman's own birth.

Despite these areas of conflict, Brubaker (2007) noted that among teens who did not realize that they were pregnant, the mother or a grandmother was the most likely person to initially identify the teen's pregnancy. Mothers of young pregnant women are clearly important during pregnancy, and just as the young women in this study adopted the view of birth that their mother expressed to them, Fouquier (2013) notes that African-American women model their personal behavior as mothers on the behavior of their own mother.

Three of the 11 young women who were interviewed were motherless, which was unexpected. Losing a mother is seen as a huge tragedy by many women, which impacts them for the rest of their lives (Tracey, 2011). It may deprive a young woman of support and information from someone she often feels she can truly trust. The loss means significant daily changes and less emotional caretaking. Bereaved women note that there are significant life transitions when a woman yearns for her mother- and birth is one of those events (Tracey, 2011). One of the two participants (063001) who thought she would not want her mother at the birth turned out to rely on her mother during her labor.

Women in Tracey's study (2011) also discussed the "silence" around the topic of their mother; in the women I studied, two of the three women whose mother had died or was otherwise absent had no idea how their mother's births went, or what they thought

about birth. It is unclear what effect, if any, this loss had on the formation of their constructs about birth. In contrast, women with mothers relied on their mothers and sometimes sisters for information and advice, with one young woman even offering the opinion that she did not think to ask the doctor many questions because “I felt like I knew, like, cause of my momma and what she seen (030801).

In completing the interviews, the researcher heard many women say that they just did not know what to think about birth, their providers or their medical care. Uncertainty in first time mothers is well described most recently by Dahlen et al., (2010a) but the bulk of the participants were White. Women in this study talked about pain, physical damage and life change. Women studied by Dahlen, et al., (2010b) expected pain, but in postpartum interviews many of them said that they found it to be worse during their labor than they expected. This report of actual labor pain being worse than what was expected contrasts with the four women whom the researcher was able to speak to after delivery. These women felt that birth itself did not hurt as much as they expected it to hurt; one woman felt that the needles and intravenous lines were more painful than labor. Another woman said, “I thought it was gonna hurt when it didn’t, like, I was surprised it didn’t hurt.” (062301)

Published studies of expectations in labor do not have as large of a focus on pain as what was found in this study. Possibly, the prevalence of epidural anesthesia/analgesia in the Western world, along with its perceived safety, explains why existing research does not talk as extensively about labor pain. It is also possible that this lack of focus on pain reflects the perspective of White women. White women who are educated and partnered constitute most of the participants of much of the published research regarding

expectations of labor and birth, and White women may feel sure that their pain will be managed. There continues to be differences between the pain relief offered to White and Black patients across the health care system (Mossey, 2011). There are indications that Black patients are more sensitive to painful stimuli, and find the feeling to be more unpleasant (Mossey, 2011). Black patients also are more likely to be concurrently depressed, and more often, their pain is under medicated (Shavers, Bakos & Sheppard, 2010). Shavers et al. (2010) described some of the factors which may influence pain management, including physician-patient interaction, physician practice styles, the prescribing behaviors of physicians, patient perceptions, prior experiences with pain, the attitudes, beliefs and behaviors of patients regarding pain, healthcare access and access to effective analgesics. Health care providers have been found to underestimate and undertreat the pain of Black patients (Shavers et al., 2010), which may lead to experiences within the community of severe pain associated with labor and birth, coupled with inadequate pain relief. It also is unclear how the fear of pain, coupled with trust issues, may affect the perception of pain.

A recent study done in the United Kingdom, comparing the worries of Black and minority women to White women found that twice as many Black and minority women worry the most about pain and the length of labor (Redshaw & Heikkilä, 2011); what is less clear is the cause of this worry. Brubaker (2007) and Raines and Morgan (2000) note that Black women prefer a relationship with care providers that they trust. Women interviewed by this researcher revealed concerns about getting pain relief when it was needed, and described one role of the family and friends in the delivery room as asking the nurses and doctors for pain medication on behalf of the patient. Another interesting

theme was the need to be “nice” to the providers so that “everything’ll go kinda quicker (042201)”. These comments suggest the possibility that there is an element of wanting witnesses in the event that care is substandard. This desire is not stated, but may be part of having many people in the room. Labor is generally painful and stressful; it is concerning that a laboring woman might feel a need to make an effort to be nice in order to improve care. Do these statements reflect, possibly, a mistrust of the healthcare system that is based on a long history of receiving a lesser standard of care than wealthier White patients? Stress, weathering (long-term effects of excessive vigilance and other effects of inequality) and health disparities affect African-American women, and are linked to mental health issues and substance abuse, cancer, stroke, high blood pressure and diabetes (Rosenthal & Lobel, 2011). It also is linked to poor perinatal outcomes, and African-American women are one group who do not find outcomes like low birth weight and preterm birth reduced by gaining an education or improving their socio-economic status. Rosenthal and Lobel (2011) speculate that weathering is due to the effects of constant vigilance for any signs of discrimination.

In discussing perineal damage from birth, one qualitative study notes that women move from preparing for the unknown, into dealing with the unexpected and eventually adjust to a new reality so that they can get back to normal (Way, 2012). One of the participants indicated in her postpartum interview (062301) that the baby “ripped me- ripped me real bad” but according to the record she had first-degree lacerations of the perineum and the periurethral area that were repaired. First degree lacerations are superficial and do not involve muscles of the perineum. Women may experience perineal pain that seems out of proportion to physical trauma, possibly related to stretching and

bruising of the perineal tissues (Way, 2012). However, some of the perceived trauma may be related to women not expecting to need a repair (Shub, Williamson, Saunders & McCarthy, 2012).

Dahlen et al., (2010a) noted that many women that were studied felt unprepared for the psychosocial changes brought by birth. Fouquier (2013) in looking at development of the maternal role in an African-American population notes that the process of becoming a mother involves expansion of the self as women acquire a maternal identity. Women engage in caring for their babies, and in the process begin to grow as persons and transform into mothers. Participants in this study who were interviewed postpartum found that becoming a mother was a maturing experience.

Only 6 (021601, 022301, 030801, 062301, 063001, 072101) of the 11 participants indicated concern for the baby when they discussed having a good birth. This lack of focus on the health of the baby is interesting, in light of the fact that Black babies suffer more perinatal and infant morbidity and mortality. A recent study (Oliva, Rienks & Smyly, 2010) completed in San Francisco noted that only 43% of African-American women surveyed were aware of disparities in infant mortality, the associated risks, and disparities in social capital. At that time in the area, infant mortality was 2.5 times higher for African-American women. There was no reported low birth weight in the infants in this study, but three were preterm, including one infant who died in utero and was delivered after an induction at 36 weeks, according to her mother. Interestingly enough, this mother reported dreaming that she had the baby, held it briefly and it was gone.

These women were not screened for depression or anxiety. Rates of depression in Black mothers are reported to range from 10-40% (Field et al, 2009) and in urban Black

women are reported to be as high as 56% in the first postpartum year (Chaudron et al., 2010). It is possible that women who presented with little verbal interaction and flat affect were actually depressed. Making and keeping appointments can seem overwhelming when depression is present and it is also possible that some of the women who could not keep appointments postpartum were simply overwhelmed with the cumulative effect of new motherhood and depression. The role of depression and anxiety in creating poor outcomes is a topic that is worthy of separate study and a larger sample than the one described herein.

Limitations

This is a small study, looking at nulliparous Black women in an urban area in the southwestern United States. This limits the ability to transfer the findings to women of different race, residence or parity. While women varied in regard to educational level and age, at the time of the interviews all were using public assistance, so themes may not apply to women with private insurance for birth. Initial interviews may have been shorter due to participant time constraints and lack of previous knowledge of or contact with the researcher. Only 4 of the 11 women initially interviewed were available for follow-up interviews after the birth, which limits the findings for Aim 2.

Implications

Outcomes for Black women and their babies continue to be worse, in almost any measurable category, than those for other racial groups or for the United States as a whole. These poor outcomes for Black women born in the United States (David & Collins, 1997; Eloy & Culhane, 2010) suggest that there are problems or deficiencies in the way that our health care system cares for these Black women. The current focus of

prenatal care in the United States is disease prevention and identification (Cunningham et al, 2010) yet the system seems to be failing young Black women in that respect. The results of this study suggest that more attention should be paid to discussion of the births of a woman's mother, beyond concerns about adequacy of the pelvis. The mother's births might be thought of as a rudder, which is invisible to the eye but which actually steers the boat of the pregnant woman's thoughts and feelings about her upcoming birth. Anxiety in African-American women was found to shorten pregnancy in one small study (Catov, Abatemarco, Markovic, Roberts, 2010) Stress and anxiety related to depression and the effects of racial discrimination, coupled with constructs about birth as painful or damaging, may have multiple effects on the woman and her fetus, including, but not limited to preterm birth.

Birth is a liminal time (Davis-Floyd, 2003) and women need to trust their caregivers. There are unspoken suggestions in these accounts that women do not trust the health care system and its providers, or that individual providers may be withholding timely treatment from women who are identified as uncooperative, or who do not communicate in expected ways. Some participants (042201, 072101) verbalized concerns that they or their friends might not be getting all the care that they needed. It is not clear if women in minority populations depend heavily on information from their mothers due to trust issues that they are not willing to discuss. Certainly, participants relied more heavily on their mothers; one young woman reported not asking the doctor much because she had her mother as a source of information. It is worth noting that when the researcher offered to answer questions for participants, scenarios that questioned the adequacy of the care which they or a friend had received were commonly proposed. During the interviews

these participants, who were already pregnant and receiving care struggled with language used by the healthcare system to describe pregnancy and birth; more than one participant did not understand terms like “vaginal” or “Cesarean”. Communication and trust are hampered when providers and patients are not speaking and understanding the same language.

This study suggests two groups need changes to their education. The first group is providers and nurses. Providers and nurses need to understand that different groups may have different perceptions of the healthcare system and have resultant different concerns. It is also true that these concerns may be very different than the ones the provider would have, so “putting yourself in their shoes”, so to speak, might not help. The second group needing better education is pregnant women. The prevailing construct in these accounts is one of “not knowing”. Models of prenatal care need to be developed which include basic anatomy, common discomforts and education for labor and birth, since making another trip during the week to the hospital or clinic for childbirth classes is difficult for many young women. Education needs to be a component of the routine visit. Care options exist for pain management, perineal management (to decrease the severity of damage) and assisting in the adjustment to new parenthood. Relevant discussion of options would empower women to make choices about their birth. These interviews suggest women are navigating birth with little assistance from the healthcare system.

Recommendations for practice

This study suggests that clinical practice could be improved if providers worked to find out more about patient concerns. Brubaker (2007) and Raines and Morgan (2000) note that Black women value personal, caring relationships with providers more than

simple task completion and education. Development of relationships with providers reduced anxiety during pregnancy, and women liked the fact that providers sat with them and spent time (Novick et al, 2011). Current practice models, which are typically large practices with many different providers, may be problematic in this population, since changing of visit providers or the appearance of an unknown provider at the birth does not allow for development of trust within a relationship.

An additional concern is the current emphasis on privacy for patients. In women's services, there is much concern about abusive relationships and the maintenance of privacy for the individual woman. This concern about abuse and privacy can lead providers to routinely separate the woman from partners or family members during prenatal visits or at admission to the labor and delivery area. Providers may refuse to have visits/conversations with other members present without obtaining the woman's consent. One participant (021601) was angered by what she perceived as the rudeness of her provider to her mother and her friend during a prenatal visit. Explanations may be rushed and in an atmosphere of historical mistrust, may not be adequate. During the course of these interviews, the researcher encountered varying amounts of understanding of basic terms related to birth, like "vaginal" vs. 'cesarean'. Patients may want their mother or other family members present to help them formulate questions and comprehend the provider's answers. Clarifying what patients mean, and developing clear and understandable responses, also takes time-but would promote an atmosphere of openness and clarity.

When caring for Black women, providers may want to begin the discussion of the woman's upcoming birth by referring to the woman's mother and her births. Some

conversation about what the woman is expecting, and what she thinks will be her sources of pain will give the provider some idea about her expectations of the birth. Provision of adequate pain relief, as evaluated by the woman, is paramount during birth. Care models that allow the woman to develop a relationship with one provider may improve outcomes by increasing trust and encouraging questions.

Future research

Future research could focus on the role of the woman's mother- the infant's maternal grandmother. Anecdotally, in clinical practice and in the fieldwork which was conducted for this study, it was apparent that mothers play an important role in their daughter's lives- and there is tremendous loss when a pregnant woman is motherless during a first pregnancy. The mother of the patient (the grandmother of the infant being born) is seen as an authoritative source of information for the patient. The researcher has observed in her clinical experience that during labor the mother of the patient is often very involved in decision making. It is possible that these older women within a family circle or community may be arranging some of the "birth attendance" that the researcher heard about in participant reports and has personally observed. Another area to research may be the effect of the presence or absence of family and friends at the bedside in labor, as well as during visits.

The phenomenon of "birth attendance" by young girls as a means of discouraging pregnancy is also worth investigation. How is this arranged? Does anyone talk to the young woman after she sees the birth? What are all of the goals of this attendance? If this experience is intended to be essentially negative or discouraging, what effect does it have on the woman's later labor and birth?

Religion often plays a large part in the African-American community. How would the community view contraceptive education? Would older women within the community be receptive to interventions aimed at increasing contraceptive use, or would the community prefer other approaches to family planning?

Future research could focus on further exploration of the role of mothers in the pregnancies of African-American women. How extensive is their role in their daughters' pregnancies? How do they see their role in maintaining or providing a safe passage to womanhood for their daughters? Another pertinent question concerns the life course of young women without a mother. Does the African-American community or the family of the young women fill the mothers' role, or are motherless young women left to find their own way? Finally, how do members of the African-American community feel about participating in research by White clinicians? Brubaker (2007), as an older female White researcher, discusses spending extensive time with the adolescent mothers that she studied, to gain their trust.

In conclusion, because of the limited amount of research in the African-American community, and long-standing issues with trust, as well as racial and gender discrimination, there are gaps in what we know about the constructions of the African-American community. This dissertation attempts to address one of those gaps, but much more work needs to be done.

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Appendix A

Interview Guide

Interview Guide

The interview focus at the initial interview will begin with a “grand tour” question. Probes that may be used are found beneath each “grand tour”.

- 1) Tell me what you think will happen during the birth of your child?
 - a) What have you heard from others about birth?
 - b) What have you heard about your mother’s birth(s)?
 - c) Where do you think you will give birth?
 - d) Who do you think will be there, and what will they be doing?
 - e) Tell me what your mother or other family will be doing during the birth.
 - f) Can you talk about labor pain and what you expect?
 - g) How are you planning to cope with labor pain?
 - h) Have you imagined or had dreams about your birth? Can you tell me more about that?
 - i) How would you explain to a friend or your sister what birth will be like?
- 2) Tell me what a good birth would look like to you.
- 3) What do you do when you want to find information about childbirth?
 - a) What do you read or look at?
 - b) Do you use the Internet? Tell me how you use it.
 - c) Who do you talk to?

If she doesn’t discuss the medical personnel, then I plan to probe:

- 4) Tell me what you have heard from friends and family about what the health care workers do during the labor and birth?
 - a) Tell me what you have heard that your provider will do during the labor and birth.
 - b) Can you tell me what you have heard that the nurses will do during the labor and birth?
 - c) Has anyone told you about any other health care workers that you expect to be present at your labor and birth?
 - d) What have you heard that they will do?
 - e) How do you know that a doctor, nurse, or other medical person is giving you good care?

The interview focus at the post-delivery interview will concern itself with the mother’s story of the actual birth.

- 1) Tell me about your labor and birth.
 - a) Tell me how you decided that you were in labor? When did you first realize that it was labor?
 - b) How did you get to the hospital?
 - c) Tell me what happened when you arrived at the hospital.

- d) Can you describe for me what happened once you were settled in your room?
 - e) Who was in the room during labor? What were they doing during this time?
 - f) When did you realize that your baby was coming soon?
 - g) Can you describe the birth? Tell me as much as you can remember.
 - h) How did the labor and birth compare with what you expected?
 - i) What was the hardest thing about labor? What was the easiest thing?
 - j) What has been the hardest thing about caring for your baby? What has been the easiest thing?
- 2) Tell me how the birth compared to what you thought would happen.
- a) What surprised you the most about labor and birth?
 - b) What seemed to be the way you thought it would be?
 - c) What would you tell a friend who is about to have her first baby?

Appendix B

Recruitment Flyer

Recruitment Flyer

Do you want to help with a research study?

Are you having your first baby? Are you 16 years old or older?

A researcher from the University of Texas School of Nursing is interested in talking to Black women who are pregnant with their first baby.

The researcher is asking about the way Black women think about pregnancy and birth, before and after the baby comes.

Women who are between 17 to 33 weeks pregnant today would be able to participate.

You would be interviewed by the researcher today, and be interviewed by the researcher again after the baby is born.

Talking to the researcher will not change the care you receive today in the clinic

If you are interested, the researcher, Marianne Moore is available in the clinic area. Clinic staff can direct you to the researcher for more information.



Marianne Moore PhD(c), CNM, RN



Appendix C

Consent Form

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER - HOUSTON
HOW DO BLACK NULLIPAROUS WOMEN COGNITIVELY CONSTRUCT
BIRTH?
HSC-SN-10-0545

INFORMED CONSENT TO JOIN A RESEARCH STUDY

INVITATION TO TAKE PART

You are invited to take part in a research project called, “How Do Black Nulliparous Women (Women Delivering their First Baby) Cognitively Construct Birth?” conducted by Marianne Moore, of the University of Texas Health Science Center. For this research project, he/she will be called the Principal Investigator or PI.

You have been invited to join this research study because you are delivering your first baby, are between 17 and 34 weeks pregnant, are over 16 years of age, are Black, and can speak, read and write English. Your decision to take part is voluntary and you may refuse to take part, or choose to stop from taking part, at any time. A decision not to take part or to stop being a part of the research project will not change the services available to you from your physician, hospital, other service agencies, etc.

You may refuse to answer any questions asked or written on any forms.

This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston as HSC- (fill in with assigned CPHS HSC#).

DESCRIPTION OF RESEARCH:

PURPOSE:

Many women have ideas and beliefs about birth. These ideas affect how women feel about labor, birth and their babies. Most studies about these ideas are done with the help of White women, so we do not know much about how Black women create these ideas, or about what Black women expect to happen in birth.

This is a local study. The study will enroll a total of approximately 20 people.

PROCEDURE:

If you choose to take part in this study, we will ask you to do the following things:

- Meet with the researcher today for an initial interview that may take up to 60-90 minutes. This interview will be recorded and converted to a written interview by the researcher for analysis.

- The researcher will call you on the phone, to be sure that we can still reach you, between 35 and 36 weeks of pregnancy.
- The researcher will check the hospital records to see if you have delivered, and will collect your delivery date, delivery method, baby's gender, baby's weight, and the gestational age of the baby.
- The researcher will arrange another interview with you two to three weeks after your baby is born. This interview may be done at your home, at the home of another friend or family member, or in a private space at the School of Nursing, depending on what works best for you. This interview may also be 60-90 minutes long. We will provide a ticket to pay for up to three hours of parking for interviews at the School of Nursing, if you drive to the interview. This interview will be recorded and converted to a written interview by the researcher for analysis.
- The researcher may contact you by telephone after the interviews if there is a need to ask you more questions, and, if you agree, you could meet with the researcher for one additional meeting.

TIME COMMITMENT:

- Total time should not be more than 5 hours, for interviews and phone calls.

BENEFITS:

Many women find it helpful to talk about their births. Talking to the researcher about birth expectations may prompt you to bring questions to your providers, if you realize that there are gaps in your knowledge. You may not receive any direct benefit from this study. However, the information we get from this study may help others in the future

RISKS AND/OR DISCOMFORTS:

No risks are anticipated, however, it is possible that talking about your experiences may upset you. The names of at least two counselors who accept Medicaid and/or provide care on a sliding-fee scale basis, with contact information will be printed on business cards and provided to all clients, in case you find that the process is upsetting in any way. If you become very upset during the interview, the principal researcher will remain with you until you feel calm enough to return home, or until a friend or family member arrives.

ALTERNATIVES:

You may select other options than being in this research study. The only alternative is not to take part in this study.

STUDY WITHDRAWAL:

If you choose not to stay in the study, you will not lose any medical benefits to which you would normally be entitled. Payment will only be made to those who complete the interviews. We will keep all information we collected from you while you were in the study.

IN CASE OF INJURY:

If you suffer any injury as a result of taking part in this research study, please understand that nothing has been arranged to provide free treatment of the injury or any other type of payment. However, all needed facilities, emergency treatment and professional services will be available to you, just as they are to the community in general. You should report any injury to Marianne Moore at (713) 500-2067 and to the Committee for the Protection of Human Subjects at (713) 500-7943. You will not give up any of your legal rights by signing this consent form.

COSTS, REIMBURSEMENT, AND COMPENSATION:

If you complete the first interview you will be paid \$10.00 in the form of a VISA gift card that will be given to you after you finish the interview. If you complete the second interview you will receive a \$25.00 VISA gift card, for a total payment of \$35.00. These VISA gift cards can be used anywhere that a VISA card is accepted.

You will be reimbursed for 3 hours of parking if you are interviewed at the School of Nursing, or if you parked your car at the clinic garage.

CONFIDENTIALITY:

You will not be personally identified in any reports or publications that may result from this study. Any personal information about you that is gathered during this study will remain confidential to every extent of the law. A special number will be used to identify you in the study and only the investigator will know your name. There is either a separate section in this consent form or a separate authorization form that you will be asked to sign which details the use and disclosure of your protected health information.

NEW INFORMATION:

While you are in the study, you will be told about any new findings (either good or bad) that might cause you to change your mind about staying in the study. If new information

is given to you, you will have to sign another consent form in order to continue to take part in the study.

QUESTIONS:

Marianne Moore, the principal investigator will be glad to answer any further questions at any time. You can contact the investigator to discuss problems, voice concerns, obtain information, and offer input in addition to asking questions about the research. Contact Ms. Moore at (713) 500-2067.

SIGNATURES:

Sign below only if you understand the information given to you about the research and choose to take part. Make sure that any questions have been answered and that you understand the study. If you have any questions or concerns about your rights as a research subject, call the Committee for the Protection of Human Subjects at (713) 500-7943. You may also call the Committee if you wish to discuss problems, concerns, and questions; obtain information about the research; and offer input about current or past participation in a research study. If you decide to take part in this research study, a copy of this signed consent form will be given to you.

Printed Name of Subject _____

Signature of Subject _____

Date of Signature _____ Time of Signature _____

Signature of Parent/Next of Kin _____

Date of Signature _____ Time of Signature _____

Printed Name of Person Obtaining Consent _____

Signature of Person Obtaining Consent _____

Date of Signature _____ Time of Signature _____

CPHS STATEMENT:

This study (HSC-SN-10-0545) has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston. For any questions about research subject's rights, or to report a research-related injury, call the CPHS at (713) 500-7943.

Appendix D

Demographic Data Form

Demographic Data
First Interview

Today's date _____

What is your age? _____

How many years of school have you attended? _____

Are you working right now? Yes No

Are you a student? Full time Part time

What is your marital status? Married Partnered Single Divorced Widowed

How tall are you? _____

How much did you weigh before you got pregnant? _____

How much did you weigh at your last prenatal appointment? _____

What is the due date for your baby? _____

Please circle any assistance that you are currently receiving?

WIC TANF Medicaid CHIPs Perinatal SNAP/Food Stamps

Record Review

Maternal weight at the last appointment before delivery? _____

Gestation at delivery by EDC (weeks and days)? _____

Gestational age of infant by new Ballard exam _____

Weight of baby? _____ Gender of baby _____

Delivery method (circle): NSVD FAVD VAVD Cesarean

Appendix E

Demographics & Findings Sheet

Category											
Age	30	19	18	25	26	25	21	22	18	17	24
Years of school	18	13	12	11	22	14.5	12		12	11	13.5
Working now	Yes	No	No	Yes	No	Yes-FT	No	No	No	No	Yes-FT
Student status	FT	No	No	PT	No	No	NA	No	No	FT	No
Height	66"	61"	68"	62"	66"	69.5"	64"	62"	64"	66"	64"
Pre-pregnant weight	150	UNK	130	146	150	160	190	213	160	130	165
BMI/ Rec wt. gain	24.3/ 25-35		19.8/ 25-35	27.1/ 15-25	24.3/ 15-25	23.1/ 25-35	32.7/ <15	39.5/ <15	27.5/ 15-25	21.1/ 25-35	28/ 15-25
Gest age at Interview	24	19+2	25+6	31+5	20	31+4	20	17+5	21	20+1	23+4
Assistance WIC-W Medicaid-M SNAP-S	M	M	W,M,S	W,M,S	M	W, M	M, S	M	M, S	W,M,S	W, M
Wt Gained?	13		20	40	31	20	36+	11+	58	56	30
Gestational age-dates	38+2	36+5	41+6	37+2	39+2	39	40+5	36	39+2	36	39+5
Gestational age- exam	40			38+		40			39	35	40
Weight of baby	6# 1 2755		7# 3181	6#12 3050	6# 11 3039	7#4 3290		fetal demise	6#14 3132	5# 12 2630	8# 12oz 3963
Gender M/F	F	M	M	F	F	F		F	M	F	F
Del. method	SVD	SVD	SVD	SVD	CS	SVD		SVD	CS	SVD	SVD
Mother available	Yes	No- deceased	No-deceased	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Mother's view of birth	Painful- get an epidural- Pain makes you a woman	UNK	Painful- twins worse-had CS & vaginal deliveries	not discussed- 7 babies, delivery method not known	Painful- really hard	Painful but you don't need medication	UNK	Had an unwanted CS- only one birth	Can be hard but offers positive ways to cope	Painful- get an epidural	Hard- lots of work and life changes

Category											
Primary expectation	Pain- wants epidural	Pain- wants epidural- doesn't discuss with anyone at all	Pain- wants IV meds & epidural	Pain & perineal damage- wants epidural	Excruciating pain-wants epidural	Pain-wants vaginal birth & epidural/ pain meds/ life changes	Painful	Pain- meds- epidural available but doesn't want one	Life changes. Pain-doesn't want CS. Mentions non-pharmacologic	a lotta pain- wants an epidural	Fear of pain & CS - life changes/ echoes mother's view
Baby's health?	Not a focus	Not a focus	Not a focus	Yes	Yes	Yes	Not mentioned	Yes	Yes	Yes	Not a focus
Has seen prior deliveries?	No	No	No	saw older sister deliver when she was 17	saw her sister deliver when she was 21	saw a friend deliver when she was 21	No	No	saw sister deliver last year-lots of people in room- she was 17	No	Yes- her own mother at age 15
Age of first story about having a baby and content	first interview- didn't ask	didn't remember and doesn't talk about it	didn't ask	17- her sister told her that birth hurt	8 or 9- her mother discussed her own births	21- the friend whose delivery she attended.	8 or 9- where babies come from	8, aunt pregnant & mother filled in details after.	8-9, cousin was having a baby- no details	12- talking about having babies among women in family	10-12, talk about having sex and "getting stuck
Final conclusion after birth			pain w/ needles > labor but ctx painful- having a baby teaches you to be mature	"all ripped up" no more babies	painful- screaming with ctx at home-C/S not as bad as she thought it would be	not as bad as she thought it would be- breastfeeding					
Dreams	#1 labor in public- doesn't see baby; #2 delivers by CS-baby doesn't look like her.	dreams of holding the baby- no labor	baby comes early, easy birth and easy baby-not grumpy	dreams of having baby RT back pain ending- doesn't describe	no dreams- knows she should have them but none	dreams she is having twins	when asked, she replied about pain	she had the baby, held it briefly & it was gone (reported demise)	dreams "one push" and has a baby boy	no dreams	dreams of delivering in ambulance- no history and delivery goes well

CURRICULUM VITAE

Marianne Frances Moore PhD, RN, CNM

EDUCATION:

University of Texas HSC School of Nursing Houston, TX	2014	PhD	Nursing
State University of New York-Stony Brook Stony Brook, NY	2004	Certificate	Nurse-Midwifery
University of San Diego Hahn School of Nursing San Diego, CA	1993	MSN	Family Nursing
Rutgers University College of Nursing Newark, New Jersey	1981	BSN	Nursing

PROFESSIONAL POSITIONS:

Sam Houston State University School of Nursing Huntsville, TX Assistant Professor	2014-present
University of Texas-School of Nursing at Houston Houston, TX 77030 Clinical Instructor	2013
Bay Area Birth Center Pasadena, TX Staff Midwife	2012-2013
Houston Baptist University Houston, TX Visiting Assistant Professor	2011-2012
University of Texas-School of Nursing at Houston Houston, TX Assistant Professor/Teaching Associate	2007-2011
University of Nebraska College of Nursing Omaha, NE Clinical Instructor	2005-2007
UNMC Community Health Center Omaha, NE Certified Nurse Midwife, faculty practice position.	2007

Pine Ridge Service Unit-Indian Health Service Pine Ridge, SD Certified Nurse Midwife	2004-2005
Clarkson Hospital/The Birthplace Omaha NE Staff Nurse, Childbirth Educator	1998-2004
Clarkson College Omaha, NE 68131 Clinical instructor	1994-1998
Mercy Hospital & Medical Center San Diego, CA 92130 Staff Nurse I, II	1989-1994
Visiting Nurse Association of Omaha Omaha, NE Public Health Nurse I & II, Optimum Care Team Member.	1983-1986

PROFESSIONAL MEMBERSHIPS:

American College of Nurse-Midwives	2002-present
American Nurses Association	1995-present
Sigma Theta Tau International	1993-present
Zeta Pi Chapter, Member	2007-present
President, Zeta Pi Chapter	2012-2014

PUBLICATIONS:

Bergstrom, L & Moore, M. (2015). Female genitalia. In Mansen, T.J. & Gabiola, J. (Eds.), *Patient-focused assessment: the art and science of clinical data gathering* (pp.964-1003). Boston: Pearson.

Littleton, L. Y & Engebretson, J. C. (2013). *Maternity Nursing Care*. Revisions of Chapter 15- Nursing Care of the Intrapartal Family and Chapter 17, Pain Management during Labor and Delivery.

Altman, G. B., Kerestzes, P., & Wcisel, M.A. (2010). *Fundamental and advanced nursing skills* (3rd Ed). Irrigating a Urinary Catheter; Irrigating the Bladder Using a Closed-System Catheter. Clifton Park: Delmar Cengage.

AWARDS AND RECOGNITIONS

2010	Zeta Pi Outstanding Doctoral Student 2010
2011	Recipient of Zeta Pi Chapter Research Funding
1992-present	Advanced Cardiac Life Support Certification
1994-present	Neonatal Resuscitation Program Provider
2004-present	Certified Nurse Midwife ACC Certificate # 11609
2007-present	Certified Nurse Midwife, Advanced Practice Nurse State of Texas Board of Nursing

PRESENTATIONS:

Moore, Marianne PhD(c), CNM. (10-28-2011). Prolonged Pregnancy & PROM: Latest Guidelines. Presented at The Gathering, an annual meeting of Texas CNMs and licensed midwives

Moore, Marianne PhD(c), CNM (5-28-13). Primary Care for Graduate Midwives in ACNM Exam Prep Workshop, held at ACNM Annual Meeting, Nashville, TN

Poster session

Moore, Marianne MSN, RN, CNM and Meyers, Stephanie MSN, MEd, RN. (June, 2008) Depression and Antepartum Bed Rest. Poster presented at the Postpartum Support International Conference in Houston, TX.