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THIRD TRIMESTER CHILDBIRTH LEARNING NEEDS OF LOW SOCIOECONOMIC PRIMIGRAVIDAS

THE UNIVERSITY OF ARIZONA  

M.S. 1984
THIRD TRIMESTER CHILDBIRTH LEARNING NEEDS
OF LOW SOCIOECONOMIC PRIMIGRAVIDAS

by
Ellen Hintz Kinnard

A Thesis Submitted to the Faculty of the
COLLEGE OF NURSING
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF SCIENCE
In the Graduate College
THE UNIVERSITY OF ARIZONA

1984

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DYANNE AFFONSO
Associate Professor of Nursing

April 27, 1984
This thesis is dedicated to my husband and two sons—without their support and encouragement, I would never have undertaken or finished this study.
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Dr. Dyanne Affonso, Thesis Chairperson
Dr. Margarita Kay, Committee Member
Ms. Alice Noyes, Committee Member
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ABSTRACT

An exploratory study was conducted to determine perceived learning needs of third trimester low socioeconomic primigravidas as these needs relate to pregnancy and childbirth. Open-ended interviews were conducted with eight informants over a period of three weeks.

All informants felt they knew what was best for them. Informants also felt their mothers and/or friends were the most reliable and readily accessible sources of information. Women were concerned about health of their infants, pain associated with childbirth, mates' acceptance of their figures, and providing for their infants. They did not feel that they had received adequate information to meet their learning needs from the prenatal clinic even though they had received pamphlets covering important concepts.
CHAPTER I

INTRODUCTION

Nurses have been intervening in the childbirth process for the last thirty years without adequate assessment of women's educational needs for childbirth, or whether the education offered actually addresses the concerns of the pregnant woman. Following the lead of Grantly Dick-Read and Frederick Lamaze (two pioneers in childbirth education), numerous methodologies were developed to teach what professionals considered important for the pregnant woman to know. In response to the growing demand for educational childbirth material, pharmaceutical companies produced volumes of childbirth education material which met the requirements of the medical profession. The pregnant woman's concerns, however, have not been fully investigated. This is especially true in regards to low socio-economic primigravidas.

Modern technology and sophisticated methods of antepartal and intrapartal care have served to decrease the maternal and infant mortality rates. Women need to understand the technology which affects them during antenatal clinic visits and hospitalization. Thus, the modern childbearing woman needs to know beyond the basic concepts
of pregnancy and childbirth; knowledge is also necessary concerning the sophisticated approaches toward prenatal care. Modern technology has thus served to compound the amount of information a woman should learn to effectively cope with the childbearing experience.

There has been a vast amount of research which focused on selected childbirth ideologies; however, there is only a limited amount of literature available which focused on the learning needs of the pregnant woman. Surveys have shown that the population largely being served by the present childbirth education system is the well-educated, middle-class population (Watson, 1977). The entire lower-middle and lower socioeconomic population of pregnant women is not adequately served by any type of childbirth educational system at this time. As the learning needs of any of the pregnant women have not been delineated, it is difficult to determine whether learning needs for pregnancy differ among socioeconomic classes, or whether the concerns of any pregnant woman are actually being met by any current childbirth educational system.

In addition to being able to choose among the different types of childbirth education available to the public, each childbirth educator is free to establish her own class content (Sasmor and Grossman, 1981). Childbirth educators do not have to be medically trained, nor are they
under any obligation to teach a specified childbirth content. Thus, there is great variability within each childbirth educational system as well as among individual instructors. Fogel and Woods (1981) state that "it is difficult for women to make informed decisions about which approach is best for them because comparable information on each method is difficult to obtain" (p. 541). The pregnant woman's learning needs for her pregnancy may still not be addressed even if she chooses to attend childbirth education classes.

For the woman who does not to attend a childbirth education class, the clinic nurse or physician is potentially a primary source from which she can receive totally accurate information concerning pregnancy. If the woman does not feel that her learning needs are worthy of discussion, if she is not outspoken, or if it is culturally unacceptable to talk about these topics with men, it is conceivable that a major learning need may be totally overlooked.

Due to the limited literature focusing on the learning needs of the pregnant woman, obstetrical health care professionals do not have information on which to structure childbirth education material efficiently. It is possible that the pregnant woman will either receive information regarding her learning needs from
non-professional sources (i.e. mother, aunt, neighbor, etc.), or she may never actually resolve these learning needs.

Due to the limited information on the learning needs of the pregnant woman during the third trimester, nurses are unable to assess the reasons for non-attendance of childbirth education classes and cannot structure information-giving to insure that the most basic pregnancy concerns are being met. Without information concerning the pregnant woman's knowledge base, the actual learning needs of the pregnant woman are difficult to identify. The basic learning needs of the woman concerning her pregnancy must be met before the woman can move on to higher level learning needs.

Many studies have been directed at justifying a certain childbirth educational system. The studies have purported numerous benefits for each system; however, most of these studies were inadequate from a scientific research perspective. The only benefit to any type of childbirth education that has been repeatedly supported by research is the psychological benefit to the mother. Since the studies have focused on the system and not on actual or perceived learning needs during the third trimester of pregnancy, there is no way of developing a childbirth education structure to efficiently meet these learning needs.
Even though women have become more vocal in expressing their concerns and desires, it is conceivable that some pregnant women may not always know what is in their best interest due to their inadequate knowledge base. A considerable knowledge base of pregnancy must be present on which to pose questions concerning all aspects of pregnancy. Many nurses feel that most women do not have an adequate pregnancy knowledge base (especially primigravidas) to enable them to determine their own learning needs during pregnancy. Regardless of the individual's knowledge base, the women are still capable of identifying their basic learning needs concerning pregnancy. Without addressing these basic issues, women may not be able to focus their attention on the higher level of learning on which childbirth education is based. Obstetrical care-givers cannot establish programs which will effectively meet the specific educational needs (with regards to pregnancy and childbirth) of women in low socioeconomic groups during the third trimester of pregnancy without first identifying their perceived learning needs.

All women have the right to childbirth education. Any information which can be given to insure a good outcome to the pregnancy should be freely given because pregnant women have the welfare of themselves and their infants at stake. In an attempt to meet the pregnancy and childbirth
education needs of pregnant women, busy prenatal clinics distribute or have readily available pertinent printed material. Merely distributing printed material to women in the lower socioeconomic groups, however, may not meet their learning needs because: 1) these learning needs have not been adequately identified; 2) the women may not be able to read, comprehend, and/or retain what they read; 3) the information given in printed form may be interpreted differently (informational meaning may have different cultural interpretations). The specific educational learning needs of women in lower socioeconomic groups must be clearly identified before they can be met.

Significance of the Problem

By the third trimester of pregnancy, a woman realizes that birth is imminent and inescapable (Colman and Colman, 1971). With this thought in mind, the woman must prepare herself for "labor and delivery and for the care of the infant itself" (Colman and Colman, 1971, p. 53). The physiologic changes which accompany the third trimester (i.e. increased discomfort from the position of the fetus, increasingly frequent but irregular contractions, etc.) contribute to the pregnant woman's anxiety and fearfulness of the unknown which she is about to face. An effective way to deal with this anxiety and fear is through effective childbirth education. Doering and Entwisle (1975) state
that "preparation of even a minimal sort appears to enable women to cope more successfully with the childbirth experience and to be more aware at the actual birth" (p. 835). Rubin (1976) states that the concern during the third trimester is for self and baby. The pregnant woman is no longer capable of separating one from the other. This contributes to her increasing receptiveness at this particular stage in pregnancy to information concerning childbirth and child care.

Although each pregnancy is considered to be a unique experience, the primigravid woman lacks experience in pregnancy and childbirth. Without the benefit of prior experience, a new knowledge base must be developed. Events in the pregnancy may be experienced as something new and different, and may have a tremendous impact on the primigravid woman.

Obstetrical care givers currently have only minimal information concerning pregnancy learning needs of primigravidas in the lower socioeconomic groups. Childbirth education classes have been structured to meet the needs of the middle-class and better educated primigravida. It is largely this middle-class population that is currently benefiting from the present childbirth education systems. Meanwhile, a major segment of the childbearing population, the lower socioeconomic group, does not receive adequate
childbirth preparation. The middle socioeconomic primigravidas have been the major focus of evaluations to identify whether the childbirth classes were helpful in meeting their learning needs for pregnancy. The lower socioeconomic primigravidas, however, have been largely ignored by childbirth educators and researchers. Researchers have not determined whether learning needs for pregnancy are specific to each socioeconomic level, or if they are common to multiple socioeconomic levels. In order to establish means for meeting the childbirth education needs of all women, all socioeconomic groups must be studied.

Lacking adequate information on the lower socioeconomic primigravidas' learning needs for pregnancy has hindered development of childbirth education which can best meet the needs of these women. These learning needs must be clearly identified so that effective means of meeting these needs may then be developed. It is the responsibility of obstetrical care-givers to be advocates for improving childbirth education and insuring that it reaches all socioeconomic groups of pregnant women.

Statement of Purpose

This study explores the learning needs of the third trimester lower socioeconomic primigravida as these needs relate to pregnancy and the impending childbirth
experience. Content areas that women request to meet their learning needs will be identified.

**Conceptual Orientation**

The conceptual orientation for this study will focus on discussion of two areas: the third trimester of pregnancy as a unique time for the primigravida, and the uniqueness of the lower socioeconomic primigravida in terms of childbirth education needs.

According to Colman and Colman (1971), the third trimester is a period of "anxious anticipation of the imminent unknown and physically uncomfortable" (p. 50). The reality of pregnancy is no longer escapable. The woman's anxiety focuses around the well-being of the child, the added responsibilities that it will bring, and the possibility that she may lose control during labor and delivery (Colman and Colman, 1971). In addition to the increasing anxiety, the woman's sense of body image is extremely poor due to her seemingly ungainly figure (Moore, 1978). This places the third trimester woman in an extremely vulnerable position.

Light and Fenster (1974) define anxiety as an "uneasiness of mind resulting from an emotionally stressful situation" (p. 46). In a study of 202 randomly selected maternity patients, Light and Fenster (1974) attempted to identify specific concerns of pregnancy. Primiparas had
more concerns than multiparas, and women with education beyond the high school level had fewer concerns than women with less education (Light and Fenster, 1974). The nine major areas of concerns for primiparas were:

1) caring for your baby's physical needs; 2) the responsibility you must accept; 3) the pain in childbirth; 4) your baby being overdue; 5) birth defects due to smoking and/or drinking; 6) birth defects your baby might inherit; 7) managing the added expenses of having a child; 8) being able to follow the diet prescribed; 9) any medication you took and its effect on your baby (Light and Fenster, 1974, p. 48).

It must be noted, however, that it was the authors who choose the areas of concerns to investigate, and not the women they were questioning. In choosing the areas of concern to investigate, the authors may have inadvertently missed some concerns.

Glazer (1980) attempted to identify anxiety levels and concerns among pregnant women. One hundred pregnant women were included in the study. Glazer found that concerns differ between trimesters, and the greatest number of concerns are expressed in the third trimester. Glazer also found that the level of anxiety was higher in women with less education.

In previous generations, women were guided through their pregnancy and delivery by family members and/or midwives. This closeness and readily accessible source of information helped to decrease anxiety in primigravidas.
This is no longer the case in the United States. With the increasing popularity of hospital deliveries, women became more dependent on medical technology. The current generation of grandmothers relied heavily on anesthetics for delivery; thus, they were passive participants in the birth of their children. These women are now unable to share birthing knowledge with their offspring, so women must rely on other sources to receive this information (Colman and Colman, 1971). The need to obtain childbirth information has been established; however, the informational needs of primigravidas (especially low-income primigravidas) have not been clearly identified.

All of the cited literature states that lower socioeconomic primigravidas experience a higher level of anxiety. Women in lower socioeconomic groups, however, seem to resist or lack interest in structured prenatal classes. Bonovich (1981) states research has repeatedly shown that "many mothers from lower socioeconomic groups do not attend formal classes for expectant mothers even when they are offered" (p. 75). Research by Sasmor and Grossman (1980) concluded that present childbirth education systems "tend to reach well-educated, middle-class consumers and, in general, do not provide for special interest groups or lower socioeconomic consumers" (p. 160). It appears that lower socioeconomic consumers, then, are a separate and
distinct group from well-educated and middle-class consumers. It is upon this premise that this study is based.

Kitzinger (1977) stated that before the lower socioeconomic and lower-educated groups can change, their "attitude towards themselves, and themselves in relation to others,"...their "ability to foresee, comprehend, plan, and prepare" must be developed (p. 16). Kitzinger (1977) also states that it is difficult for a woman who is struggling for survival to be concerned with the concepts of childbirth education. Although she may not be concerned with the concepts of childbirth education, her anxieties and concerns about pregnancy are not negated--they simply exist on a different plane than those of middle-class women. Thus, it is essential to identify the nature of these anxieties and concerns.

Women of lower socioeconomic status and education are less likely to seek out the services of health professionals (Bauwens & Anderson, 1978). Even though these women may not seek out health services, they should not be abandoned or ignored. Their learning needs concerning pregnancy and childbirth are just as real as those of the more vocal and educated woman. Someone must take the responsibility to identify these needs and help these women.
Operational Definitions

Primigravida

For the purposes of this study, primigravida is defined as any woman who is carrying her pregnancy to the third trimester (gravida one) for the first time, and is not considered to be at risk.

Third Trimester

The twenty-eighth through the fortieth gestational week of pregnancy.

Learning Needs

A learning need is whatever a woman desires to know about pregnancy and the impending childbirth experience during her third trimester of pregnancy.

Childbirth Education

Childbirth education is defined as any type of information concerning pregnancy and childbirth that the pregnant woman initiates and seeks.

Low Socioeconomic Group

Women were considered low socioeconomic group members if their gross family income is less than $15,000 per year, and they have completed no more than a high school level of education.
Summary

The purpose of this study is to identify the learning needs of the third trimester primigravidas in the low socioeconomic groups. Although a great deal of research has focused on childbirth education and the anxiety and concerns present during the third trimester of pregnancy, primigravid learning needs of women in low socioeconomic groups have not been clearly identified. Women in low socioeconomic groups represent a separate and distinct group. Research has shown that this group of women have more anxieties and concerns than women in middle socioeconomic classes. Thus, the conceptual orientation of this study focuses on the uniqueness of learning needs for third trimester primigravidas and the uniqueness of lower-socioeconomic primigravidas. The operational definitions on which this study operates are primigrava, third trimester, learning needs, childbirth education, and low socioeconomic group. The study utilized the exploratory method of interviewing informants to identify the learning needs concerning pregnancy of this unique group. The process of childbirth education was explored in terms of the content areas identified as important by the third trimester primigravid informants from low socioeconomic groups.
CHAPTER II

REVIEW OF LITERATURE

The review of the literature will give a brief history of the development of childbirth education, an overview of several childbirth education systems, a review of the evidence for efficacy of several of the systems, and a brief statement about third trimester and low-socioeconomic learning needs.

Historical Perspective

The use of relief for labor pains generated a tremendous amount of controversy in the 1800's. According to Beck and Hall (1978), "On January 19, 1847, J. Y. Simpson of Edinburgh created a furor among the Anglican clergy by utilizing chloroform as a means of ameliorating pain in labor" (p. 371). This technique was condemned by the clergy until 1853 when Queen Victoria delivered her eighth child using chloroform. Basing their protest on the scriptures, Christian clericals remained adamantly opposed to analgesia (Beck and Hall, 1978). Beck and Hall (1978) state that there have been few other obstetrical issues which have remained so controversial for such a long period of time. On one hand, control of pain during childbirth
has been proclaimed an extremely significant advancement of modern science; on the other hand, it has been seen as a primitive and unacceptable practice.

The classic ideas of psychological relief of pain during childbirth began in the 1940's when Grantly Dick-Read coined the term "natural childbirth" and published the first book on the subject in 1944. In his book, Dick-Read purported that childbirth pains were a socially induced phenomenon; childbirth was not really a painful process. Dick-Read proposed two alternative hypotheses for his "fear-tension-pain" cycle. In the first hypothesis, socially-induced fears regarding labor "caused sympathetic arousal which produced muscular tension in the circular muscle fibers of the lower part of the uterus, which in turn produced increased uterine pressure, resulting in the perception of pain" (Beck and Hall, 1978, p. 371). In the second or alternative hypothesis, uterine ischemia produced by sustained muscle tension caused pain. In an attempt to counteract the "fear-tension-pain" cycle, Dick-Read proposed that mothers be provided information that labor was not, or did not have to be, painful (Beck and Hall, 1978). In support of Dick-Read's "fear-tension-pain" cycle, Genest (1981) said, "There is little argument that fear is deleterious to the patient and does produce generalized increased skeletal muscle tension" (p. 82).
To eliminate labor pains, Dick-Read proposed that mothers be provided with correct information and be taught muscle relaxation techniques as outlined by Jacobson. Instruction was to be provided by the obstetrician as part of the routine antenatal care. The obstetrician was to be cheerful and supportive, personally direct the patient's care, and stress the positive. Contractions were not to be described as "painful," nor were poor maternal or fetal outcomes to be stressed (Beck, Geden, and Erouder, 1979). Due to the controversial nature of his ideas, Dick-Read was subsequently barred from practice in South Africa.

A second major movement concerning prophylaxis was developed in the Soviet Union by A. Nikolayev. Applying the term psychoprophylaxis to the Soviet technique, Nikolayev's ideas were presented to Western scientists by Velvovsky, Platonov, Ploticher, and Shugom (Beck et al, 1979).

The Soviets hypothesized that pain was not a consequence of labor, but rather an unusual circumstance. Special circumstances would include pain from pathological conditions, "conditional reflex labor pain," multiparae, and "cortical pain" (Beck et al, 1979, p. 247). Velvovsky et al developed a training procedure based on Pavlovian theory to inhibit pain perception at the cortical level (Beck and Hall, 1978). The Soviet theory employed three
techniques to decrease cortical sensitivity to incoming stimuli: 1) deep breathing during each contraction; 2) stroking of the abdomen or small of the back combined with deep breathing; 3) applying pressure to certain "pain prevention points located along the small of the back and the medial surface of the anterior superior ilia" (Beck et al, 1979, p. 248).

The original Soviet program has been modified in recent years to include three more regimens: 1) gymnastic training to promote health and perineal elasticity; 2) hydrotherapy; 3) ultraviolet light treatment. The benefits provided by the last two treatments are unclear. The claim that the treatments may be beneficial in the treatment or prevention of toxemia are unsupported in the literature (Beck et al, 1979).

Fernard Lamaze, a French obstetrician, became acquainted with the technique of psychoprophylaxis during a tour of Russia in 1951 (Beck et al, 1979). According to Genest (1981), Lamaze and Vellay, a Swiss practitioner, "became enthusiastic proponents of the psychoprophylactic method in France" (p. 82). Lamaze and Vellay modified the Soviet techniques to include rapid, shallow breathing during the second stage and crowning; deletions from the technique included stroking, timing contraction, and "pain prevention points" (Beck et al, 1979, p. 250). Lamaze also
"advocated the use of 'controlled neuromuscular relaxation' during labor," but failed to specify the means to achieve this relaxation (Beck et al, 1979, p. 250).

Marjorie Karmel, a patient of Dr. Lamaze, brought the method to the United States in 1959 (Huprich, 1977). Karmel wrote a tremendously popular book describing the psychoprophylactic method used by Lamaze. Joining forces with Elizabeth Bing, the two women founded the American Society for Psychoprophylaxis in Obstetrics (ASPO). The books that these two women have written and the work of the ASPO have been largely responsible for the widespread popularity of Lamaze in the United States since the 1960's (Beck et al, 1979).

**Childbirth Education Systems**

There is a wide variance in the material presented by the various preparatory techniques. According to Beck et al (1979), three components are present in most of the methods: 1) accurate information regarding pregnancy, labor, and delivery; 2) relaxation training; 3) breathing patterns. Husband participation is also frequently recommended.

According to Croft (1982), the primary purpose of childbirth education classes is to "teach methods which reduce the fear-tension-pain cycle and help to make the childbirth experience a more positive one, seemingly
facilitating maternal-infant attachment" (p. 333). All of the childbirth education classes function to dispel myths and teach the birthing process (Croft, 1982).

The American Red Cross offers a prenatal education course with heavy emphasis on infant care. According to Whitley (1979), content for the series of classes is: "personal care during pregnancy; discussion of general aspects of labor and delivery; discussion and demonstration of baby bath and layette, formula preparation, and infant feeding; birth film; session with an obstetrician including obstetric analgesia/anesthesia; film on infant behavior; hospital tours" (p. 109). Optional sessions provide information on breastfeeding and Lamaze (exercises, breathing, massage, and counterpressure).

Johnson (1980) offers self-hypnosis as a means of controlling childbirth pain, and suggests that it is also useful in dealing with other discomforts associated with pregnancy. Self-hypnosis leading to "an altered state of consciousness, is achieved by the subject with some initial guidance, but ultimately on her own or with some assistance from a coach" (Johnson, 1980, p. 98). Johnson (1980) purports that the positive benefits of an altered state of consciousness include "a change in the perception of discomfort and pain, distortion in time sense, and the
ability to give oneself positive suggestions" (p. 98). No literature is used to support these claims.

Johnson teaches self-hypnosis during a series of three two-hour classes. During these classes, students are taught an induction technique, several muscle relaxation techniques, and imagery. Students then work to develop their own rapid induction technique. Stages of labor, along with the appropriate breathing techniques and type of hypnosis for each stage are also discussed. Students are encouraged to become familiar with the hospital environment in which they will deliver so that their hypnosis induction technique will not be hindered.

Lamaze classes are usually taught during the last trimester of pregnancy when the woman's concern about the impending labor is high. There are usually twelve hours of instruction spread out over a six to eight week period. Typical course content includes: biological dynamics of pregnancy, labor, and delivery; how the psychoprophylactic method works; psychology of pregnancy, labor, and delivery; myths about pregnancy and childbirth; psychoprophylactic methods of breathing and muscle relaxation; husband-wife roles; medications available and their effect on mother and fetus; situation role-playing; typical hospital routines for labor and delivery (Huprich, 1977).
According to Worthington, Martin, and Shumate (1982), almost all of the childbirth education classes "use the Lamaze childbirth method or some variation of this procedure" (p. 45). Coping strategies that are part of the Lamaze method include: complex breathing patterns; coaching; focal point for concentration; conscious muscle relaxation; effleurage; stress rehearsal; and systematic practice (Worthington et al, 1982).

Current trends in childbirth education in the United States were explored in a survey conducted by Sasmor and Grossman in 1980. The results of the study are based on 238 responses of childbirth educators. The study shows that the two major childbirth education organizations in the United States are the American Society for Psychoprophylaxis in Obstetrics (ASPO) and the International Childbirth Education Association (ICEA). According to Sasmor and Grossman (1980), the preparation for childbirth educators ranged from "1 to 4-day workshops to the preparation being a regularly scheduled component of a Master's degree program" (p. 156).

Most educators began classes with expectant mothers during the seventh month of pregnancy; the range, however, was from two to eight months (Sasmor and Grossman, 1980). Most class participants had attained at least a high school education. Sasmor and Grossman (1980) state that the vast
majority of classes are intended for couples. Results of the study indicated that most educators felt that the physicians supported the program.

Sasmor and Grossman (1980) found that the course content was widely diverse; eight categories generally not covered by many educators were: exercises appropriate for pregnancy; adequate diet and appropriate weight gain; drug use; normal processes; potential problems; neonatal care; family relationships; "strategies for coping with the health care system" (p. 158). The respondents stated that they did not see a need for any improvement of course content. Even though guidelines for childbirth education course content have been developed by the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG), course instructors are under no obligation to follow them.

Sasmor and Grossman (1980) concluded that "the service itself tends to reach well-educated, middle-class consumers and, in general, does not provide for special interest groups or lower socioeconomic consumers" (p. 160). Their conclusions are further supported by Watson's 1977 study of 611 parents who had attended childbirth education classes in Rhode Island. The results of this study showed the majority of parents represented better educated middle-class families. Watson felt that only a select portion of
the pregnant population was being served by the childbirth classes; a greater effort needed to be made to reach the population not served by the present childbirth classes.

Research on Efficacy of Childbirth Education

Many studies have been conducted to prove the efficacy of certain psychoprophylactic techniques. While the studies have made various claims to efficacy, few studies have been directed at determining the woman's perception of usefulness or need. Even fewer studies have been directed at identifying the learning needs of lower socioeconomic women. This section gives a brief overview of some of the studies which have been conducted to prove the value of childbirth education.

Beck and Hall (1978) reviewed many studies on psychoprophylactic efficacy. The reported psychologic benefits included decreased pain perception, increased cooperativeness during labor, decreased post-partal depression, and a more positive attitude toward future pregnancies. Reported obstetric benefits included decreased use of analgesics and anesthetics, less blood loss, decreased obstetric interventions, and decreased length of labor. Other studies purported decreased prematurity and fetal mortality in preeclampsic patients (Beck and Hall, 1978). Benefits to the child that have been reported included better oxygenation of fetal blood, quicker initiation of breathing
after expulsion, decreased need for resuscitation, better nursery adjustment, and decreased neonatal morbidity and mortality (Beck and Hall, 1978).

Although the claims of these early studies sound good, a closer examination of the techniques used in the studies reveal inappropriate control or methodology, or the presence of other experimental errors (Beck and Hall, 1978). An overview of some of the psychoprophylactic method (PPM) studies follows.

A 1962 study by Davis and Morrone looked at the effects of childbirth preparation and support on labor. The study compared the births of 463 primiparous women. Davis and Morrone found no differences in duration of any stage of labor, use of forceps, or use of anesthesia (Cogan, 1980). Differences between the prepared and unprepared groups were found, however; the prepared women were older, better educated, in a higher socioeconomic group, had a more positive attitude about pregnancy, exhibited less anxiety, had developed concrete plans for their babies early in pregnancy, had a higher percentage of women who planned to breast-feed, and most did not smoke (Cogan, 1980). According to Cogan (1980), problems with the study included failure to present data, possible investigator bias, and failure to observe the subjects during labor.
Charles, Norr, Block, Meyering, and Meyers (1978) studied 249 women, 95 of whom had PPM training, in an attempt to determine psychologic and obstetric benefits of PPM while controlling for socioeconomic status and psychological attitudes. The results showed the prepared group had a decreased use of anesthesia and an increased level of enjoyment. The study did not show any effect on the condition of the infants between the two groups. The greatest benefit of PPM training seemed to be psychological; however, PPM training did "not appear to have any obstetric disadvantages" (Charles et al, 1978, p. 50).

Timm (1979) conducted a study on 118 pregnant women to determine whether childbirth education classes "affected the amount of medication administered to women during labor and the birth weight of the newborn regardless of the mother's parity, age, or race" (p. 338). In an attempt to control for the effect of group support, the women were divided into three groups: one childbirth education group, one knitting group, and one control group. The results showed no difference in the birth weight of infants between the groups; however, class participants "used significantly smaller amounts of medication during the course of their labor" (Timm, 1979, p. 340). Timm felt that the tendency to use less medication in the prepared group is extremely significant since the study population consisted of women
considered high risk for child abuse. Timm's ascertainment was that the less medicated mother and infant would be able to bond more thoroughly and sooner than medicated women and their infants.

Klusman (1975) studied forty-two primiparas to determine the effect of childbirth preparation (conducted by ICEA) on maternal fears, and to see if anxiety was related to pain perception. A group of primiparas who received prenatal education from the Red Cross served as the control group. The study showed that the women who attended ICEA classes were from higher socioeconomic groups, but both classes were effective in reducing maternal fears. Only the ICEA class was effective in decreasing general anxiety, however. Klusman did find a significant relationship between reduced anxiety and a decreased level of pain perception (1975).

Stone, Demchick-Stone, and Moran (1977) studied the Lamaze method to determine the effective components of Lamaze; "in-vivo" imagery was compared to the effectiveness of Lamaze. The study sample consisted of 100 female college students. A cold pressor tank was used as the pain stimulus. The results showed "neither the respiration technique nor focal-point visualization seemed to enable subjects to withstand cold pressor discomfort longer than" control subjects; conversely, the "in-vivo" imagery
"significantly surpassed the effectiveness of focal-point visualization" and respiratory techniques (Stone et al, 1977, p. 455). Stone et al (1977) realize that cold pressor pain is not equivalent to labor pain; however, they felt the results of the study warrant further investigation into the imagery technique's use as an effective pain control mechanism for labor.

Worthington et al (1982) also studied Lamaze by subjecting 104 nulliparous women to ice water submersion of their non-dominant hand. Results of the study showed that "structured breathing was more effective than regular breathing, and that effleurage was less effective than no effleurage" (Worthington et al, 1982, p. 45). Further findings were that the combination of coaching, focal points, and structured breathing was more effective than each technique individually (Worthington et al, 1982).

In a well controlled study by Scott and Rose, 258 primiparas were studied to determine the effectiveness of Lamaze training. Of the total sample, 129 women had Lamaze training. The groups were similar in number of complications, dysfunctional labor, fetal distress, birth weight, Apgar scores, and infant morbidity (Cogan, 1980). Scott and Rose concluded that the main advantage to psychological preparation was the decreased need for analgesia or anesthesia during labor.
Freudian psychologist Helen Deutsch felt that "feelings of anxiety during childbearing were psychologically desirable because they had an important role to play in the emotional preparation of the pregnant woman for the stresses of labour and delivery" (Astbury, 1980, p. 9). In an attempt to validate Deutsch's hypothesis, Astbury (1980) conducted a study of ninety patients who were divided into three groups; half of the women had also attended childbirth education classes. Analysis of the results showed no significant difference in the mean anxiety states between childbirth education participants and non-participants, or of participants who received an information treatment during labor. Astbury (1980) felt that the study results supported Deutsch's hypothesis and suggest that the "anxiety related to the stresses of pregnancy and labour is of a particularly obdurate kind, which cannot be easily altered through information at the time of labour or by childbirth education in pregnancy" (p. 13).

In an attempt to determine if positive perception of childbirth was associated with locus of control, two studies were performed. Willmuth, Weaver, and Borenstein (1978) found that childbirth education did not increase childbirth satisfaction; thus, it was hypothesized that childbirth satisfaction was associated with an internal locus of control. Humenick (1981) did not feel that
Willmuth et al's hypothesis was justified; her alternative hypothesis was that satisfaction with childbirth was associated with a woman's sense of mastery of the childbirth experience. Humenick (1981) conducted a study on thirty-three primigravid women; no control group was used. The results showed that childbirth preparation led to internalizing the locus of control relative to the amount of participation in the childbirth experience (Humenick, 1981).

Studies concerning maternal-infant attachment and the effects of childbirth education show contradictory results. The results of a study conducted by Croft (1982) showed that childbirth education adversely affected maternal-infant bonding. Conversely, a study conducted by Masterpasqua (1982) using high-risk mothers as subjects, showed childbirth education to be of "considerable psychological benefit to mother and newborn," but no medical benefits were noted for childbirth education (p. 58).

In an attempt to clarify the factors associated with a satisfactory labor and delivery experience, Willmuth (1975) reviewed the records of 145 women who had attend childbirth education classes. The results showed that the major factor associated with a positive outcome seemed to be the woman's perception that she "had been able to maintain control of pain perception during labor and delivery"
Being in control also referred to the ability to participate in decisions and maintain autonomy during the labor and delivery process. The women felt that participation in childbirth classes had provided them with the means to control pain and other discomforts associated with labor, and prevent surprises that would decrease their sense of control by orienting them to pregnancy, labor, delivery, and the hospital (Willmuth, 1975).

When McCraw and Abplanalp (1982) interviewed seventy-seven primiparas to determine why they took Lamaze classes, 42.9% stated they attended classes to gain information for themselves and their husbands. Decreasing medication needed during childbirth was given by 24.7% of the respondents. The third (20.8%) most frequently given reason was so that the husband could be present and involved during childbirth. The authors concluded that since the majority of women were not taking Lamaze classes to decrease medication, they may not be practicing the exercises as frequently or long as necessary to be effective. Therefore, this needs to be considered when doing research on the effects of childbirth classes (McCraw and Abplanalp, 1982).

The results of studies concerning the efficacy of childbirth education are confusing and often contradictory. A careful examination of the results of the studies,
however, consistently show four positive effects of childbirth education; no negative effects have been associated with it. Positive effects of childbirth education include: reduced medication during labor and delivery; reduced expression of pain during labor and delivery; decreased forceps usage; a more positive attitude toward future pregnancies (Cogan, 1980).

The psychoprophylactic method (PPM) gives women the tools necessary to make childbirth a positive experience. The power of PPM appears to lie in its psychological benefits. "When someone is able to master a situation himself, he will feel better about that experience than if someone else masters it for him" (Moore, 1977, p. 25).

An important variable in the research which has been done is the characteristics of class participants. Vinal (1982) conducted a study on 201 married postpartum women to determine the reason/differences between women who attended prenatal classes and those who did not. Significant differences were noted between the two groups. Vinal (1982) found that "non-participants had had more pregnancies, more living children, were older, had been married longer, and had fewer years of education" (p. 184). Vinal (1982) did not find significant differences "in terms of whether the pregnancy was planned, family income, refusal of husband to attend, transportation difficulty, being
unaware of classes, being too tired, or not being able to afford classes" (p. 185).

In a 1979 survey conducted by Whitley, results showed that women who attended childbirth education classes were older, nulliparous, and planned to breastfeed when compared with a control group. The main reason given for attendance of childbirth classes was to have husbands participate in the labor experience (Whitley, 1979).

In a survey of sixty-six postpartal charts of women who had attended an obstetrical clinic serving primarily low-income women, Kinnard (1983) found that only twelve (18%) of the women had attended prenatal education classes, although approximately fifty percent were primigravidas. A corresponding survey of community resources for childbirth education classes showed that only twenty-seven percent of the childbearing population for that year had attended childbirth education classes. The childbirth educators in the community reported that the vast majority of their students were well-educated and from middle to upper-middle income groups (Kinnard, 1983).

Third Trimester and Low-Socioeconomic Learning Needs

It has already been established that the third trimester is the time of heightened learning needs (Glazer, 1980). It is also the time when women's receptiveness to learning is at its peak (Clark and Affonso, 1979). Thus,
this is the time normally chosen for childbirth preparation classes. What of women who choose not to attend classes?

Colman and Colman (1971) stated that the current generation of grandmothers are unable to answer many of the questions concerning childbirth because they had passively participated in the birth of their own children. Women in better educated groups may be able to obtain necessary information to decrease their anxieties by reading some of the childbirth literature currently available on the market. Even if the middle-class woman chooses not to attend childbirth education classes or read articles concerning childbirth, the women in this socioeconomic class are more likely to be able to obtain the needed information from their physicians or nurses. This is not the case with women in lower socioeconomic groups who are less likely to seek medical care (Bauwens, 1978). Thus, primiparas in the lower socioeconomic groups experience increased anxiety, yet they do not have readily available sources for satisfying their informational needs.

It is not enough to offer these women free childbirth education classes. Research has shown that even when these classes are offered, women in lower socioeconomic groups do not attend (Bonovich, 1981 and Kinnard, 1983). Research tells us what is, but it fails to tell us why it is. The reason why women do not choose to attend
childbirth education classes needs to be established. One step in this direction is made by having the women involved (the experts) identify their learning needs. We will then be able to set about establishing ways for meeting those needs.

Katona (1981) sees the function of childbirth education as "inducing or favourably conditioning women to have less painful and less uncooperative labours" (p. 28). By providing women with information prior to the childbirth experience, it is felt fear and anxiety are reduced, thus making labor and childbirth a more pleasurable experience. By decreasing the laboring woman's anxiety, she is able to concentrate more fully on the birth of her infant. This experience should not be denied any woman.

Summary

The literature reviewed the development of childbirth education. The various childbirth education classes all appear to utilize some of the techniques advocated by Dick-Read and Lamaze. Most research has been directed at proving the therapeutic value of a particular technique and not at determining the perceived learning needs of the women utilizing these classes.

Research has repeatedly shown that formal childbirth education participants are well educated and from
middle socioeconomic groups or above. The reasons why women from lower socioeconomic groups do not attend childbirth education classes remain obscure. More research must be directed at discovering the perceived learning needs of pregnant women before efficient means for reaching all women can be developed. Although some research has attempted to identify learning needs for specific groups, research to actually delineate the learning needs of the pregnant woman is sparse. There is even less known about the learning needs of women in lower socioeconomic groups.
CHAPTER III

METHODOLOGY

This chapter presents information on the research design, sample selection, setting, protection of human subjects, data collection, reliability and validity, and data analysis.

Research Design

An exploratory design was chosen for this study in order to allow the subjects to identify their learning needs during the third trimester of pregnancy. The major emphasis of exploratory studies "is on discovery of ideas and insights" (Selltiz, Wrightsman, and Cook, 1976, p. 90). Open-ended (or unstructured) interviews allow the researcher considerable flexibility to examine different aspects of the phenomenon being studied as these phenomena present themselves (Selltiz et al, 1976). Kerlinger (1973) states that information such as "reasons for behavior, intentions, and attitudes can best be obtained with the open-end question" (p. 485). Open-ended interviews provide an additional advantage of not depending on respondent literacy which could be a major complicating factor with the low socioeconomic group being studied (Diers, 1979).
Interviewing and/or participant observation are extremely useful for researching a social phenomenon or group of people about which little is known (Polit and Hungler, 1983). Since little is known about the pregnancy and childbirth learning needs of low socioeconomic third trimester primigravid women, open-ended interviews allow the researcher to obtain information which could be missed with a questionnaire. While open-ended questions "supply a frame of reference for respondents' answers, they put a minimum of restraint on the answers and their expression" (Kerlinger, 1973, p. 483). Kerlinger (1973) further states that through their response to the open-ended questions, informants may "give unexpected answers that may indicate the existence of relations not originally anticipated" (p. 484).

In exploratory research, the informants are considered to be the experts. The interviewer enters the situation willing to learn from the "experts". Rather than random sampling, exploratory research utilizes purposive or theoretical sampling (i.e. the sample is chosen from people who know the research topic). In this study, the experts are the third trimester primigravid women from low socioeconomic groups. These women are considered the experts because they live in the situation being studied, they know the culture of their group, and they are capable
of identifying and relating that information which is meaningful to them. To merely use a questionnaire does not allow identification of items other than those listed, and may only serve to propagate the ideas prevalent in the middle class. The expert for the questionnaire is the person who developed that questionnaire. There is not sufficient information available at this time to develop a reliable questionnaire on this topic. Interviewing the experts and allowing them to respond in a culturally relevant manner will begin to provide the necessary information for questionnaire development.

The flexibility of the interviewer enables her to respond naturally to the interview situation, while at the same time posing general, provocative, or stimulating questions. Questions are frequently generated during the interview as new information is introduced by the informant.

Funnel questions are a special type of open-end question that are useful to reach attitudes and probe specific practices (Kerlinger, 1973). Funnel questions are a "set of questions directed toward getting information on a single important topic or a single set of related topics" (Kerlinger, 1973, p. 484). The funnel begins with broad questions and gradually narrows down to specific points related to the research topic. An example of this would be: "What kinds of things do you want information about
concerning pregnancy and childbirth?" Following the informant's response, the interviewer may then ask, "What kinds of things would you like to know about your diet?"

Informants may feel that they do not know enough about the topic being investigated to be considered a knowledgeable source of information. They may require repeated assurances from the interviewer that they are providing important information about which the interviewer is interested and ignorant.

Due to the overwhelming volume of words spoken during an interview, interviews should be tape recorded (Bogdan and Taylor, 1975). The taped interviews allow the researcher to focus her attention on what the informant is saying. The transcription of the tapes allows the researcher to notice information which had been missed during the interview because the interviewer cannot take in everything at one time. The transcribed data are then used to generate questions for future interviews.

The knowledge that the researcher gains from the interviews is used for thematic analysis (Polit and Hungler, 1983). The themes that emerge are then analyzed for relationships to other variables.

**Sample Selection**

The sample consisted of eight primigravid women identified to be in a low socioeconomic group. Selection
criteria included:

1) The woman was carrying her pregnancy to the third trimester for the first time;
2) The woman was in her twenty-eighth to fortieth gestational week of pregnancy;
3) The woman had attained no more than a high school level of education;
4) The gross family income was less than $15,000 per year;
5) The woman was not considered to be at obstetrical risk;
6) The woman spoke English.
7) The woman attended a university hospital obstetrical clinic primarily serving low socioeconomic women. Clinic charts and records were examined to determine parity, age, educational background, known risk factors, and annual income.

Women who were considered to be at high risk were excluded from the study because it was felt that high risk was a complicating factor. In addition to the normal concerns of pregnancy, women with high risk pregnancies may be concerned about their life and/or the life of their infant. The purpose of this study was to identify learning needs for pregnancy and childbirth; the study was not
designed to identify learning needs related to specific, individualized health problems which high risk pregnant women may have.

The cut-off income level of $15,000 was chosen to select women who categorized in or near poverty level. Green's (1970) work was used as a basis for determining the income and education level of lower socioeconomic groups. The income levels presented by Green were adjusted for inflation before the cut-off points were established.

A list of possible informants who met the above criteria was obtained from the review of clinic patient charts. Each potential informant was then contacted by telephone and the study was explained. If the informant gave verbal consent to participate in the study, an interview time and place convenient to the informant was set.

**Setting**

The location of the interviews was established when the informant gave consent to participate in the study. The informants were given their choice for interview location in order to provide a comfortable atmosphere that would be conducive to free and open conversation (Bogdan and Taylor, 1975). All of the informants chose to be interviewed in their homes. Only two of the second interviews were conducted in the informant's homes, however; to
prevent further attrition of subjects, the other six inter-
views were conducted over the telephone at the request of
the informants. The sample size may have been further
diminished without the option of the telephone follow-up
interview.

The need for the use of a tape recorder was ex-
plained to each informant. After getting the informant's
verbal consent, all interviews were taped. Before taping
telephone interviews, the informants were asked again for
permission to tape record their responses. Initial inter-
views lasted approximately one hour. Follow-up interviews
lasted ten to twenty minutes.

**Protection of Human Subjects**

The rights of the informants were protected in
accordance with the guidelines established by the Human
Subjects Committee (see Appendix A). Human Subjects ap-
proval was also obtained from the obstetrical clinic. The
investigator explained the voluntary nature of the study
and the participant's right to withdraw at any time. The
purpose of the study and its benefits, procedures, risks,
costs, and time involved were explained to each informant.
This detailed information was also given in written form to
each informant (see Appendix B). Every attempt to safe-
guard the rights and privacy of the informants was made.
Procedure for Interview

Potential informants were initially contacted by telephone. An appointment was made for an interview at a time and place convenient to the informant. Each informant was given an information sheet during the initial contact. Rather than assuming that the informant read and understood the Subject Disclaimer Form, the purpose of the study and the informant's rights were verbally explained at the beginning of the first interview. The purpose of the tape recorder and field notes were explained and permission to use them was sought from the informant. A Subject's Disclaimer Form with the name and telephone number of the interviewer was given to each informant.

The interview began with an introductory statement reexplaining the purpose of the study, the interview format, and the topic for discussion. The first question (When do you expect your baby?) was designed to put the informant at ease and to get her talking.

Data was collected by using descriptive, structural, and contrast questions. Descriptive questions encourage informants to use their own language to describe certain situations or settings (Spradley, 1979, p. 60). An example of a descriptive question used during the interview is: What do you want to know about pregnancy and childbirth?
Structural questions were asked concurrently with descriptive questions. Structural questions were used to discover how informants organize their knowledge by using native folk terms and asking informants to classify them (Spradley, 1979, p. 60). An example of a structural question used during interviews would be:

You mentioned "the pain" as something you talk to your friends about. What is another kind of thing about pregnancy or labor that you would talk to your friends about?

Contrast questions are used to help the researcher discover the informant's meaning of objects and events by finding out how they are similar and/or different from other objects or events in the informant's culture (Spradley, 1979, p. 60). Contrast questions are thus used to show relationships between symbols or words. An example of a contrast question used during interviews is:

You said you wanted to have your baby naturally. How is this different from having the baby unnaturally?

After each interview, the tape was transcribed. Questions for subsequent interviews were individually derived from each informant's initial interview. Secondary interviews were used to clarify each informant's individual data.

All tapes and field notes were numbered. In order to assure informant anonymity, the names of informants were destroyed after the second interview.
Data Analysis

Analysis of transcribed data began with identification of themes. Themes were identified as frequently recurring ideas which most or all of the informants expressed. Thematic analysis was followed by searching for themes that emerged in relation to other variables (i.e., informants were not interested in prenatal exercises because the exercises did not produce sweat).

After the themes have been identified, the researcher must validate his findings. This was done by asking informants during the second interviews if the interpretation of their data was appropriate. If the informant did not agree with the researcher's interpretation, the informant was asked qualifying questions to disperse the discrepancy.

The final phase in the data analysis involved summarization of the findings on a theme-by-theme basis. Informant's quotes are used to support the researcher's propositions (Polit and Hungler, 1983).

Reliability and Validity

In an exploratory study, the informants are considered to be the experts, and through interviews yield information about a specific situation (Spradley, 1979). The data obtained is significant from the perspective of the informants' cultural group. Since statistical analysis
does not interpret the meaning of the data or the reasons why specific choices were made, the primary purpose of an exploratory study is to understand the meaning of the data (Selltiz et al, 1976).

The attitude, interpretation, and biases of the researcher may influence the reliability of the data. In addition, the lack of a systematic system for integrating informant's responses may further sacrifice reliability (Polit and Hungler, 1983). Repetition of the interviews with informants, however, provides a form of test-retest reliability. Clarification of information by the informants during successive interviews is used to produce data with a high degree of validity (Pelto, 1970).

Findings from this research apply only to the people studied. It is highly unlikely that these opinions are held by all low socioeconomic third trimester primigravid women. This study does, however, provide a foundation on which further research may be based. The purpose of an exploratory study is to describe that which little is known about; no quantitative implications are possible.
CHAPTER IV

PRESENTATION OF DATA

This chapter describes the pregnancy and childbirth learning needs of low socioeconomic primigravidas in the third trimester of pregnancy. The chapter includes the characteristics of the sample, field problems in data collection, interview results, and themes to responses.

Characteristics of the Sample

The sample consisted of eight primigravid women classified low socioeconomic according to income and years of education. The women ranged in age from eighteen to twenty-two; four of the women were eighteen years old. Years of education ranged from nine to twelve years; four of the women graduated from high school. Four of the women were married, and four were single. Income ranged from zero to $14,000. The income of the single women ranged from zero to $5,200, while the income of the married women ranged from $6,760 to $14,000. All but three of the women were experiencing their first pregnancy; three of the women had previous abortions. The majority of the women in the sample were Anglo-Americans; two were Mexican-Americans.
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<th>Informant</th>
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Field Problems in Data Collection

The original intention for data collection was that initial contact be made in the clinic setting; however, the wide variation in scheduled appointment times resulted in initial contact being made by telephone for most potential informants. Only potential informants who did not have a telephone number listed on their clinic records were contacted in the clinic.

Thirty-five potential informants were contacted, of which twenty agreed to be interviewed. Another five potential informants voiced interest in being interviewed, but never had time for the interview when contacted. No future time or place could be arranged with these women, in spite of their declared verbal desires to participate in the study. Three of these women said they would call, but none did.

Twelve of the twenty women agreed to a time and place for the interview, but did not keep their appointments. Most simply were not home at the prescribed interview time. None of the women called to cancel interviews even though they had been given a telephone number to contact the interviewer. Telephone contacts to reschedule interviews resulted in messages that the informant was not
The problems encountered in data collection resulted in alterations in the data collection process and a reduction in intended sample size. Follow-up interviews were conducted via telephone to prevent further loss of informants due to their reluctance to commit to a specific follow-up interview appointment.

**Interview Results**

The interview began with an introductory statement reexplaining the purpose of the study, the format to be used, and the topics for discussion. Open-ended questions were used to allow the informants to describe their point of view (Dean, Eichhorn, & Dean, 1969). "Funnel questions" were used to elicit discussion on the desired topic. These are broad questions which were gradually narrowed down to probe specific points which the informant mentioned. Funnel questions provided the researcher with a better understanding of the informant's frame of reference (Kerlinger, 1973). Four funnel questions were used in this study.

**Question 1:** When do you expect your baby?

The purpose of the first question was to put the informant at ease and to start her talking. This first
question, however, yielded unexpectedly valuable information about the informants' lifestyles and frame of reference (see Table 2). Most of the women expressed confusion about their due date. Comments such as, "I wasn't keeping track" were very common. The women also did not understand the way their due dates had been calculated.

Table 2
Selected Comments from Informants Concerning Their Due Dates

"I wasn't exactly positively sure the date of my last period."
"I wasn't keeping track."
"I have an aunt who says that it is going to come sooner; a lot of people say that...I agree with them."
"I think it will be sooner...I'm not sure when my period was ending or starting."
"From what my Mom says and everything, she thinks according to what happened to her, I'll have it earlier."
"It seems like from the way I've been going along, I'll have it earlier."
"I don't know. It doesn't seem to coordinate with the calendar."
"It confuses me how they figure it out. They're figuring 40 weeks instead of 36 weeks, but that's ten months!"
They felt the doctors were in error because "everyone knows a woman is pregnant for nine months and not ten. The doctor says forty weeks, and that's ten months!"

Comments made by friends or relatives stating that the baby would come sooner were readily accepted. The women felt the doctor was probably wrong about their due date even though the doctor confirmed expected dates of confinement by measurements. The women felt their friends or relatives knew best because they were going by the "signs" (i.e. the position of the baby, the way the woman was acting, or the shape of the abdomen).

Question 2: What do you want to know about pregnancy and childbirth?

Almost all of the women responded to this question by voicing concerns about their fetuses (see Table 3). They wanted to know "if it's going to be healthy, if it's going to be all right, and things like that." Another informant was concerned with keeping "it healthy and happy."

Only two of the women expressed concerns about themselves. One informant wondered how her skin could "stretch like that". The other woman wondered "what to eat, what I can do to stay healthy, and... how I'm going to have it when the time comes."
Table 3

Selected Comments from Informants Concerning What They Would Like to Know About Pregnancy and Childbirth

"I want to know how to take care of it right--how to feed it."

"How to keep it healthy and happy."

"If it's going to be healthy, if it's going to be all right, and things like that."

"Whether it is already healthy or not, and some of the things that can happen right now."

"What I'm going to have and if it will be healthy."

"What to eat, what I can do to stay healthy, and I just wonder how I'm going to have it when the time comes."

"I don't really know."

"How does your skin stretch like that?"

This original funnel question was too broad for most of the informants to comfortably answer. The enormity of the question appeared to overwhelm the informants; after a brief response, they became silent. As a result, the interviewer addressed narrower topics normally covered in childbirth education. As the informants began talking about the selected topics, they brought up other topics concerning pregnancy and childbirth which they wanted to discuss. Responses to the selected narrower questions to elicit more information on the funnel topic area are presented in the following sections A to E.
A. Do you want information about your diet? Only two of the women were concerned about diet information. The other women were generally unwilling and/or unable to incorporate the diet recommended by the prenatal clinic into their life style. Most of the women in this study repeatedly stated they knew what was best for them (see Table 4). A typical response was: "All I know is that what things are needful and I don't push them off. I try to get as much as I can, but I never really read the pamphlet that they gave me. It's like I already have it in my head that I know what I need to eat." The feeling of knowing what was best included the types and amounts of

Table 4

Selected Comments from Informants Concerning Diet

"...Some of the diets are wrong. You should know on your own what is right for you instead of having somebody tell you."

"In a booklet they tell you what foods are good for you, and you should know on your own what foods are good for you and what ones aren't."

"...I'm a real bad junk-food person. I don't take vitamins like I should. I think about the fact that I should be eating, but I don't eat right."

"I have my own diet...I see a commercial on TV, and sort of get hunger pains."

"I think I know, it's just a matter of doing it."

"Not a whole lot. I don't think when I go to eat a candy bar or something--I just eat it."
foods to eat. Most of the women did not see any need for small, frequent meals. Three meals a day were all they felt were needed and, therefore, were all they would try to eat. An extremely underweight subject stated this attitude best: "I just couldn't seem to, uhm, to kind of redo my patterns over, and start eating three big meals or five small meals a day. I just couldn't do it...I end-up eating three small meals a day, and that's all I need."

The informants did not associate weight gain with infant health, even though some of the women stated they did not want the infant to "come out too thin or too weak." All of the women felt the clinically recommended twenty-five pound weight gain was entirely too much. Even one informant, who had attended childbirth education classes, explained what the extra weight was for, and then stated that twenty pounds was too much to gain "because the baby doesn't weigh that much."

Most of the women stated they were trying to keep their weight gain to a minimum. The general feeling was that if they did not gain the weight to begin with, they would not have a difficult time losing it after they had their babies. All of the women were determined to return to their prepregnant shape as soon as possible. One of the informants explained, "I've only gained ten pounds...partly because I know how I am. If I gained a lot of weight, I
wouldn't be able to lose it." Another informant stated that "some women use pregnancy as a reason to gain weight; I'm not sitting around all day and letting myself get fat!" A lot of the concern about gaining too much weight centered around the feelings that their mates found them fat and unattractive (see Table 5).

Table 5

Selected Comments from Informants Concerning Feelings of Mate

<table>
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<th>Comment</th>
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<tr>
<td>&quot;I worry about his feelings...is he going to like me less?&quot;</td>
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<tr>
<td>&quot;It's hard for him to accept the fact that I've gained so much weight and things like that, that I look so different all at once.&quot;</td>
</tr>
<tr>
<td>&quot;My husband keeps saying things like, 'After the baby is born, we're going to join Nautilus.' It sounds like he thinks I'm really going to be fat.&quot;</td>
</tr>
<tr>
<td>&quot;I worry about whether I'm going to get back into shape, or am I going to get fat or something. Am I going to be an embarrassment to him?&quot;</td>
</tr>
</tbody>
</table>

B. Do you want information about exercise? None of the informants exercised regularly. One woman expressed concern that exercise could injure her infant. The other seven women felt that the recommended exercises were really not exercises at all because they did not "work up a good sweat" when they did them. One informant summarized the general opinion of the group:
They were so easy, I mean, it was like sitting here doing this bit, you know. I mean, those weren't exercises to me. To me, an exercise is breaking out in a sweat, you know, and when you're done, you feel it; you know you've been exercising. To me, those aren't like an exercise. It was just like doing something around the house.

Most of the women felt they knew the exercises they needed. "I can tell what my body needs and then I do it."

C. Do you want information about labor and delivery? All of the women were worried about the "pain" of childbirth (see Table 6). When asked why they thought childbirth would be so "painful", all of the women stated their mothers and friends had told them about it. The pain

Table 6
Selected Comments From Informants Concerning Labor and Delivery

"I want the shots for pain. I can't take pain."

"I'm just afraid of how much pain there's going to be..."

"You have to keep telling yourself that it's not a pain--not a hurting pain."

"Everybody that I've talked to says that natural is very painful, especially if you have a long labor."

"I know it's going to hurt, but I just keep telling myself that it's a good thing that you don't have to go through it all of the nine months."

"No matter how much information I get, I'll always be scared of that."
was a frequent topic of discussion whenever these women got together with friends who had children.

D. Do you want information about infant care?

Most of the women were somewhat concerned about caring for their infants both prenatally and postnatally (see Table 7). Prenatally, some of the women were concerned they might not eat properly thereby causing their infants "to

Table 7
Selected Comments from Informants Concerning Prenatal and Postnatal Infant Care

"I wonder am I eating the right foods for it. I don't want it to come out too thin or too weak."

"My Mom always reminds me when I'm doing something that isn't helpful to the baby."

"My Mom tells me how to do it."

"It's scary holding a tiny baby... because it's so little, and you never know what it's crying about, so you change its diaper and it still cries."

"I wonder if I can handle it."

"I'm going to breastfeed because everyone I know that has breastfed, their baby has been a lot healthier, and I think they're happier."

"I always wonder how is that [working] going to coordinate with breastfeeding? I may end-up having to bottlefeed it whether I want to or not."

"If I'm living by myself, I'll have somebody that has had and breastfed and whatever I'm choosing to do that they've done--I'll see if they'll stay with me for a while, until I get the hang of it."
come out too thin or too weak." Most of the women relied on guidance from their mothers to prevent them from doing something harmful (acts of commission or omission) to their infants. All but one of the women planned to breastfeed their infants. The reasons given for this ranged from the cheap cost of breastfeeding to feeling that this was better for their infants. The chief source of breastfeeding information was friends of the women. Two of the single women who wanted to breastfeed their infants were concerned about how they would manage to breastfeed and work full-time. One of these women stated, "As soon as I'm able, I have to go out and get work...I always wonder how is that going to coordinate with breastfeeding?"

E. Do you feel prenatal care is important? None of the informants' replies answered this question. Their responses did, however, provide insight into their course of prenatal care. Half of the women in this study stated they delayed seeking prenatal care until their sixth month of pregnancy. One informant explained, "I didn't see a doctor until I was already six months or something...I didn't really know where to go, and I knew I couldn't really afford it." Planned Parenthood and the Women, Infants, and Children Program (WIC) supplied information to many of the subjects concerning low-cost care and community resources. All of the women chose the particular prenatal
clinic because of the clinic's sliding-scale fee based on family income. All of the women expressed discontent with their prenatal clinic visits (see Table 8). One woman stated, "They hear the baby's heartbeat when you go, and you have to wait three hours for them to do that!" Another woman stated, "How can you get to know somebody if you're just like a number to them?"

Table 8
Selected Comments from Informants Concerning Clinic Visits

"All you do is just sit, just sit."

"They measure my stomach, and that's it."

"Each time I go in, I ask them a question, and they won't tell me."

"The doctors don't talk very much. I avoid asking them questions."

"Every time you go to the clinic, it's the same thing. They say okay whether you answer yes or no."

"All he did was, I walked in the room, put a stethoscope on my stomach, and said, 'Okay, go home.'"

"I usually decide I don't want to ask the questions I think of."

Question 3: What kinds of things do you wonder or think about concerning this pregnancy?

The women in this study had many of the common concerns most women who are pregnant have (see Table 9).
Their chief concerns about pregnancy centered around "something going wrong" and the reversibility of the body changes pregnancy causes (i.e. "getting fat" and "getting back a regular shape"). The women were also concerned about sex harming the baby or causing early labor.

Concerns about labor centered around the "pain" they associated with childbirth and whether or not they

Table 9

Selected Comments from Informants Concerning Things to Wonder About

"I just wonder how I'm going to have it when the time comes, and I hope that it will be healthy, and wonder what it looks like."

"I worry that it won't come out right, or something's going to be wrong with it."

"I worry a lot about my appetite, like why am I getting so fat."

"I worry about being in the delivery room having it; it seems like a really weird thing."

"What it's going to be when it grows up—is it going to turn into a juvenile or is it going to be something decent?"

"I think about if I'm going to be have enough money to have enough food and stuff. Mostly, where am I going to get the things that I need for it."

"When I first got pregnant, I thought they were going to kick me out of the house, so I mostly worried where I was going to live."

"If I'm going to take care of it right. I don't know everything about taking care of a baby, you know."
would be able to have their baby "natural". Only two of the women associated natural childbirth with no anesthesia; one had attended childbirth education classes, and the other had a sister who was a registered nurse. The other six women felt that natural childbirth meant having the baby vaginally. One woman stated, "If it was up to me, I think I would just have a shot and have them take it out, but I don't want them to cut me. That's why I'm having it natural, because I don't want them to cut me."

Question 4: When you wonder about these things, where do you get your information?

The women in the study identified a large network of information sources (see Table 10). Only one of the women did not identify her mother as her most reliable source of information. This was a teenage informant who stated that "things have changed too much since my mother had babies for her to be much use." Other sources of information included friends and relatives. Only two of the women read the clinic material on pregnancy and childbirth. One of these women "skimmed" the material, but felt it did not pertain to her. She explained that the information was about the later stages of pregnancy and childbirth; since she was only three months pregnant, she felt "foolish" reading the material. She could no longer find the material when the appropriate stage of pregnancy was
reached. The other informant who read the clinic material had not obtained prenatal care until her sixth gestational month of pregnancy.

Table 10
Selected Comments from Informants Concerning Sources of Information

"I ask my friends who had babies."
"I asked my sister about that."
"I don't really ask too many questions."
"I haven't attended any of those classes or anything. I'm sure that every girl that's pregnant knows somebody else that's already had a baby. Just ask them."
"Everything they say, I always talk over with my Mom."
"That helps a lot when they give you books that tell you how it grows."
"I just want to learn on my own."
"I want them to tell me instead of giving me a book to read."
"I like to get different opinions sometimes, so I'll ask my mother, and I'll read that thing, and I'll talk with my nurse about it."

Themes to Responses

The responses elicited from the respondents were categorized into common themes. Four themes emerged:

1. I know what I need.
2. My mother and friends know best.
3. I am afraid of the pain.
4. I must get slim again.

I Know What I Need

Throughout the interviews, the informants continually indicated they considered themselves to be the experts when it came to their bodies. One informant stated, "I have my own ways. I don't like people telling me how to do this...or that. I just want to learn my own way." For most of the women, learning their own way meant asking their mothers or friends.

Knowing what was best for themselves included diet, weight gain, and exercise. None of the informants followed the prenatal diet recommended by the clinic. Although some of the informants felt they could not afford to buy the recommended quantities of food, others simply preferred not to. One informant stated that "some of the diets are wrong. You should know on your own what is right for you instead of having somebody tell you." The recommended weight gain was not followed because "the baby doesn't weigh twenty pounds" and the additional weight could be difficult to lose after delivery. The prescribed prenatal exercises were considered too easy. The consensus of opinions was that "I can tell what my body needs..."
My Mother and Friends Know Best

All informants stated they sought advice from their mothers and friends first. "On everything, I ask my Mom questions." Women living in a different vicinity from their mothers sought advice from friends. Friends included relatives with children, women with children, and in one instance, women without children. The answers provided by friends and relatives took precedence over information given in the clinic. One informant summarized this feeling very well when she stated, "I haven't attended any of those classes or anything. I'm sure that every girl that's pregnant knows somebody else that's already had a baby. Just ask them." Another informant stated, "Everything they say, I always talk over with my Mom."

I Am Afraid of the Pain

Fear of the pain of childbirth permeated all of the informants' interviews. The women knew childbirth was painful because their mothers and friends had told them so. "Everybody that I've talked to says that natural is very painful--especially if you have a long labor." All of the women worried about how they would cope with this ominous pain, even though they knew little else about labor. An informant who stated she did not even know what labor was said she wanted "the shots for pain--I can't take pain." All of these women were terrified that they would not be
able to cope with the pain, and many felt they had no options available to them. One informant stated, "Everybody just has it natural unless there's a problem—don't they?" Another informant stated, "No matter how much information I get, I'll always be scared of that."

I Must Get Slim Again

The women in this group repeatedly expressed the need to regain their former figures as soon as possible. Most of the women expressed the feeling that their mates may not like the way they looked. One informant who had only gained ten pounds in thirty-six weeks of pregnancy stated: "It's hard for him to accept the fact that I've gained so much weight, and things like that, that I look so different all at once. I used to be pretty thin and everything. I worry a lot about what he thinks about how I look..." Women who were single were more concerned about the way their mates might perceive their new shapes.

All of the women were determined to exercise and diet to get back their former shape as soon after the baby was born as possible. Their efforts to regain their figure included keeping pregnancy weight gain to a minimum. One informant stated, "I've only gained ten pounds...partly because I know how I am. If I gained a lot of weight, I wouldn't be able to lose it."
Summary

An exploratory study utilizing open-ended questions was conducted. The sample consisted of eight primigravid women classified as low socioeconomic according to income and education level. Field problems resulted in decreased sample size and altered data collection methods. Of the twenty women who agreed to participate in the study, only eight provided interviews. Follow-up interviews were conducted via telephone to prevent further attrition.

Four funnel questions were used to elicit discussion on the desired topic in terms of:

1. When do you expect your baby?
2. What do you want to know about pregnancy and childbirth?
3. What kinds of things do you wonder or think about concerning this pregnancy?
4. When you wonder about these things, where do you get your information?

The second funnel question appeared to overwhelm the informants. After a brief response, informants became silent. As a result, five narrower questions were asked:

A. Do you want information about your diet?
B. Do you want information about exercise?
C. Do you want information about labor and delivery?
D. Do you want information about infant care?
E. Do you feel prenatal care is important?

Four themes emerged from the informants' responses.

1. I know what I need—all of the informants indicated they knew what was best for their bodies. Knowledge areas included diet, weight gain, and exercise. Information provided by the prenatal clinic in these areas was largely ignored.

2. My mother and friends know best—informants sought and valued advice from their mothers and friends over that of the prenatal clinic. Friends included relatives with children, women with children, and women with special community status.

3. I am afraid of the pain—all of the women expressed grave concerns about the pain of childbirth. This was a frequent topic of discussion among the informants and their mothers and friends who reinforced this concept of pain.

4. I must get slim again—regaining their former figure as soon as possible was extremely important to all of the informants. The informants (especially the single women) were very concerned about their mate's opinion of their physical appearance. This resulted in an effort to gain minimally during pregnancy.
CHAPTER V

CONCLUSIONS

This chapter discusses the responses obtained from the questions and their resultant themes. Nursing implications and recommendations for further study are also presented.

The purpose of this study was to explore the learning needs of low socioeconomic third trimester primigravidas as these needs related to pregnancy and the impending childbirth experience in order to improve formal and informal childbirth education. An exploratory method utilizing open-ended interviews was used to identify the content area of these learning needs.

When Do You Expect Your Baby?

All of the women in this study expressed great confusion over their due dates. Some of the confusion was attributed to lack of understanding regarding how expected dates of confinement are calculated. More importantly, however, much of the confusion could be attributed to the woman's failure in recording her menstrual cycle. There appeared to be a large knowledge deficit in the area of menstruation and self-care. Women did not miss their
periods until a considerable amount of time had elapsed; this resulted in a vague recollection of the dates of their last period, and an inability to remember whether it was normal.

Women's confusion about their due dates was further compounded by the conflicting information they received from their mothers and friends. Friends and relatives of the women predicted due dates by the "signs" (i.e., fetal position, behavior patterns, abdominal shape, and previous experience). Comments made by friends or relatives that the baby would come sooner were readily accepted by the women; this behavior demonstrated a lack of trust of the health care system. The conflicting information obtained from the clinic and the woman's friends and relatives resulted in a barrier between the woman and the clinic staff.

What Do You Want to Know About Pregnancy and Childbirth?

All of the women had great difficulty articulating their own questions regarding what they wanted to know about pregnancy and childbirth. Although they were able to respond to questions relating to specific content areas (i.e., diet, exercise, etc.), their initial reluctance to initiate discussion of a topic area may be important in itself. It appeared that these women had the same type of
difficulty responding to the common "Do you have any questions?" frequently asked in the prenatal clinic.

Women in the study lacked basic information about the body changes associated with pregnancy. They lacked an understanding of the necessity for gaining weight, the reason for the increasing size of their abdomen and breasts, and the reason for striae. One of the subjects who has two sisters with children stated that even though she had seen her sisters get larger with their pregnancies, she had thought that they were only "letting themselves go", and she would be able to remain thin throughout her pregnancy. All women expressed shock that their breasts had increased in size.

The financial situation of the informants strongly influenced their prenatal care. The primary reason the women had chosen a particular clinic for their prenatal care was because the clinic offered a sliding-scale fee based on the family's income. None of the women was satisfied with her prenatal care. They felt the clinic was impersonal and very rushed. Most women felt the clinic visits were a waste of their time and effort. Not being able to establish rapport with a particular physician was very upsetting. "How can you get to know somebody if you're just like a number to them?" Most women
(particularly the Mexican-Americans) generally did not feel comfortable asking a stranger questions.

The financial situation of some women affected the degree to which they could follow the prenatal regimens recommended by the clinic. Their ability to follow the recommended prenatal diet was most greatly affected. All women stated they recognized the need to eat better, but felt they did not have the means to improve their diet. For most women, "junk food" remained a major staple in their diet because of its perceived low cost and easy accessibility. A general sentiment was, "our finances aren't too easy, so we do what we can in order to get by." Women did what they could to improve their diet; however, it did not appear to be a high priority in most of their lives.

The inability to develop a trusting relationship with their physicians served to stifle questions and promote resentment in the women. Even though they were not content with the care they received, the women did not feel they had other options for prenatal care. Continuing with prenatal care despite dissatisfaction seemed to demonstrate that prenatal care was valued by the informants. However, it may only have been a means of remaining in the health care system in order to have a place to deliver their infants.
What Kinds of Things Do You Wonder or Think About Concerning This Pregnancy?

Women in this study had many of the common concerns described by most pregnant women (see Table 11). They did, however, have one outstanding concern/worry that is of particular importance. Money was a major concern for most of these women. Women who were single worried about having a place to live while they were pregnant, and how they were going to be able to find a job to support their new family after delivery. The acquisition of maternity clothes was a major problem for many women. The WIC program advised these women of community resources available to them. This helped to allay some of their concerns temporarily, but women remained concerned about feeding and clothing their infants after they were born.

The second major concern of these women was "the pain" they associated with childbirth. All women identified "the pain" as something they worried a lot about. The pain was a frequent topic of discussion whenever they got together with friends who had children. The mothers of these women reinforced the concept of terrible pain at childbirth. This led to an exceedingly high level of anxiety about labor and delivery.

Most women were somewhat concerned about caring for their infants both prenatally and after birth. Although
Table 11
Things to Worry About

<table>
<thead>
<tr>
<th>Infant</th>
<th>Labor</th>
</tr>
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<tbody>
<tr>
<td>Caring for infant</td>
<td>Baby won't come out the right way</td>
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<tr>
<td>Whether it's healthy</td>
<td>Being unprepared</td>
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<td>Being a good parent</td>
<td>What they're going to do in the hospital</td>
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<td>Whether child will be &quot;delinquent&quot;</td>
<td>Things going wrong at delivery</td>
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<tr>
<td>or &quot;decent&quot;</td>
<td>The pain of labor</td>
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<tr>
<td>Money</td>
<td>Pregnancy</td>
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<td>Having enough</td>
<td>Something going wrong</td>
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<tr>
<td>Getting enough food and stuff</td>
<td>Changes in my body</td>
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<tr>
<td>Getting things the baby needs</td>
<td>Getting fat</td>
</tr>
<tr>
<td>Getting a good job</td>
<td>Getting back a regular shape</td>
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<td>Getting maternity clothes</td>
<td>Sex harming the baby</td>
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<td>Finding a place to live</td>
<td>Sex causing early labor</td>
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<td>Buying clothes when the child is older</td>
<td>Getting a little pain and thinking something is wrong</td>
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all women were concerned about the health of their infant, they did not feel that the size of the infant was in any way related to its health. The health of an infant was related to freedom from diseases or deformities. The informants explained that small babies were more likely to come out the natural way. A small infant, therefore, was desirable because there was less likelihood of needing a caesarean section.

When You Wonder About These Things, Where Do You Get Your Information?

When asked where they got information concerning pregnancy and childbirth, women in the study identified a large network of information sources (see Table 12). Only one woman did not identify her mother as her most reliable source of information. The next most influential group was friends and relatives with children. Women without children, but working in a "medical profession" (i.e. secretary in a doctor's office) were also considered to be highly reliable.

All women in the sample received printed pregnancy material from the prenatal clinic; most, however, did not read it. The informants stated they no longer knew where the pamphlets were. All women felt the information provided by the clinic did not meet their needs. At least part of this problem appeared to be due to the terminology
used by the medical staff and the different cultural meaning for the term. To women in this group, premature infant merely meant that the infant would be small. This did not have any meaning because the women did not associate the size of the infant with its health. One woman who smoked stated, "I'm sure that there's got to be more effects---there's got to be more to it than just premature

Table 12
Sources of Information

<table>
<thead>
<tr>
<th></th>
<th>Themselves</th>
<th>Mother</th>
<th>With Children</th>
<th>Friends</th>
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<td></td>
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babies." To her, merely having a premature infant was no reason to stop smoking.

**I Know What I Need**

Throughout the interviews, the informants continually pointed out they considered themselves to be the experts when it came to their bodies. One informant stated, "I have my own ways...I just want to learn my own way." To most, learning their own way meant asking their mothers or friends questions. Thus, the information apparently had to be sought by the informants before they would listen to the advice.

Knowing what was best for themselves included diet, weight gain, and exercise. Diet information was not readily accepted by the informants. The diet pamphlets were rarely read and never followed by any of the informants. When asked where they got information about diet, an informant responded, "It's like I already have it in my head that I know what I need to eat." Another informant stated that she did not follow the diet "because some of the diets I think are wrong." The informants explained that you learn "from growing up if this is fattening, or it has vitamins in it, or enough for you and the baby at the same time."

All informants were concerned about their prenatal weight gain. All felt that twenty pounds was an excessive
amount to gain for the baby; however, only two women stated they were trying to keep their weight down—one was the informant who had taken childbirth education classes. The major incentive for keeping weight gain to a minimum was so they "wouldn't have so much to lose." Women were very concerned that their mates no longer found them attractive.

Only one informant did any of the prenatal exercises recommended by the clinic, and she only did "the one for the breast muscles, one for the inner thighs, and one for my back." Even this informant had modified the exercises according to some other information she had obtained outside of the clinic. All the other informants felt the exercises were not necessary. The feeling was that they knew what their bodies needed. One informant explained that "there is a need (for exercises), but I know how much exercise that I do need." Most women continued to do whatever form of "exercise" they had done before pregnancy (i.e. housework, swimming, or stretching).

The informants still felt they knew what was best even on the subject of smoking. One informant explained in the following way why she continued to smoke:

He said that I should cut down on it. I don't smoke as much as I used to, but I know how much I should and shouldn't...To me, I don't think that it bothers the baby that much. They just tell you that because they think it's wrong...To me, it's like a scare tactic...I was concerned because they told me, but then I knew myself what my limit should be on it.
My Mother and Friends Know Best

The informants stated they sought advice from their mothers and friends first. Some women stated they felt uncomfortable asking doctors questions; however, most women felt that the impersonal and rushed atmosphere of the prenatal clinic precluded asking questions.

Women in this particular clinic had a primary nurse assigned to their care. Some women developed a trusting relationship with their nurses and would ask them questions. Other women stated that their nurse would either give them a pamphlet or tell them to ask their doctor. This rushed attitude and seeming lack of interest caused women to stop asking questions.

I Am Afraid of the Pain

Fear of the pain of childbirth permeated all of the informants' interviews. The women "knew" childbirth was painful because their mothers and friends had told them so. The women did not know anything else about labor other than the "terrible pain." They worried about how they would cope with something so ominous. The clinic pamphlet on labor lacked credibility because it did not address the issue of pain. When one informant tried to ask her nurse about the pain, the nurse told her it was in the pamphlet. So, these women turned to their reliable sources of
information, and they learned how "terribly painful" childbirth would be. This made them very afraid of childbirth.

One woman had a friend who told her about an epidural and how it would let her have her baby without the terrible pain. This seemed to decrease some of her anxiety. Another woman, however, had a friend who told her that drugs would affect her baby, and the baby would "come into the world all drugged-up." This woman was terrified that she would not be able to cope with the pain, and felt she had no options available other than going through labor without medication. The combination of the fear of the pain and the fear of failing her infant resulted in extremely high levels of anxiety for this woman.

I Must Get Slim Again

All informants were determined to exercise and diet to get back their former shape as soon as possible after the baby was born. For some, the attempt to regain their former shape was so pressing, they were determined to keep their weight gain for pregnancy to an absolute minimum. One informant stated her doctor told her "the less you gain, the less you have to lose." She was determined not to have to lose very much.

All informants confused the necessary weight gain of pregnancy with becoming fat. They did not understand the distribution of the gained weight, nor did they
comprehend the normal weight loss which occurs during the puerperium. Sexuality was a major concern for these women. Fear of losing their sexual attractiveness to their mates was a major factor in the woman's desire to keep weight gain to a minimum. The actual physiology of pregnancy was meaningless.

**Nursing Implications**

The major goal of this research was to determine what women in lower socioeconomic groups perceive as their learning needs for pregnancy and childbirth. Identification of these learning needs would enable obstetrical nurses to better meet the needs of these women.

Women in this study were able to identify some specific areas of concerns which have remained basically unmet even though the clinic they attended gave them pamphlets which covered this information. The pamphlets remained largely unread, and women did not feel comfortable asking questions about these topics in the clinic. For the few women who tried to ask questions, they did not feel they had received an appropriate response, and, therefore, would not ask any other questions.

Providing women with printed material is obviously not enough. Perhaps part of the problem is the reading and comprehension ability of the women. Since many women did
not finish high school, it is reasonable to suspect they may have impaired reading skills. Aside from not understanding what they read, the women may not enjoy reading, and, therefore, avoided reading. For those women who expressed an interest in the reading material, the time during the pregnancy when the materials were presented was a major factor in the utilization of the printed material. These women were interested in information pertaining to their current phase of pregnancy. Information for later phases was not read when presented to the women, and was invariably lost by the time the material was appropriate.

This study points out the need for nurses to provide individualized care to every patient. Standardized care plans are very convenient, but they cannot take the place of patient assessment. The learning needs which were felt to apply to all pregnant women apparently do not. Nurses must find out what each woman feels she needs to know, and then determine the best method of teaching her.

Some of the most important data obtained from this study came from the informants who verbally agreed to participate in the study, but made themselves unavailable. These women gave an authority figure what they perceived to be the correct answer with no intention of personal commitment. Their response served to get them immediately out of a situation in which they felt insecure. When they
were out of the threatening environment of the clinic, they did what they wanted to do. Unfortunately, this lack of following through applied to the eight informants as well. The informants gave an appropriate response in the prenatal clinic, and then did what they wanted to do. It may be worthwhile to further explore this evasive behavior. These women may verbally acknowledge a statement, but then fail to follow-up on it. However, part of the evasive behavior demonstrated by the informants may be due to the Mexican-American woman's extreme desire to please others.

An extremely significant finding in this study is the informant's process of responding to nursing services. The informants were unable to respond to general questions of what they wanted to know about pregnancy and childbirth. At the same time, they displayed behavior which seemed to demonstrate that the answers which the nursing staff gave (i.e. pamphlets, diet counseling, etc.) were irrelevant to the women. They responded appropriately to this information in the clinic, but the concepts which were being presented were never really accepted. Perhaps this is because they have not developed the "ability to foresee, comprehend, plan, and prepare" as Kitzinger stated (1977, p. 16).

The data which was obtained for this study was elicited in the confidential, non-threatening environment
of the informant's home. It is doubtful that any of this data would be obtained in the prenatal clinic where the informants fell threatened, insecure, and impersonalized.

Nurses must strive to develop interpersonal relationships with these women before they can expect their advice to be valued and followed. The information which nurses offer must help the woman understand the meaning of her pregnancy and how it relates to her life. The possibility of frequently used medical terminology conveying different meanings to the woman must be explored before teaching proceeds. It is extremely important not to take her understanding and correct interpretation of the shared information for granted.

The influence of the woman's peer group cannot be ignored. Even if a trusting relationship has been established, the woman may have trouble accepting the information the nurse may give. The woman's misconceptions and fears have been developed over a long period of time and have been reinforced by her peers. The nurse will need to frequently reinforce her teaching and provide positive feedback to the woman. It is also extremely important that the nurse explain the basis of her teaching. Merely giving the woman facts or directions will most likely result in non-compliance. It is possible, however, that an
explanation stating why something is important may lead to greater compliance.

Rather than working to make the woman a model patient, the nurse needs to strive at improving the woman's health care. For example, it is highly unlikely that the woman would change her dietary patterns to totally conform to the recommended pregnancy levels of intake. However, helping improve her dietary standards by working within her habits (i.e. adding a slice of cheese to her hamburger) may result in a dietary improvement. It may not be a perfect diet, but the overall diet of the woman and her family may be permanently improved.

The woman's fears and anxieties about childbirth will greatly affect her behavior during labor and delivery, and the extremely high anxiety levels could affect the outcome. Labor and delivery nurses must be willing to accept the woman's behavior, but they must also try to give her the reassurance and support necessary to get her through labor. Helping the woman get through labor and delivery with as much control of the situation as possible will not only help her in future pregnancies, but may also help break the cycle of fear for other women she talks to.

A woman's mother may also greatly influence the woman's ability or desire to breastfeed. If her mother and/or friends have negative attitudes towards
breastfeeding, she will probably have difficulty if she decides to breastfeed. The nurse from the nursery must assess the woman and her family's/friends' attitudes toward breastfeeding in order to provide optimal teaching and support. Without added support, the woman will probably be unable to successfully breastfeed her infant.

The major contribution of this study is not the identification of many new facts, but its support for one of the basic concepts in nursing—teaching is appropriate only when the nurse learns what the patient knows, what the patient's capabilities for learning are, and when the patient's readiness for learning is activated. In order for teaching to be meaningful, it must occur at the appropriate time and it must be appropriate for the situation. Nurses who proceed with teaching without first making an adequate assessment are merely fulfilling their own need to present content.

Recommendations for Further Research
The following are recommendations for further research:

1. Replicate this study to determine if the problems encountered in data collection were isolated events or indicative of group behavior patterns.

2. Replicate the study with different ethnic groups to determine if there are differences in perceived learning needs between different groups.
3. Develop an assessment tool to use in prenatal clinics to determine individualized learning needs. The tool must insure that the information will be given at the appropriate gestational stage of pregnancy and over a period of time.

4. Conduct a community needs and feasibility survey to determine the best way to offer childbirth education to this socioeconomic group.

5. Conduct a study to determine to what extent women in low socioeconomic groups use the pamphlets distributed by prenatal clinics.

Questions generated from this study for further research:

1. Do women in lower socioeconomic groups fear the painfulness of childbirth as reinforced by their sources of information?

2. Do women in lower socioeconomic groups have decreased information seeking behaviors, or do they instead seek information from non-medical sources?

3. Do women in lower socioeconomic groups desire to limit their weight gain during pregnancy?

4. Do women in lower socioeconomic groups seek prenatal care because it is valued, or is it merely a means of providing a place in which to deliver their infants?
5. Do women in lower socioeconomic groups have difficulty articulating questions, or do they not have questions?
Memorandum

To: Ellen J. Kinnard

From: Ada Sue Hinshaw, R.N., Ph.D. Katherine J. Young, R.N., Ph.D.
Director of Research Chairman, Research Committee

Date: July 5, 1983


Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Sub-committee of the Research Committee, and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research, if you need access to it.

We wish you a valuable and stimulating experience with your research.

ASH:des
4/83
APPENDIX E

SUBJECT DISCLAIMER FORM

I am conducting a study to determine what the learning needs are for a woman who is in the later stages of pregnancy for the first time. I feel that this information is necessary for developing childbirth education systems to better meet your needs.

I will ask you questions in a semi-formal interview format. You will be interviewed up to three times over a three week period. With your permission, I would like to tape record the interviews so that I can pay attention to what you are saying instead of what I need to write down for later reference. The interviews will be scheduled at a time and place convenient to you.

The information you provide will remain completely anonymous. I will assign your case a number which will be used to reference your information; I will be the only one that can associate your name with the number assigned. The information will be used to complete a thesis and possibly for publication in nursing journals. A copy of the completed thesis will be available in the medical and main libraries of the University of Arizona.

There will be no monetary or immediate benefit from your participation in this study. You are free to withdraw from the study at any time. Your participation or non-participation will in no way affect the care you receive in the clinic.

I will answer any questions you have regarding the study at any time.

Ellen Kinnard

881-4749
APPENDIX C

INITIAL INTERVIEW QUESTIONS

1. When do you expect your baby?
2. What do you want to know about pregnancy and childbirth.
3. What kinds of things do you wonder or think about concerning this pregnancy?
4. When you wonder about these things, where do you get your information?
APPENDIX D

SUMMARY CHARACTERISTICS OF EACH RESPONDENT

Informant A

Informant "A" was a single Mexican-American woman. "A" was nineteen years old, and had a twelfth grade education. "A" had previously had an induced abortion. "A" was living with her parents in a small single family unit, but planned on living with her boyfriend after the baby was born. "A" had a reported income of $4,160 per year.

Informant B

Informant "B" was a married Anglo-American woman. "B" was nineteen years old, and had a ninth grade education. "B" had not had any previous pregnancies. "B's" mother lived with her and her husband in a modest single family dwelling. The reported family income was $12,000 per year.

Informant C

Informant "C" was a married Anglo-American woman. "C" was eighteen years old, and had dropped out of school in the eleventh grade. "C" had no previous pregnancies. "C" and her husband lived in a modest apartment complex.
managed by her parents. "C" had a reported family income of $6,760 per year.

Informant D

Informant "D" was a single Anglo-American woman. "D" had no previous pregnancies. "D" lived with her mother in a single family unit in ill repair. "D" had no plans for moving after the baby was born. "D" had a reported income of $3,910 per year. "D" was very concerned because a clinic physician had told her that she would have to decrease her working hours, and "D" did not feel she would be able to survive on less income than she currently received from her part-time job.

Informant E

Informant "E" was a married Anglo-American woman. "E" was eighteen years old and had a twelfth grade education. "E" had no previous pregnancies. "E" and her husband lived in a modest apartment complex. "E" had a reported family income of $13,500 per year.

Informant F

Informant "F" was a married Mexican-American woman. "F" was twenty years old and had a twelfth grade education. "F" had previously had an induced abortion. "F" and her husband lived in a small well-kept single family unit. "F" had a reported family income of $14,000 per year.
Informant G

Informant "G" was a single Anglo-American woman. "G" was twenty-two years old and had a twelfth grade education. "G" had no previous pregnancies. "G" was currently living with a female friend and her two children in a low-income housing project. "G" thought that she might have to move to another apartment after the birth of her baby. "G" had a reported income of $5,200 per year, but was currently unemployed. "G" had no plans of seeking employment until after her baby was born.

Informant H

Informant "H" was a single Anglo-American woman. "H" was eighteen years old and had dropped out of school in the twelfth grade. "H" had previously had an induced abortion. "H" currently lived with her mother and seven year old sister in a modest apartment complex. The apartment only had one bedroom which her mother and sister shared; "H" slept on the living room sofa. "H" had no reported income of her own; her mother's income was $9,800 per year. "H" was considering moving to another state with her current boyfriend (not the father of her baby) after her baby was born.
REFERENCES


