A QUALITATIVE STUDY OF THE ATTITUDES OF WOMEN OF LOWER SOCIOECONOMIC STATUS TOWARDS CHILDBIRTH AND THE CHILDBIRTH EXPECTATION QUESTIONNAIRE

BY

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A thesis
presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Master of Nursing
in the
School of Nursing

Winnipeg, Manitoba, Canada

ISBN 0-315-71935-4

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DEDICATION

To my husband, family and friends

who supported and encouraged me throughout this project.

Thank you.

ACKNOWLEDGEMENTS

I would like to thank my supervisor, Dr. J. Beaton for her guidance and support. I would also like to thank the other members of my thesis committee, A. Gupton, Dr. P. Kaufert for their assistance and suggestions.

I would like to thank all the women who participated in the design and study phases of this study.

The cooperation of staff from Red River Community College and Mount Carmel Clinic was greatly appreciated.

ABSTRACT

Maternal childbirth expectations affect a woman's experience in labour and delivery and her ability to assume a mothering role. Further research is needed to determine the nature of expectation development.

The Childbirth Expectation Questionnaire (CEQ) was developed by Beaton and Gupton for use in this research. The CEQ was developed and tested on middleclass women all of whom were attending prenatal classes.

The question arose, would this tool be appropriate for use among other social groups. Childbirth research has indicated that women of lower socioeconomic status have different expectations and attitudes towards childbirth than their middleclass counterparts. Literacy research indicates that differences also exist between these groups in their use of language and their comprehension of the written word. It was anticipated that the CEQ might present difficulties at both a conceptual and linguistic level.

This two phase descriptive study was conducted a) to evaluated the CEQ for use with women of lower socioeconomic status and b) to gain a better understanding of their childbirth expectations. The conceptual framework was the social construction of reality theory by Berger and Luckmann. This theory states that reality is socially constructed. A nonprobability convenience sample of 15 subjects of lower socioeconomic status. Indepth interviews were conducted and data subjected to qualitative analysis.

Findings indicate that the CEQ was conceptually and linguistically inappropriate for use among the study population. The subjects suggested many revisions and recommended the tool be used for educational purposes. Interview themes were fear, fatalism and communication difficulties. Many implications for the delivery of nursing care to this population arose from the study. As well there were many implications for research being conducted with this population.

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APPENDICES

CHAPTER 1: INTRODUCTION

The Childbirth Expectation Questionnaire (CEQ) was devised and tested with women from the middle class. This study was conducted: a) to evaluate the CEQ for use with women of lower socioeconomic status and b) to gain a better understanding of their childbirth expectations. Given the differences among social groups in their attitudes and use of language an assessment of the tool was considered necessary before using it in a population other than the one for which it was designed.

The introductory chapter will include the statement of the problem, purposes and significance of the study, as well as the conceptual framework and definitions used in the research.

Statement of the Problem

Childbirth is an event that is almost always accompanied by a long period of anticipatory thinking. Most women begin to formulate childbirth expectations early in their lives (Leifer, 1980; Whaley & Wong, 1979). As children grow and develop, so do their expectations about the process of conception, pregnancy, birth and parenthood. The ideas

formulated throughout a woman's youth and early adult years become more defined during pregnancy. Leifer (1980) found that her subjects' knowledge increased during pregnancy through discussions with their mothers and friends as well as through attendance at prenatal classes. Expectations generally were most clearly formulated in the last months of pregnancy.

Discerning how expectations affect a person's ability to cope with the anticipated event has been the objective of many investigators. Janis' (1958) research with surgical patients investigated the relationship between preoperative anxiety, expectation development, and postoperative outcomes, provided the foundation for further expectation studies. Janis and subsequent investigators, studying childbirth, (Davids & De Vault, 1962; Klusman, 1975; Lederman, Lederman, Work & McCann, 1979; Lunenfeld, Rosenthal, Larholt & Insler, 1984) found that inappropriately high or low anxiety levels were associated with unrealistic expectation development and/or poorer outcomes. Although not universally accepted (Niven & Gusbers, 1984), realistic childbirth expectations have been linked to: reduced distress and pain during labour (Clark, 1975; Fridh, Kopare, Gasaton-Johansson & Norvell, 1988; Lumley & Astbury, 1980; Nettelbladt, Fagerstrom & Uddenberg, 1976), shortened labour (Davids & De Vault, 1962; Leifer, 1980; Levy & McGee, 1975), and to greater satisfaction with the birth experience (Levy & McGee, 1975; Scott-Heyes, 1986). "When the expectations are realistic, the outcome is perceived as a

positive experience however, when expectations are unrealistic the outcome is perceived in negative terms" (Clark, 1975, p. 413).

Expectations, through their influence on the labour experience, and the subsequent evaluation of the event, affect both the woman's ability to integrate her experience into her self concept, and her capacity to assume a mothering role (Butani & Hodnett, 1980; Doering, Entwisle & Quinlan, 1975; Gotlick & Barrett, 1986; Grace, 1978). A women's evaluation of her childbirth experience affects her self esteem not only for the days immediately following the birth, but as well for a number of months after the event (Bloch, Bond, Qualls, Yalom & Zimmerman, 1976; Mercer, 1985; Scott-Heyes, 1982). "The labor experience influences not only the woman's attitude about herself but also her attitude toward her child [and] . . . may have long term effects on both her self-esteem and her mothering ability" (Butani & Hodnett, 1980, p. 75). Since pregnancy and childbirth are major developmental tasks, failure to successfully traverse this stage will affect the ability of the woman to move to the next developmental stage, that of mothering (Butani & Hodnett, 1980; Mercer, 1985; Swift, 1986; Tilden, 1980). Research focusing on bonding, suggests that the perception of the birth experience affects maternal-infant attachment (Doering & Entwisle, 1975; Elias, 1971; Sugarman, 1977). Mercer (1985) found a significant positive relationship between satisfaction with birth for

subjects in their teens and twenties and maternal behaviour. Lack of both maternal self esteem and/or bonding have been identified with increased potential for child abuse and neglect (Altemeier, 1984; Benedict & White, 1985; Broome, 1987; O'Conner, Davis & Sahlein, 1984; Oates, 1984; Swift, 1986; White, Benedict, Wulff & Kelley, 1987). How women view an event such as childbirth is important since what they expect will impact on how they respond.

Many authors have supported the importance of expectations, and their impact on self esteem and maternal behaviour, and have suggested screening pregnant women (Horsley,1972; Lederman et al., 1979; Levy & McGee, 1975; Lumley and Astbury, 1980; O'Connell, 1983; Stolte, 1987). Such screening is viewed as the first step in determining which women require counselling and support in order to modify their expectations. If expectation modification is successful then improved prenatal care and more positive health outcomes should result. "Accurate assessment, useful instruction, appropriate structuring of expectations, and meaningful support can make the difference between a positive and a negative experience for both primiparas and multiparas" (Clark, 1975, p. 428). Further research is required before screening tools and programs of intervention can be developed.

Before effective screening is possible, research must be conducted to answer questions about the development and exact nature of childbirth expectations. "An important step in

determining answers to these questions is the development of a reliable and valid instrument to measure maternal childbirth expectations" (Beaton and Gupton, 1990, p. 133). The tools used in childbirth research to date have not specifically focused on expectations. Many of the studies have investigated childbirth in general and contained only a few questions related to expectations. The questions were usually of a yes/no variety or open ended and provided data of a general nonspecific nature. In many of the childbirth studies no explicit questions related to expectations were included meaning that information on expectations had to be inferred from related questions. Therefore, no tool suitable for the specific measurement and study of expectations was available.

Beaton and Gupton (1987) designed the Childbirth Expectation Questionnaire (CEQ) (appendix A) to meet the need for a research tool to study maternal childbirth expectations. This questionnaire focuses on the areas of concern which were identified by pregnant women during in-depth interviews and through a review of childbirth expectation literature. The CEQ, was then tested on 200 women attending prenatal classes. Refinements to the tool were made and the instrument was again administered to an additional 100 women who were attending prenatal classes. This revised tool is currently being used in research on the development and range of childbirth expectations.

All who were interviewed in the initial phase of the development of the CEQ, as well as all those who completed the CEQ during its refinement, were attending prenatal education classes. Generally, attenders of prenatal classes are from a middle class background (Beck et al., 1980; Glazer, 1980; Norr, Block, Charles, Meyering & Meyers, 1977). In addition, all the women who participated in the development stage of the CEQ had a grade twelve or higher level of education. If education is used as an indicator of class then the women who participated in the development of the CEQ can be considered middleclass. Given the methods used in its development there is no doubt that the CEQ reflects both conceptually and linguistically, the expectations of the middle class women with higher education who attend prenatal classes. The question is whether the statements contained in the CEQ also reflect the expectations of women from a different social class and with a different educational and economic background. The next logical step in the testing of the CEQ is to establish whether it is acceptable conceptually and linguistically to women from a lower socioeconomic background. The fact that the CEQ was devised and tested primarily among middle class women means the tool might not be conceptually or linguistically congruent with the perceptions of women of lower socioeconomic status. Significant differences in attitudes and language between women of middle and lower socioeconomic status were anticipated based on the theory of

the social construction of reality (Berger & Luckmann, 1967). This theory suggests that the perspective and value given any experience is determined, at least in part, by the social group in which the individual is a member. In addition, the theory suggests that the language used to describe an experience is also determined by class membership. The anticipated differences in expectations and attitudes toward pregnancy, childbirth, and motherhood were supported by the limited research available. Only a few studies have actually focused on the impact of the social group on childbirth attitudes. These studies found a marked difference between the attitudes of middle class and lower or working class women. Hubert (1974) noted that expectations vary greatly within Western society and suggested this variability may be related to differences in socioeconomic status. Westbrook (1979) and Rosengren (1961) found differences in attitude and coping styles between women of middle and working class backgrounds. Reid (1983) found the basic assumptions held by the researchers were not shared by their working class subjects. "Childbirth was viewed not as an event to be anticipated . . . (but) as something to be got through" (Reid, 1983, p. 87). Many of these subjects placed a lower value on the childbirth experience than did their middle class counterparts. Reid noted that these differences have resulted in differing criteria for satisfaction between social classes. Nelson (1983) concurred with Reid and found that her working class

subjects tended to have a more negative attitude toward pregnancy, to be more apprehensive about labour, and to expect less control. Based on her findings, Nelson proposed that differences between social classes have resulted in different childbirth models for each group. These studies suggest that significant variations in attitudes and expectations exist and are consistent with social class distinctions.

There are two components of language. The conceptual underpinnings of language are associated with class beliefs and attitudes and vary among groups. The vocabulary used and reading ability of an individual is closely linked to education level and the person's class. Problems in communication can arise out of either of these aspects and are particularly problematic when using written materials because of the lack of opportunity for clarification. There may be real differences in expectations but the extent to which these expectations vary and can be measured is obscured by the language barrier that exists among social groups. Berger and Luckmann (1967) state that communication within social groups occurs through the use of a "common language". When two social groups meet, as in a health care setting, difficulties often arise because of the differences in language. Hubert (1974) noted that "little is communicated because of a fundamental lack of rapport between educated, informed staff and comparatively uneducated patients" (p. 38). Many other researchers have noted difficulties of communication between

social groups (Graham & Oakley, 1981; Hubert, 1974; Pedraza-Bailey, 1980; Samora, Saunders & Larson, 1961).

The problem of language cannot be ignored in any study that focuses on members from the lower socioeconomic population. Language carries connotations which vary among social groups. The use of language identifies a speaker with a social group and the values that are associated with that group. Therefore, even if the language used by one social group is understandable it cannot be assumed to be acceptable to another.

Members of the lower socioeconomic population are known to have less education and are therefore more likely to have poor reading skills and vocabulary development. The problem of the level of difficulty of written health materials has been the subject of much discussion (Bakdash, Odman & Lange, 1983; Cole, 1979; Davis & Kendrick, 1989; Richwald, Wamsley, Coulson & Morisky, 1988). "The result of nonselective use of these materials can range from a total lack of communication, to a partial understanding which creates unnecessary fears and hazards . . ." (Mohammed, 1964, p. 100).

The client's reading skill, and the reading level of the written material need to be determined prior to use of the materials. Tests to establish reading skill are available, but these are generally for use in schools and are not appropriate for administration in a clinical setting. Testing reading skill remains a problem and the last grade completed is still

the accepted means of determining ability. However, this method is not a reliable predictor and needs to be used carefully especially with an adult population (Farkas, Glenday, O'Connor & Schmeltzer, 1987; Irwin & Davis, 1980; Meade & Byrd, 1989; Mohammed, 1964). Unfortunately, reading ability is often not considered or assessed, by any method, when written material is used in health settings.

A variety of formulas, each with their own strengths and limitations, is available to estimate the reading level of written material (Holcomb, 1983; Klare, 1976; Pichert & Elam, 1985). None is specifically structured for questionnaire evaluation. The Dale-Chall method of evaluation, makes use of word familiarity and sentence length to estimate readability. Using the Dale-Chall method, it was found that the equivalent of a college education was needed to comprehend the CEQ. Other formulas estimated the education level required to understand the CEQ at a level which varied from grade 7 to grade 10. Thus reading formulas provided widely divergent results, and demonstrate the problem which exists when using formulas to assess readability. These formulas can accurately estimate levels only within several years (Farkas et al., 1987; Irwin & Davis, 1980; Klare, 1986; Pickert & Elam, 1985). Field testing of materials, although time consuming, has been suggested to be the most reliable method of determining readability (Farkas et al., 1987; Nicoll & Harrison, 1984). Before the CEQ could be used to study expectations of women of

lower socioeconomic status, it had to be evaluated for use in that population. The investigator believed this evaluation needed to be conducted in the field using appropriate methodology. This would ensure that all the results related to the conceptual and linguistic aspects of the tool were reliable.

Summary of the Problem

Research has demonstrated that a pregnant woman's expectations of childbirth impact on her experience in labour and delivery, and on her subsequent adjustment to motherhood. Although much research has been conducted, there are a number of questions still to be investigated. Further study is needed to determine how expectations are formed and shaped, and the manner in which they influence the experience itself. The CEQ was developed to assist further research into the development and nature of expectations.

However, preliminary research indicates that expectations differ among women according to their socioeconomic status. Given the fact that the CEQ was developed and tested with a middle class population, it can not be assumed that it is an appropriate tool for use at all socioeconomic levels. Therefore, a thorough evaluation of the conceptual and linguistic appropriateness of the instrument, along with a broader general understanding of these women and their

expectations, is required prior to using the CEQ with women of lower socioeconomic status.

Purposes

The specific purposes of this study were to gain a better understanding of the expectations, regarding childbirth, of women of lower socioeconomic status, and to evaluate the CEQ for use with this group of women. The CEQ was examined for the appropriateness and relevance of its method of administration, language, structure, and concepts. Alternative or more appropriate methods of administration, language, structure and concepts were sought.

Significance of the Study

There is a great need for an improvement in our understanding of women of lower socioeconomic status since these "women are at risk of poor pregnancy outcomes" (Sevenhuysen, 1986, p. 5). Higher incidence of perinatal, neonatal, and postnatal deaths have been consistently recorded for the lower socioeconomic groups (Antonosky & Bernstein, 1977; Durwold, 1984; Graham, 1984; Sevenhuysen, 1986). Incidence of low birth weight and congenital malformation have also been used as outcome measures. These too have higher

incidence among the lower socioeconomic groups (Alberman, 1964; Milosevic, Djukic-Tadic, Krstic & Radojkovic, 1972).

Other measures of pregnancy outcomes such as: maternal satisfaction, psychosocial morbidity of the mother or baby, and difficulties in family adjustment, are more difficult to examine. However, these soft outcomes, as Oakley (1983) discusses, are important to consider since they reflect the quality of life and are measures of wellness. Little research has specifically addressed the relationship between soft outcomes and socioeconomic status. Hubert's (1974) study of women from lower socioeconomic backgrounds implied a high rate of unmet childbirth expectations and mothering problems in this population. A higher prevalence of parenting problems such as failure-to-thrive syndrome (Bithoney & Newberger, 1987; Casey, Bradley & Wortham, 1984; Oates, Peacock & Forrest, 1985) and of child abuse (Elmer, 1981; Gill, 1975; Horowitz & Walock, 1981; Mayhall & Norgard, 1983; Pelton, 1981) have been identified among lower socioeconomic families.

It would appear that women in the lower classes are at greater risk of poor outcomes, both hard and soft, than are their middle class counterparts. The poorer pregnancy outcomes of this group suggests that changes in the delivery of maternal health care are particularly urgent. Before the needed changes can be developed more research is required. Given the strong correlation between expectations and

outcomes, further research into childbirth expectations is one aspect of the needed research.

The significance of this study is that it will determine the appropriateness of using the CEQ in conducting research with this population. It will also increase the understanding of the childbirth expectations of women of lower socioeconomic status. In so doing it will contribute to the knowledge needed to guide future research, and eventually, changes to the health care provided to this social group.

Conceptual Framework

The social construction of reality theory (Berger & Luckmann, 1967; Elias, 1971; Hayes-Bautista, 1978) provided the conceptual framework for this study. This theory has four major aspects. The first, is that reality is socially constructed (Berger and Luckmann, 1967, p. 1). This means that what is considered real and the meaning it is given depends on the perspective of the defining group. Life events are given their meaning or value by a social group rather than by some inherent objective quality. Individuals from one social group may ascribe very different values to the same event than do individuals from another group. An example might be the value placed on the birth experience. Some women place high value on the event preparing for it through reading and attendance at class. They anticipate it as one of life's peak experiences

and express concern that anything interfere with the fulfillment of their expectations. Other women see the event as a means to an end and something one has to go through. They do not value the process and in fact find it strange how some do. Each group perceives the situation differently and places very different value on it. Thus the meaning of a situation and reality itself, is determined by the social group.

The second major aspect of this theory, which is closely linked to the first, is that "knowledge, thought, perception . . . is primarily determined by the structure of the human groups where they are produced" (Elias, 1971, p. 149). Therefore, different explanations of reality, or different knowledge, is not randomly distributed throughout the population, but is held in common by social groups. This commonly shared knowledge is group specific and partially explains the difference in perspective evident when groups interact. The attitude toward the use of medication during childbirth is very different among groups. Some women believe that a medication-free birth is preferrable and that medication during labour is harmful. These women demonstrate the extent of their belief by attending Lamaze classes and diligently practicing breathing and other pain control exercises prior to childbirth. This group of women have an extensive knowledge of alternative pain control measures. During labour they use the practiced relaxation methods and attempt not to use medication. Other women feel medication is

useful and wish to receive it. They do not accept that medication is harmful and consider its benefits to outweigh any negative aspects. This group of women may have little knowledge of alternative pain control measures but are quite well informed as to the variety of medications available to them. Other differences in expectations of childbirth could be anticipated, since social groups have as one of their characteristics a distinct body of shared knowledge and attitudes.

The third aspect of social construction of reality theory deals with the role of language. Language provides the means to share experiences and to develop and transmit common knowledge. The reality of everyday life is that it is intersubjective, that is, to exist means to continually interact and communicate (Berger & Luckmann, 1967). Language is shared and is specific to social groups (Berger & Luckmann, 1967; Bernstein, 1972). "An understanding of language is thus essential for an understanding of the reality of the everyday life" of a given social group (Berger & Luckmann, 1967, p. 37). Therefore, interactions between social groups are marked not only by differences in perspectives but by differences in the understanding and use of speech. "Peoples speaking different languages may be said to live in different 'worlds of reality' in the sense that the languages that they speak affect to a considerable degree both their sensory perceptions

and their habitual modes of thought" (Hoijer quoted in Bernstein, 1971, p. 121).

The fourth aspect of this theory is concerned with the means by which social groups perpetuate themselves. Primary socialization occurs within the family as "the individual not only takes on the roles and attitudes of others, but in the same process takes on their world. . . . Language constitutes both the most important content and the most important instrument of socialization" (Berger and Luckmann, 1967, p. 133). The world and language learned during primary socialization is deeply embedded and persistent. An individual's sense of identity develops as the common knowledge and common mother tongue of the social group to which the individual belongs are learned. Through further socialization processes identification with a given social group might change. However the mother tongue, which embodies the perspective of the social group of origin, will continue to be self explanatory in nature and will influence later socialization.

Hayes-Bautista's (1978) work, based on Berger & Luckmann's theory, examined oral communication patterns between social groups. In his study of communication between medical professionals and their lay patients he found three patterns: congruency of expression, partial congruency with or without conflict, or total incongruence and conflict (Hayes-Bautista, 1978, p. 8). His analysis and diagrammatical

presentation of these communicative patterns when modified to reflect questionnaire to individual communication had relevance for the design of this study. This study was proposing to examine the level of congruency between the language and concepts of two groups--the middle class as represented by the CEQ, and women of lower socioeconomic status (Appendix B). Congruence would have meant that the CEQ was both relevant and comprehensible to women of lower socioeconomic status. Incongruence would have meant that the CEQ was completely irrelevant and incomprehensible to woman of lower socioeconomic status. A finding of partial congruence would have suggested that the CEQ failed to fully reflect the views of women of lower socioeconomic status, in either its language, and/or in its conceptual base.

The CEQ was derived from the "common knowledge" and vocabulary of middle class women who had attended prenatal classes. A question which arose was whether the CEQ reflected exclusively the expectations of middle class women regarding their birth experience. Given Berger & Luckmann's theory of the social construction of reality, one could expect that the CEQ may require modification to encompass the conceptual and linguistic reality of women from the lower socioeconomic population.

In summary, the theory of the social construction of reality proposes that social groups interpret and give meaning to life events, that they share a common language and

knowledge, and that they pass this on through primary socialization which is resistant to obliteration. The theory contends that significant differences exist among social groups in both the relevance assigned, and the language used, to describe reality. These conceptual and language differences result in problems when different social groups interact. Accepting that differences among social groups do exist, this study examined the relevance both conceptually and linguistically of the CEQ for women of lower socioeconomic status. In so doing it explored both the meaning of, and the language used to describe, their childbirth expectations.

Definition of Terms

1. Acceptability - the degree to which words, concepts or methods of administration are understandable, appropriately formal and hold the same connotation for the subject as was intended by the author. Understandability refers to the ability to comprehend the intent of the meaning. Formality refers to the degree that language follows established standard form as opposed to the conversational or vernacular of the person. Connotation refers to what a word suggests apart from the dictionary definition. It is the attitude that is implied by using a given word.
2. Concept - a formally structured set of ideas.

3. Congruency - the degree to which two bodies of thought are consistent.

4. Expectation - a preconceived idea or opinion with regard to what will take place. As such, it is developed through anticipatory thinking about an event prior to its occurrence. These thoughts may be clearly formulated, or vague in nature, and may evoke positive, negative or mixed emotions.

5. Language - the vocabulary and grammatical structure of oral and written communication and the resulting effect.

6. Lower socioeconomic individual - generally, an individual lacking higher education, and gaining livelihood from jobs not requiring advanced education. In this study women with less than a grade 12 education and obtaining income from social assistance or with an income comparable to the amounts paid by social assistance were considered to be of lower socioeconomic status.

7.Middle socioeconomic individual - generally, an individual with an undergraduate degree and working in a position commiserate with their education. In this study women with a completed grade 12 and further education in some field, not necessarily at a university, were considered middle class.

8. Readability - the degree of ease with which a document can be read. It includes such factors as difficulty of vocabulary as well as complexity of sentence structure.

9. Relevance - the extent to which a person is able to relate to a concept and the degree of importance that concept holds for the person.

10. Social Assistance - a government program which provides income to individuals who are unemployed and prove a need for financial support. It is an income transfer benefiting individuals of limited economic means.

Conclusion

The importance of expectations in relationship to outcomes has been established and the need for further research into the development and nature of childbirth expectations is evident. The lack of research among lower socioeconomic women, combined with indications that they are at risk of poorer outcomes supports the need for research among this population. Therefore, this study examined the childbirth expectations of women of lower socioeconomic status in general terms and specifically evaluated the Childbirth Expectation Questionnaire (CEQ) for use with women from this social group. Since the CEQ had been devised and tested primarily on middle class women, its validity among women of other classes could not be assumed. The study was guided by the theory of the social construction of reality, as outlined by Berger and Luckmann (1967), and further developed by Hayes-Bautista (1978). This theory proposes that life events are

given meaning by the social group defining them, and that these events can only be understood by examining the social group involved. The theory also proposes that through the socialization process individuals are taught the language and perspective of their social group. Differences in perspective lead to communication difficulties, and messages between groups may be congruent, incongruent or partially congruent (Hayes-Bautista, 1978). The language and concepts of the CEQ were examined for congruency with regard to the childbirth expectations held by women of lower socioeconomic status.

CHAPTER 2: LITERATURE REVIEW

Introduction

The literature review is organized around the three major topic areas which were brought together to provide a frame of reference for this study. These three subject areas were: expectations, differences related to socioeconomic status, and readability.

Expectations

Over the past thirty years expectations have been studied, in the medical field, from a variety of perspectives. A diverse subject pool has included volunteers in research laboratories (Chaves & Barber, 1974; Epstein, 1973; Johnson, 1973) as well as in clinical settings such as surgical, dental, psychiatric, abortion and obstetrical units (Bloch et al., 1976; Collins & Hyer, 1986; Hartfield, Cason & Cason, 1982; Janis, 1958; Lindsay, Wege & Yates, 1984; Major, Mueller & Hilderbrandt, 1985). Janis's (1958) work provided the foundation for research into expectations. Since his landmark study is so pivotal to subsequent work, it is frequently

referred to throughout the following discussion of expectations.

Expectations, Anxiety and Outcomes

Janis (1958), using surgical patients as subjects, examined the role of anxiety and the "work of worry" in expectation development as well as the importance of expectations in coping with stress. The development of realistic expectations was found to be associated with different levels of anxiety. Janis defined three types of responses to the stress of anticipated surgery: the extremely anxious, the moderately anxious and the inappropriately not anxious. Patients with moderate anxiety periodically thought about their surgery, enunciated specific concerns, sought information and developed realistic expectations. The development of realistic expectations resulted in effective coping with the event of surgery. Highly anxious patients, who were worrying constantly, were unable to focus their concerns or to use information effectively. The patient with very low anxiety, or a blase attitude, failed to worry and used trivialization and denial to deal with the fear of surgery. Both high and low anxiety patients failed to develop realistic expectations, found the surgery highly stressful and postoperatively experienced more dysphoria during their longer recovery period. The work of worrying observed in those with moderate anxiety, was seen as increasing an individual's

tolerance to stress. The more thoroughly this work was done, the better was the adjustment to the crisis. Janis found that the ability to adjust to a crisis involved the development of realistic expectations whereas a reduced ability to cope was associated with the failure to develop realistic expectations.

The work by Janis (1958) was followed by many studies in the field of childbirth. Some of these studies focused on the relationship of anxiety to the childbirth experience. Since Janis linked anxiety to expectation development, studies that explore the relationship of anxiety to labour, may also explore the effect of expectations on childbirth.

Lederman et al. (1979), in a prospective study of 32 primigravidas, found a correlation between high anxiety and longer labours. These researchers also "demonstrated that specific psychological factors, measured in the third trimester are predictive of progress in labour" (Lederman et al., 1979, p. 97). While the psychological factors did not explicitly include expectations of labour, this concept was likely captured in such variables as amount of preparation for labour and acceptance of pregnancy. This research supports the contention that psychological factors impact upon the physiological aspects of the birth process.

Davids and De Vault (1962) and Lunenfeld et al. (1984) report that high anxiety during pregnancy is significantly associated with poorer labour outcomes. Davids and De Vault found that all their subjects who experienced delivery room

difficulties had been markedly more anxious during pregnancy. Lunenfeld et al. measured expectations, but unfortunately did not specifically report on their findings. However, they did report "that higher anxiety state and trait before birth associated significantly to a negative childbirth experience" (Lunenfeld et al., 1984, p. 165). Considering the findings by Janis (1958), it is reasonable to suggest that the highly anxious women in these three studies may have lacked appropriate anticipatory thinking and failed to develop realistic expectations.

Two researchers (Hubert, 1974; Nelson, 1982b) examined expectations of women of lower socioeconomic status and found that these women generally displayed less concern about labour during pregnancy. Janis's theory (1958) again may be used to examine this situation. These are women who, through denial and other means, may have failed to develop clear realistic expectations. For example, they failed to worry. Because of the lack of psychological preparation they could be expected to be more anxious during labour. Nelson (1982b) reports that these women are in fact, more anxious during labour and less satisfied with their childbirth experience.

Expectation Development and the Relationship to Preparation

Given that expectations affect how individuals are able to deal with stressful events, it becomes extremely important to understand when and how expectations develop. Janis (1958)

states that "the work of worrying is assumed to begin before a blow strikes, as soon as the person becomes convinced that he is in genuine threat of potential danger" (p. 375). Relating this to childbirth, one would expect pregnant women to begin the work of worrying early in pregnancy and for expectations to gradually form as the event of labour draws near. Currently there is little information about the development of childbirth expectations during pregnancy. Most researchers (Areskog, Uddenberg & Kjessler, 1981; Brucker & MacMullen, 1987; Clark, 1975; Lunenfeld et al., 1984) simply have accepted that it is "in the third trimester women begin to assume the caretaker relationship and direct their thoughts towards the resolution of pregnancy, labor and delivery" (O'Connell, 1983, p. 163). Glazer (1980) and Leifer (1980) have studied expectation development throughout pregnancy. Glazer found that women's concerns differed according to trimester and increased as the pregnancy progressed. Throughout the pregnancy they were most concerned about the baby and childbirth.

Leifer (1980) found that most women begin their pregnancy with generally negative attitudes towards childbirth and gradually became more knowledgeable and less negative. Leifer also raised the issue of the impact of expectations formed during pregnancy on the subjects' subsequent reaction to labour. She found that birth expectations varied with the type of preparation pregnant women had obtained. Their

preparation, in turn, was reflected in their childbirth experience. Those women who were most informed as to the process of labour were most satisfied with their experience, whether they chose to have a natural childbirth and had prepared through Lamaze training or to have a labour with little pain and planned to have a conductive anaesthetic. Since these women had accurate knowledge of the process, perhaps they had formulated realistic expectations. Women who wished to have natural childbirth, but had not received training, had the most difficulty in childbirth. "They had more complications and more induced labours. Subjectively, they reacted to childbirth as a difficult, negative experience" (Leifer, 1980, p. 140). These women tended to romanticize delivery during pregnancy. Their lack of preparation for natural childbirth might demonstrate a lack of realistic expectation development. Leifer's work supports a positive association between preparation, knowledge and the expectations developed as well as the outcomes experienced.

Expectations and Preparatory Information

Janis (1958) discussed the type of information which assists in realistic expectation development, stating,

> probably the most effective preparatory communications would be those which give a detailed factual account of the outstanding perceptual experiences that are most likely to occur, concentrating on the vague and ambiguous

> events that are the most likely to be misinterpreted. . . In general, there is probably little or no gain from giving any technical information which is not essential for conveying a realistic picture of what the patient will actually perceive. (p. 370)

Studies which have explored informational needs of patients support Janis' proposition. Johnson (1973) used an experimental design for his studies in a laboratory setting, while Hartfield et al. (1982) used a quasi-experimental design for their research in a clinical setting. Both studies examined the impact of sensation-oriented as opposed to procedure-oriented information on the expectations of individuals experiencing physically distressing situations. Both of the studies report that subjects receiving accurate information about sensations experienced less anxiety and distress during the procedure. Johnson (1973) concluded "that emotional response to a threatening event is affected by incongruence between the expectations and experience" (p. 273). "Sensational information may reduce emotional responses by decreasing the incongruence between what individuals report they expect to feel and what they report is actually felt" (Hartfield et al., 1982, p. 205). Lindsay et al. (1984) examined anxiety prior to a procedure. They suggested that anxiety prior to a procedure may be unnecessarily high, even when the procedure is understood, because of overestimation of the pain and anxiety while anticipating the treatment. The

study demonstrates that pretreatment anxiety can be reduced when accurate information regarding sensations is provided allowing realistic expectation development. Information about sensations enhances congruency thereby reducing the anxiety experienced during a procedure. As previously stated, realistic expectations are important since they influence the individual's interpretation and integration of an experience. Thus information about sensations would enhance the development of realistic expectations and reduce anxiety prior to and during the event.

No attempt has been made to examine these perspectives for the childbirth experience. However many studies have evaluated prenatal education and provide insight into the content of such programs. The findings of these studies are inconsistent. Some of the research suggests that the focus of prenatal education is procedural in nature. "Current programs that teach expectant parents the processes of normal labour serve an important function but do not appear sufficient to assist parents to cope with psychological conflict in pregnancy and anxiety in labour" (Lederman et al., 1979, p. 97). Stolte (1987) found that her subjects understood the events of labour, and that their expectations concerning the roles of other participants were met (procedure-oriented information). However, their expectations of pain and relief from it through the use of medications were not met (sensation-oriented information). Butani and Hodnett (1980)

also found many of their subjects' expectations concerning the pain, difficulty and length of labour were not met regardless of whether they had attended prenatal classes. Similar findings have been reported elsewhere. Astbury (1980) found that, although subjects with childbirth education were more knowledgeable and had formed expectations of labour, they did not have these expectations fulfilled significantly more often than women who had not received prenatal education. Furthermore, trained women were not significantly less anxious nor did they experience less pain during labour. Women whose expectations of labour had not been met were found to experience significantly more pain.

Lumley and Astbury (1980), in their book Birth Rites and Birth Rights provide a fascinating review of the historical attitude toward childbirth. They summarize the aims of childbirth education: "to provide women with information upon which they can form realistic expectations of labour, and learn successful techniques for coping with it" (Lumley & Astbury, 1980, p. 50). In their research they found little to support the claims of some childbirth educators that with appropriate training women will not experience pain and will be less anxious during childbirth. Lumley and Astbury (1980) report that,

> the trained women who felt that their expectations of labour had been violated expressed negative attitudes, including blame and failure, in the week after delivery.

> These feelings were turned inward upon themselves, as well as outwards to 'danger-control' personnel such as doctors and nurses. . . [They conclude] that it is psychologically dangerous to provide women with a model of childbirth which avoids all mention of pain and, furthermore, sees pain as a form of psychological failure. (p. 52)

Avoidance of the use of the term pain in childbirth education, suggests that women have not received information on the sensations to be expected during childbirth. This may explain the fact that women with prenatal education often have unrealistic expectations concerning the degree of pain to be experienced. One could conclude that prenatal education has focused mainly on the procedure-oriented rather than sensation-oriented information.

Such a conclusion is not supported by all the research. Proponents of prepared childbirth, (psychoprophylaxis, Read, or Lamaze methods) suggest that through training women can overcome fear and experience childbirth as a pain-free, very fulfilling experience (Lumley & Astbury, 1980; Vellay, 1972). Implicit in the findings of those who disagree is that prenatal programs provide information on sensation that results in the development of realistic expectations. Given the work by Janis (1958), Johnson (1973), and Hartfield et al. (1982), realistic expectations are most likely to develop when sensation-oriented information is provided.

Some investigators who have examined the effectiveness of prenatal education report that subjects with childbirth education experience less anxiety and reduced pain or its expression (Beck et al. 1980; Klusman, 1975; Enkin, Smith, Dermer & Emmett, 1972). Enkin et al. (1972), in a study that controlled for volunteer bias, report that "patients who took classes required less sedation, less anesthetic and less operative intervention than two closely matched control groups. . . . [Furthermore] the classes group reported significantly more favorable experience in labor and delivery" (p. 65). Zax, Sameroff and Farnum (1975),in a study which did not control for influence of volunteer bias, found that prenatal education did not reduce anxiety in expectant mothers nor reduce the length of labour. Prenatal education was associated with reduced anaesthetic use, increased desire expressed by the mothers to play an active role in labour, and more positive feelings toward the baby. Others have found that prenatal education impacts on awareness and correlates with more positive attitudes to childbirth and/or the newborn (Clark, 1975; Deoring & Entwisle, 1975; Doering, Entwisle & Quinlan, 1980; Leifer, 1980; Vellay, 1972). These studies suggest that childbirth education may promote the development of expectations, which may in turn be due to the fact that programs include information on sensations.

An area of prenatal preparation which has received little examination concerns the informal preparation of the

pregnant woman for her childbirth experience. Levy and McGee (1975) explored the relationship between the type of information provided by the mother of the pregnant woman on her perception of her subsequent labour and delivery experience. They found that women who had received moderately negative information evaluated the childbirth experience favorably and rated it as better than expected. Women who received extremely positive, extremely negative or no information from their mothers evaluated their childbirth experience unfavorably and described it as worse than anticipated. Levy and McGee suggest that moderate communication (positive or negative) encouraged the women to perform the work of worrying and in so doing, they prepared themselves for their labour and delivery. No communication, or extreme information (positive or negative), tended to encourage denial and in so doing, necessary realistic rehearsal of labour and delivery was impeded. Levy and McGee suggest that an effective method of determining the nature of a woman's expectations of childbirth is assessing her perception of her mother's labour and delivery experience. They recommend that prenatal education should be individualized based on these perceptions. For some women it would be important to reduce their anxiety while other women would require an increase in their anxiety in order to promote the work of worrying and the development of realistic expectations.

Summary

Janis (1958) found that extremely high and low anxiety levels in preoperative patients, was associated with inappropriate expectation development, and resulted in more negative evaluation of the experience. Likewise, the findings of childbirth studies suggest that extremely high or extremely low anxiety, resulted in poorer labour outcomes. One cause may be unrealistic childbirth expectations. "Expectations vary among women, as to how realistic they are, some expectations help a woman cope while others may cause anxiety and decrease her ability to cope" (Hubert, 1974, p. 99). Incongruence between the expected, and what is actually experienced, is a factor that has been identified in increased anxiety and negative reactions.

Research suggests that realistic expectations result in congruency between the expected outcome and the event, which in turn results in a more positive evaluation of the experience. Expectation formation and congruence are improved by the provision of accurate information regarding sensations. Although it is yet to be established whether prenatal education is actually providing appropriate information, it is accepted that one of the purposes of such programming is the promotion of realistic expectations.

The next section of this literature review will examine the research concerning differences related to socioeconomic

status, focusing particularly on studies of childbearing women.

Differences Related to Socioeconomic Status

Berger and Luckmann's theory of the social construction of reality provided the conceptual framework for understanding and studying social class differences. Their work, along with associated writings, was discussed in Chapter 1. In this literature review, research studies examining differences related to socioeconomic status are discussed. Studies which identify education, income, neighborhood or occupation as influencing factors are in fact identifying socioeconomic status as an influencing factor since all of these are used as a determinant of social status.

General Differences Related to Social Status

Evidence was found of differences between social classes related to attitudes toward authority, expression of opinion, and use of language as well as in issues of control.

Eysenck (1971) found the working class to be "more tough minded and more conservative" with regard to social issues, such as the punishment of crime, and more likely to favour an authoritarian approach (p. 201). Eysenck also found that the higher social classes demonstrated more strongly structured attitudes and showed less tendency to respond with 'don't

know' answers. The study contains a major flaw. It failed to consider differences between social groups in their verbal skills. The questionnaire contains many lengthy sentences with difficult words. The tendency for people of lower verbal skill (the lower socioeconomic population) to answer, 'I don't know' may not reflect unformulated opinions but rather a lack of understanding of the question. Therefore, Eysenck's results must be considered only suggestive, not definitive in nature.

A number of studies have examined differences between social groups in their use of language.

> Language is considered one of the most important means of initiating, synthesizing, and reinforcing ways of thinking, feeling and behaviour which are functionally related to the social group. It does not, of itself, prevent the expression of specific ideas or confine the individual to a given level of conceptualization, but certain ideas and generalizations are facilitated rather than others. That is the language-use facilitates development in a particular direction rather than inhibiting all other possible directions. (Bernstein, 1971, p. 43)

Bernstein and Henderson (1973) studied the "effect of social class position of the mothers on their perception of the role of language as a socializing process" (p. 27). They report marked differences between mothers of middle class and working class status in the use of language for the teaching

of skills and in the interpersonal realm. Bernstein and Henderson suggest that the reason middle class mothers emphasize the use of language in the teaching of motor, perceptual and manipulative skills is that they focus on the transmission of the principles underlying the skills in order to enhance autonomy. By contrast, working class mothers emphasize skill performance rather the principles underlying the skill. In the interpersonal context the middle class mothers demonstrated markedly more use of language and also more highly valued verbal exchange. Mothers from the middle class tended to verbally interact more frequently with their child, answering questions, explaining the reasons for behaviour and encouraging the expression of emotions.

Hawkins (1973) studied how children from middle class and working class backgrounds related the story from a series of pictures. He found that children from the middle class tended to be more elaborate and explicit in their communication which allowed the story to be understood outside the context of the picture series. By contrast the working class children made many assumptions, used considerably more pronouns and told their story in a fashion that required reference to the pictures. Hawkins stated that both groups possessed the same vocabulary but chose to use it differently. The finding that there were considerable differences between the type of speech produced by the two groups supports the theory that language differs according to the social status of the speaker.

Robinson (1973) studied the impact of mothers' communication on their daughters and found that "overall, mothers whose answers used language more powerfully and efficiently had children whose mastery of language was greater: maternal strategy, style, information and modes could be used to predict aspects of grammatical, lexical and contextual expertise in children" (p. 232). This study indicates that communication is taught primarily within the family and is distinctive to the family's social group.

Henderson (1973) also reported differences in the form of communication used according to social class. He states that this difference "simply reveals that subcultures or, indeed cultures, place a differential emphasis upon language in the context of socialization. The differences . . . point to differences in social function of linguistic communication" (p. 71).

Research studies have examined and found differences between social groups regarding their expectation for control (Garcia & Levenson, 1975; Rotter, 1966; Wallston et al., 1983). Rotter (1966) studied the issue from an external versus internal locus of control perspective, while Garcia and Levenson (1975) looked at the role of chance and powerful others (external locus of control). Both found that their subjects of lower socioeconomic status were more external in their locus of control, believing that their lives were controlled by chance. Other investigators have supported these

findings (Kumar & Tripayhi, 1986; Powell & Vega, 1972; Yuchtman, Yaar & Shapira, 1981).

Wallston et al. (1983) examined the relationship between an expectation for control over health and a desire for control over health. This research involved four distinctly different subject pools and included individuals: dealing with death, participating in a primary clinic, receiving prenatal care, and attending an ambulatory care facility. A wide range of age, income and educational preparation was represented in the sample. Wallston et al. (1983) report that,

> persons who believe their health is controlled by powerful others are less likely to agree with items advocating self-treatment, or with the active behavioral involvement of patients in medical care. Similarly, persons who believe that their own behaviour affects their health (internal locus of control), have more positive attitudes toward self-treatment and active involvement in their own care. (p. 381)

These findings demonstrate how such an internal versus external locus of control toward health held by an individual will impact on that individual's response to illness and treatment plans. The differences in expectations result in differences in the sense of responsibility and approach to health. In this study "the more highly educated the sample, the more they wished to participate actively in their own care" (Wallston et al., 1983, p. 383). These findings suggest

that individual differences are not randomly distributed but correlate with certain social factors such as education. The expectation for control over one's own health and its associated behaviour, is linked to social class.

Differences in attitude towards authority, expression of opinion, use of language and issues of control exist between social groups. Differences in attitudes toward childbirth have also been clearly documented in the literature.

The Influence of Cultural and Societal Differences on Attitudes Towards Pregnancy, Childbirth and Motherhood

Literature addressing cultural differences in childbirth practices suggests "the many variations in the ways in which human beings handle birth" (Newton & Newton, 1972, p. 151). The attitudes and beliefs of a given society affect both the expectations and interpretation of the birth experience (Homans, 1982; Hubert, 1974; McClain, 1983, 1987; Newton & Newton, 1972). One example of this impact of ethnic or cultural origin was observed by McClain (1987) who found the decision to have a repeat c-section correlated with ethnicity. Another example comes from Newton & Newton (1972) who observed that among the Navaho two words exist for the sensation of labour. One means labour alone while the other refers to pain of labour, permitting labour to be described in two ways and suggests that labour may or may not be painful. Thus, an understanding of vocabulary which embodies the cultural

expectations provides insight into the social attitudes of a group (Berger & Luckmann, 1967; Newton & Newton, 1972).

One reason for studying other cultures is to bring into focus one's own cultural attitudes and expectations. Most historical and anthropological writing and medical case reports assume a homogeneity in attitudes of a given culture. This assumption of homogeneity may be appropriate for cultures with little role differentiation. However, such assumptions have been demonstrated to be inappropriate in industrialized countries where specialization and role differentiation is well developed (Homans, 1982; Hubert, 1974). In such societies differences have been noted between groups within the culture. One example of such differences is in the medical as opposed to the maternal perspective of childbirth (Graham & Oakley, 1981; Lumley & Astbury, 1980; Lunenfeld et al., 1984). Graham and Oakley (1981) state that "doctors and mothers have a qualitatively different way of looking at the nature, context and management of reproduction" (p. 51), implying that a single maternal attitude exists. Other investigators (Homans, 1982; Hubert, 1974; Nelson, 1983; Reid, 1983) agree that medical and maternal models exist, but suggest that the maternal model is not homogeneous and that the differences correlate to social status. Women of lower socioeconomic status differ considerably, in childbirth beliefs and behaviour, from their middle class counterparts, as researchers from the Australia, Britain, Sweden and United

States have demonstrated (Cave, 1977; Homans, 1982; Hubert, 1974; McClain, 1987; Nelson, 1983; Reid, 1983; Rosengren, 1961).

Homans (1982) interviewed British and Indian women residing in London at their initial antenatal visit and again at eight months. She compared the attitudes of each group to the other and within itself. A number of issues were examined including: the status of women as reproducers, mothers, wage earners and managers of pregnancy, transition from pregnancy to childbirth, separation of parturient women from society, and reintegration of the mother into society. Since the British women's views were considered most relevant to this study, the review will focus on their attitudes. Homans (1982) does not state how she determined her subjects' social status but does state that "for British women, education and social class were highly correlated" (p. 232). She compared the attitudes of women of middle and lower class status and found many differences. Voluntary childlessness as a viable alternative to motherhood was primarily restricted to white middle class women. Reasons for seeking work outside the home showed differences related to socioeconomic status. Only working class women stated economic necessity as a reason for working outside the home. Another reason given for working focused on issues of identity and was expressed quite differently by women of middle and lower socioeconomic status. Women of middle class status expressed this in terms of career

while their counterparts stated they were "fed up with being a Mum" (Homans, 1982, p. 237). "It would appear that it is mainly the British middle class women who derived status from work outside the home . . . lower social class women tended to work outside the home because it was economically necessary" (Homans, 1982, p. 240). The majority of women in both classes felt it was their duty to stay home and look after the children.

Since attitudinal differences associated with social status were evident throughout this study one could assume differences also existed in the area of labour expectations. Unfortunately, Homans (1982), in her discussion of preparation for and concerns about labour, generally failed to identify the impact of social status. She does report that the professional and lay advice given to women often depended on social class and that communication problems between health care professionals and pregnant women were also related to socioeconomic status. "The more traditional women . . . seem to accept that childbirth in Britain should be set apart from home, family and friends whilst the less traditional women are wanting to share their birth experiences with others from their personal social circle" (Homans, 1982, p. 257). Traditional values are associated with lower socioeconomic status (Eysenck, 1971). Although Homans failed to report the relevance of membership in a specific social class to being 'traditional' one could assume a relationship exists. This

failure weakens her proposition that in "pluralistic, industrial societies, the transition experiences women have, and their responses to them, depend to some extent on social class . . . "(Homans, 1982, p. 231). Clearly she believes his work supports the argument that more than one maternal model of childbirth exists, since she concludes that "to become a mother has different meanings to women in industrial society, depending on their social class . . . " (Homans, 1982, p. 260). This demonstrates how social classes express different beliefs and rituals and had a different relationship to the medical establishment concerning childbirth and the maternal roll.

Hubert (1974) examined the attitudes and expectations of women living in South London. Using an intensive interviewing technique she focused solely on women of lower socioeconomic status. Hubert (1974) supports the suggestion that maternal and medical models exist and proposes that ideas and beliefs "are not consistent or homogeneous even within one social class" (p. 50). Hubert's research included a wide range of subject areas. Over two thirds of the pregnancies were unintentional and unwanted. A wide diversity of beliefs concerning conception and birth control were held. Many of the women stated in the postnatal period they did not want another unplanned child, but they also were still using the same ineffective non-method of birth control. A lack of knowledge about the normal symptoms of pregnancy was displayed and many

were treated as marginally ill by their families. A widespread ignorance of labour was also evident even among the women who had attended classes since the classes "assumed too high a level of sophistication and knowledge. . . . Although not particularly concerned with labour prenatally, in a number of cases the onset of labour began a protracted period of bewilderment and fear" (Hubert, 1974, p. 44). The vast majority expressed a desire for the support of their mothers, not their husbands. Motherhood was usually not realistically conceptualized with the expected baby often thought of as a doll.

Nelson (1982b, 1983), working in the north eastern United States, primarily used education as the indicator for social class. Women, "whose highest level of education was a high school diploma, were included in the 'working class' category; anyone with an educational level of at least 4 years of college was included in the 'middle class' category" (Nelson, 1982b, p. 341). Those who fell between were classified on the basis of their jobs. A comparison was made between the attitudes of women from each social group who had not attended prenatal classes to determine if different attitudes toward childbirth existed between the two groups.

Some differences were found. "Working class women were more likely to say that they found the information offered by doctors, mothers, spouses, and relatives 'very important' than were middle class women" (Nelson, 1982b, p. 343). Unlike their

middle class counterparts, working class women were not convinced of the merits of natural childbirth and did not anticipate every step of the birth process. Differences between the two groups were reflected in their prenatal plans. Women of middle class status: preferred less intervention, chose active involvement in the birth, wanted to have a support person with them, planned to breast feed, and to have the baby with them for extended periods of time (rooming in). At the birth, each group's prenatal plans tended to be fulfilled with women from the working class receiving much more intervention. One attitude which was viewed similarly by both groups was the importance of the childbirth experience in terms of its impact on the parent-child relationship.

The attitude toward childbirth classes was also examined. Nelson (1982b) found that "80% of middle class women attended childbirth classes or intended to do so. Only half of the working class women chose formal preparation for childbirth" (p 342). The responses of working class women who had attended prenatal classes were compared with the responses of women of the same socioeconomic background who had not attended classes. The impact of prenatal education classes on the attitudes of women of the middle class was studied in the same manner.

For working class women the advice of others was less important and the birth experience was more highly valued after attending preparation classes. Working class women who

had attended childbirth classes also had much more concrete and detailed plans for birth, and at the birth, tended to use less medication and have a support person with them more often than their unprepared working class counterparts. Although the decision to breast feed was more likely for prepared, versus unprepared, working class women they were still less likely to breastfeed than either prepared or unprepared middle class women. An increased commitment to natural childbirth was noted in all women who had prenatal education. Nelson (1982b) concluded that,

> The attitudes and experiences of middle class and working class women appear to converge as a result of this training, but differences between the two groups remains. . . . Our data tend to affirm the persistent importance of social class as a variable in the sociological analysis of health related activities, despite the fact that most recent work in the field of childbirth has minimized this factor. (p. 350)

The differences between working and middle class women led Nelson (1983) to propose that two client models exist that are distinct from each other and from the medical model. These models develop out of the different contexts in which each group of women bear children. Nelson (1983) suggested that the middle class model of childbirth has its roots in: the social movements of feminism, consumerism, natural childbirth and back-to-nature romanticism. All of these movements have had

more relevance to middle class women, with their understanding of self control and the right to make choices. The middle class plans their pregnancies to balance the ideas of family size, career, child care and social concerns. They also have money, mobility and a greater ability to obtain information and make choices. These movements have had less relevance for working class women because they have less sense of control over their lives. Their pregnancies are more often unplanned and their financial resources are limited. Subjects of lower socioeconomic status in this study lacked control over other aspects of their lives including which medical practitioner will see them. Although all women in Canada, because of universal medical care, can determine their medical practitioner, other aspects of their life are subject to external control. Women on social assistance not only have limited incomes, but also have restrictions placed on its use. Those realities reinforce their belief in external control. Nelson (1983) concluded "childbirth is a biological experience mediated by class position. We have to learn more about what women at different locations in their social structure want rather than pass judgement on what they do" (p. 296).

Like Homans (1982), Hubert (1974) and Nelson (1982a, 1982b, 1983), Reid (1983) found women of lower socioeconomic status had attitudes and expectations which differed from those of women of a middle class background. These subjects from Glasgow often expressed views which "at times were in

direct contradiction to those presented [by middle class subjects] in preceding birth studies" (Reid, 1983, p. 87). Her subjects felt that birth was not an event to be anticipated but something to be 'got through'. Their different expectation of the experience affected their evaluation of the event. Like others, Reid identified that these women had less concern regarding the use of medication and that some even expressed concern over possibly being denied it. The whole issue of control over one's body, or the event, was a non-issue for most of Reid's subjects.

In a study of pregnancy as illness or normality Rosengren (1961) found a relationship between a women's social status and her concept of pregnancy. In this study social status factors such as income, education and occupation were used to determine social status. Through semi-structured interviews the subject's role expectations during pregnancy were determined. A low "sick role" score was assigned if the women: did not expect to be exempted from usual social responsibilities, did not feel pregnancy was a condition to "get over", did not worry about organic complications, and did not accept pain and suffering as an expected part of the condition. Women of middle class status were found to have low sick role scores and were relatively rejecting of a subordinate role to the attending obstetrician. "Women of low socioeconomic status tended to regard themselves as more 'sick' and [were] more inclined to act 'as-if' they were sick

than did women of higher socioeconomic status" (Rosengren, 1961, p. 267).

Studies related to preference in delivery method further confirmed differences between social groups. In a retrospective study, Cave (1978) examined differences among American women in their preference for natural childbirth. Three groups were identified: natural childbirth adopters, non-adopters using spinal or general anaesthetic, and non-adopters using local or no anaesthetic without reference to natural delivery. Considerable differences were identified between adopters and non-adopters. "Adopters were, on the average, two years older than non-adopters . . . had more college education . . . showed a higher average income; and the husband's education and the average socioeconomic index score were significantly higher . . ." (Cave, 1978, p. 899).

McClain's (1987) study of patient decision-making focused on the choice of delivery method after a previous cesarean section. Two thirds of her subjects chose a trial of labour while one third chose repeat c-section. It was found that membership in a minority ethnic groups and lower education were the only factors which were significant in determining choice of delivery method.

Norr et al. (1977) examined factors that impacted on the level of pain and enjoyment of childbirth. They found "women of higher social status, less traditional attitudes toward sex roles, and greater marital closeness are more likely to

prepare for childbirth, to have husband's help during labour and delivery and to have less pain and more enjoyment during birth" (Norr et al., 1977, p. 260). Socioeconomic status was named as one of the variables with a strong positive correlation with enjoyment although not with pain.

The impact of social class on childbearing was addressed by Beck et al. (1980). These researchers examined the prediction of pregnancy outcome using three factors: maternal preparation, anxiety and attitudinal set. A variety of outcome measures were used from pain in labour to apgar scores. Beck et al. found that class participation was positively correlated with socioeconomic status and "class participation and maternal attitudes were found to be significantly predictive of pain ratings during labour. . . . [As well] social class and maternal attitudes were predictive of patient manageability during labour" (p. 344). These findings indicate that childbirth is experienced differently by women of lower and middle class status.

In a study of 200 Australian women who had delivered a child within the previous year, Westbrook (1979) used neighborhood of residence and husband's occupation to determine socioeconomic status. She found that socioeconomic status was significantly associated with differences in attitudes and coping styles among the subjects. Although working class women were generally positive about motherhood, they showed less ability to cope, and experienced greater

stress than middle class mothers. Their coping strategies took the form of avoidance and fatalism rather than the techniques of confrontation and information seeking practiced by middle class women.

Summary

All the above named studies support the theory that significant differences exist between social groups in their expectations and experiences of childbirth and early motherhood. Women of lower socioeconomic status tended to display the following characteristics: They were more traditional in their attitudes and were perceived as more externally controlled or fatalistic than were women of the middle class. Their pregnancies tended to be unplanned and were viewed as an illness. They were less likely to attend prenatal classes, and were more likely to want medical interventions. Childbirth was more stressful and was viewed as an event to be endured rather than experienced. Early motherhood was also more stressful. These differences have resulted in different childbirth models related to socioeconomic status. Homans (1982) states,

> It is important to discover how far experience conforms to expectations, when and how these expectations are acquired and how far they are confirmed by what actually happens, since this affects a new mother's behaviour, her relationship

> with her baby and fundamental early decisions regarding it. (p. 40)

This statement confirms the need identified by Nelson (1982b, 1983) and Reid (1983) for further studies of the lower socioeconomic population. A more in depth understanding of the expectations of childbirth and the language used to express them is needed if communication between the lower socioeconomic population and the medical establishment is to improve.

Readability

The problem of ineffective verbal and written communication between medical personal and patients has been the focus of much attention for over 25 years. The difficulties of verbal communication are increased in the written format since there is no opportunity to clarify or to correct misunderstandings. Problems of communication related to limited literacy is an issue that can not be ignored since it impacts negatively on health (Health Promotion, 1989). Literacy has been linked with educational level and is therefore a more prevalent problem among people of lower socioeconomic status.

Karp, Silbermen and Winters (1969) studied cognitive functioning among boys and adults of lower and middle socioeconomic status. They found that social, occupational and

economic status measures are not related to cognitive abilities. Significant differences however, were found in language comprehension tests. These findings suggest that while mental ability is not linked to social status, use of language is socially linked. This research supports the proposition that written material be assessed for readability before it is used.

A two fold problem exists in the selection of appropriate material for clients. One is to establish the reading ability of the client and the other is to establish the readability of the material. Establishing reading skill level is difficult in an adult population. Development and use of reading skill tests suitable to adult populations in a health care setting has received little attention. Last completed grade is not highly correlated to ability to read (Eysenck, 1971; Irwin & Davis, 1980; Meade & Bird, 1989; Mohammed, 1964). However, short of doing reading tests on clients, it is the most effective and appropriate method to determine skill.

Meade and Bryd (1989) found that among their subjects the mean difference between reading ability as measured by wide range achievement test (WRAT) and last grade completed was 3.8 grades. In their sample the average grade achieved was grade 10 while the average level of reading ability was determined to be grade 6. This discrepancy indicates that reading difficulty of material needs to be much lower than the average level of education among the target population would suggest.

Establishing the readability of material has for some time been a matter of great interest to educators. The goal has been to establish the degree of difficulty of the work. Educators use formulas to assess books according to the ease with which a reader can grasp and understand the meaning of the passage. They then assign a grade level to the work. While each of these formulas have strengths, they have been tested primarily on school populations and are most useful when applied to material for that group.

Length, format and vocabulary of written materials have been identified as factors associated with reading level. "The most powerful determinants of prose difficulty are vocabulary (whether the words used are familiar or unfamiliar) and syntax (whether the grammar of the sentence is simple or complex)" (Nicoll & Harrison, 1984, p. 597).

Studies examining the client's understanding of commonly used medical vocabulary represent different perspectives. One such study, interested in oral communication, avoided the problems of literacy by having the interviewer read the questionnaire to subjects (Samora et al. 1961). Each word to be defined by the subject was identified, then used in a statement to provide the appropriate contextual clues available during conversation. The sample included individuals with a below average educational level, a large percentage of persons being from minority groups and of lower socioeconomic status than the general public.

Another study, using a written format, examined problems of vocabulary in printed material (Cole, 1979). Cole selected words not explained in the text or glossary of selected health education materials. In order to provide contextual clues each word was given in the sentence in which it originally appeared. Four possible definitions plus an 'I don't know' option were listed. The results were similar with no one identifying all the words correctly despite the fact that Cole's sample included individuals from both low and high social classes. The results suggest that "it should not be assumed that people of high educational level are necessarily familiar with medical words, and thus the level of readability, in terms of medical vocabulary, should be under rather than over estimated" (Cole, 1979, p. 120). Both studies found that problems of misunderstanding are increased when individuals are from a lower socioeconomic environment and/or have less formal education.

A number of studies measuring the readability of health materials have demonstrated the problem of -- and the need to assess -- the readability of this literature. Bakdash, Odman, and Lange (1983) examined twenty periodontal health education materials. Using the Minnesota Interactive Reading Approximation Program (MNIRAP) the educational grade level of each item was assessed. Three of 20 could be understood by individuals with a sixth grade reading level. Seven of 20 required a reading level of grade 10. A third year college

reading level was required by the rest. Richwald et al. (1988) report that most written instructions provided by condom manufacturers required at least high school reading level and none were suitable at less than a grade 10 level. In this study three reading formulas were used, the Dale-Chall Formula, Fry's Reading Graph and SMOG Grading Formula. Zion and Aiman (1989) used the SMOG formula to assess reading difficulty of 74 pamphlets developed by the American College of Obstetricians and Gynecologists (ACOG) Committee on Patient Education. Sixty-one of the 74 pamphlets were estimated to be at a grade 11 or higher reading level. The mean reading difficulty was "about four years beyond the mean literacy level of grade eight" (Zion and Aiman, 1989, p. 958).

Other studies took into consideration not only the level of difficulty of the literature but also tested the reading level of their subjects. Mohammed (1964) tested the reading comprehension level of clients attending a diabetic clinic by having them read test paragraphs and then answer four questions regarding the paragraph. The grade level of each paragraph was determined by the Dale-Chall Reading Formula. He found the average educational level of clients was at a grade 6.8 level while the clinic's written material was assessed to be at an eighth grade level. This meant that only 22% of the clinic's pamphlets were understandable to the population it served. Meade and Byrd (1989) evaluated 49 smoking education booklets and found they ranged from grade 3 to

scientific/professional level. They used six different reading formulas (Dale/Chall, SMOG, Raygor, Fry, FOG, Flesch) in assessing the literature and found a high correlation between the results. For the purposes of comparison they selected the SMOG formula. Using SMOG the mean reading level of the literature was estimated as grade 10.5 with 80% of the booklets written at a grade 9 or higher level. Reported years of schooling ranged from less than grade 3 to above grade 12. The median reading level of the sample, when determined by years of schooling, was 10. However, when a reading test (WRAT) was conducted the median level of skill was found to be grade 6. "A serious disparity existed between the reading levels of patients and the reading estimates of smoking literature" (Meade & Byrd, 1989, p. 205).

Despite the value of formulas for estimating readability an over dependence on them has been criticized (Nicoll & Harrison, 1984; Pichert & Elam, 1985). Formula limitations need to be recognized. Reading formulas tend to evaluate material on the number of polysyllabic words and/or sentence length. Comprehensibility of material is more than these two factors. Many short words also present difficulty, for example, 'thus, germ and virus'. Incorporating a definition may correct problem words. However, sentences that include a definition of technical words automatically raise the reading level despite the fact that this increases understanding. Conversely, understanding may actually be reduced when

splitting long sentences as it "may force the reader to make inferences where the longer sentence explicitly stated a relationship" (Pichert & Elam, p. 187). Another problem with reading formulas is that the reader's interest and life experience are not taken into account. Finally, "these formulas. . . . have never been validated on real patients using educational materials designed for them and their medical condition" (Pichert & Elam, p. 186). Most have been tested on school children and therefore may not be appropriate for adults. "There are no substitutes for the more rigorous tests of patient comprehension and acceptability . . . Field tests using printed material with the target group are the surest guide to comprehension . . . " (Nicoll & Harrison, p. 599).

Conclusion

This literature review has demonstrated the importance of expectations on experience. It has been shown that information on sensations, rather than information on the procedural aspects, assist in the development of realistic expectations. Expectations which were realistic were found to positively correlate with outcomes such as satisfaction with the experience. Expectations regarding pregnancy, childbirth and motherhood have been the object of study. Research is needed to improve understanding of the nature and development of

childbirth expectations. The Childbirth Expectation Questionnaire (CEQ) could be used in this research. Before it is used among women of lower socioeconomic status it needs to be evaluated. The literature indicates that readability of written materials is a common problem especially for those with limited education. The literature also indicates that differences exit between social groups in their childbirth expectations and use of language. Therefore, the CEQ may not be conceptually or linguistically appropriate for use among women of lower socioeconomic status. The CEQ needs to be assessed for relevance, readability and acceptability before it can be used among this population.

CHAPTER 3: METHODOLOGY

The intent of this study was to collect information on the expectations of childbirth held by women of lower socioeconomic status and obtain their suggestions for changes to the CEQ to improve its applicability to this population. The study was divided into two phases, the design phase and the study phase. An exploratory descriptive design was chosen, and a convenience snow ball sampling method was used.

This chapter will discuss: subject selection and recruitment, ethical considerations, research setting, instrumentation, and the design and procedure used in data collection and analysis. Finally, the limitations of the study will be addressed.

Subject Selection and Recruitment

A convenience nonprobability sampling method was used in both phases of this study. Female volunteers who met the following criteria were included:

1. between 18 and 40 years of age
2. completed less than grade 12
3. receiving social assistance or equivalent income
4. pregnant or have had a child

5. spoke English in the home
6. resided in Canada for more than 10 years and were currently residing within the city of Winnipeg.

The rational for each of these criteria will be briefly discussed.

Women over 40 were excluded for two reasons. First, because of generational differences their views may not have been representative of the majority of childbearing women in their social group. Second, a number of years would likely have elapsed since their first childbirth which would probably reduce their ability to recall the experience in the detail required. Although some of the subjects had given birth to their first child prior to the age of eighteen, it was important to the investigator that the subjects be able to discuss the experience from an adult perspective. Therefore, women under the age of eighteen were also excluded.

Criteria two and three were included to ensure that subjects were members of the target socioeconomic group. The classification of individuals into socioeconomic groups may be done using a number of criteria including material possessions, housing district, occupation, income, education, or any combination of these (Abramson et al., 1982; Graham, 1984; Morgan, 1983; Nelson, 1983; Westbrook, 1979). Abramson et al. (1982) suggest that the use of multiple criteria is a preferred method of establishing membership in a given social group and state, "the choice of indicators should be

determined by practical considerations and by the conceptual framework . . ."(p. 1739). Morgan (1983) discusses the advantages and disadvantages of the different measures for determining social status and suggests balancing the relative strengths and weaknesses of the classification systems in relation to three factors: the objectives of the study, the age and composition of the population to be studied, and the ability to collect the needed data for classification. Material possessions and housing were rejected as indicators because the investigator thought that it would be difficult to collect the needed data. Establishing an individual's material possessions would require questioning that might be considered prying, whereas, housing districts lack specificity because many neighborhoods are of a mixed nature. Occupation was also rejected. Women who work at home are not given a category on the occupation scales. In addition, women from the social group of this study who wish to work outside the home are often unable to find employment. Using the occupation of the husband/partner was not considered an appropriate alternative for a number of reasons. Many women in the target population do not have partners. Among those who do have partners there were problems associated with using the partner's employment status. Unemployment is high among the men in this social group making the use of this classification scale impossible. In addition, many of the women were supported by the financial assistance program. One of the regulations of this program is

that all household income should be reported. To avoid loss of benefits, women and their partners either maintain separate households or do not report their cohabitation. Given the sensitivity of the issue, collecting accurate data on the occupational status of the women's partners was considered impractical. Finally, the appropriateness of the practice of determining a married woman's status by her partner's occupation has been questioned (Delphy, 1981; Morgan, 1983). One cannot assume that the partners' occupation and social status reflects the social status of the woman. Since women are traditionally the caretakers of health, it has been suggested that the women's social status, as measured by education, or her occupation, or the social class of her family of origin, is a more appropriate measure of class than is the husband's occupation in studies of health issues (Graham, 1984; Morgan, 1983).

The woman's education and income levels were chosen as dual indicators of socioeconomic status in this study. They were considered both the most practical and relevant criteria to use, as well the most conceptually appropriate. "Education is viewed as a particularly sensitive indicator of individual attitudes and behaviors and for this reason is often employed as a social classification in studies of the uptake of preventative health services" (Morgan, 1983, p. 121). Educational achievement was considered an accurate and useful indicator of social status by Nelson (1982b) in her research

into the childbirth expectations of women. An advantage of using education as an indicator rather than the woman's income or occupation is that it avoids the problems associated with the fact that many women do not have jobs commensurate with their educational achievement and/or are employed in female dominated occupations that are traditionally poorly paid.

Income level was included as a second indicator because, while income alone may not reflect social status, a low income combined with a low education level was considered a more accurate method of determining the social status of subjects and has been used in similar research (Nelson, 1982b).

The investigator wanted to study expectations of childbirth as well as the language of the CEQ. Only women who had delivered a child or were pregnant were considered to have the experiential knowledge necessary to respond to the study questions.

The language requirement was important because the investigator was fluent only in English and the CEQ is an English document. The investigator was not interested in examining cross cultural issues but rather differences within a culture as determined by social status. The language spoken is indicative of the cultural group with which one associates. Therefore, women who preferred to speak a language other than English at home were excluded from the study to reduce the effect of differences in culture. In fact, these differences could not be entirely eliminated since women of Native, Metis,

as well as European and other cultural backgrounds could meet the inclusion requirement. While recognizing that each of the above named groups are culturally unique, the extremes of cultural differences were considered sufficiently controlled by the language and residency requirements. Wishing to control extreme cultural differences, the investigator did not wish to restrict excessively the population from which the sample could be selected for the study. To make selection criteria too narrow would result in a sample that did not represent the diversity of the lower socioeconomic population.

The requirement of 10 years in Canada was used to ensure basic acculturation of immigrant women. This criteria, combined with language in the home, was used to screen out major cultural differences within the sample. In fact, all of the subjects were born in Canada. Finally, the restriction of residence within the city of Winnipeg was included to make visits in the home possible.

The study included two phases as figure 1 illustrates.

	Data Collection Method	Data Collector	Sample	Setting	Analysis
Design Phase	In-depth interviews; individual & group	Investigator	1st year students from community college special program	Community college	Content analysis Design of study phase - order of interviews - approach - instrument revisions
Study Phase	In-depth individual interviews	Investigator	Multiple access routes used. - community clinic & investigator's personal network	Interviews in setting of choice - clinic home restaurant	Qualitative compilation of suggested modifications to CEQ.

Figure 1. Phases of the Study

Recruitment--Design Phase

The objective of the design phase was to determine a suitable design for the study phase. The investigator hoped it would also provide insight into the problems that might arise during the study and assist in developing strategies to prevent or handle problems.

Students enroled in a special nursing program at a local community college were approached for the design phase. This special three year program targets individuals with educational, financial and social needs and is structured to assist them in overcoming their previous educational disadvantage and thus facilitate their obtaining a nursing

diploma. All students in this program receive financial assistance. Many have not completed grade 12. The few who have grade 12 do not have the subjects to meet entry qualifications in the regular nursing program at the college.

Only first year students in the special program were invited to participate in the design phase. They were considered to have experienced less secondary socialization than second or third year students and therefore, would be better able to provide the desired insight in designing the study phase.

At the end of a regularly scheduled class the instructor introduced the investigator and departed. The study was explained (Appendix C), the inclusion criteria reviewed (Appendix D), and the invitations to participate were distributed (Appendix E).

In the design phase women without children were allowed to participate. The assumption was that these women could provide valuable insight into design issues. Since the childbirth expectations of these participants were not being studied, elimination of women without children was considered an unnecessary limitation. Apart from this, the inclusion criteria for both phases was the same to ensure group similarity.

To prevent undue pressure to participate the students were told that the names of those participating, and any information shared, would be kept confidential. It was also

explained that the data collected would be combined, and no identifying comments would be used in reporting the results of the study. The investigator specifically stated that the students' instructors would not be told who participated and that their choice to participate would in no way affect their studies at the college. A convenient time and place for the meeting was agreed upon by the class. All who met inclusion criteria were urged to participate. All but four of the 12 eligible students completed and returned the section of the invitation indicating their decision regarding participation. These four students were undecided and wished to keep the response sheet. They were encouraged to think about participating and to contact the investigator with their decision or to just come to the group discussion. The investigator and students decided that any change to the agreed upon time and place would be relayed to the class by the instructor. In this way those interested would receive the information without being identified as participants. Since only three of the 12 eligible students committed themselves to participating in the study, the investigator suggested that any of those who met inclusion criteria could come to the meeting, even if they had not signed up.

Scheduling problems arose and the interviews were delayed. The participants were contacted and arrangements were made to meet them individually wherever and whenever it was convenient. All but one chose to meet with the investigator at

the clinical setting where they were receiving exposure to the practice of nursing. First year students from the college who were also assigned to the given clinical setting, but had not signed up to participate in the study, agreed to do so when they were invited to participate a second time. The investigator considered this increased participation very beneficial as it provided greater depth and insight for the design of the study phase.

In this manner the assistance of a convenience, non-probability sample of six first year nursing students, who were of similar socioeconomic status as the target population for the study, was obtained.

Recruitment--Study Phase

The purpose of the study phase was to collect data on the childbirth expectations of lower socioeconomic women, and to specifically evaluate the appropriateness of using the Childbirth Expectation Questionnaire (CEQ) within this population.

The fifteen study subjects were recruited from the community of Winnipeg in four ways. The first was through a community health clinic located in the core area of Winnipeg. Nurses working in the clinic identified clients whom they thought met inclusion criteria. They would then briefly discuss the study with these women (Appendix F) and ask if they were willing to participate. This request was often met

with shrugs and comments like, "I don't care". The nurses were aware that in this population, this was a positive response, and would introduce the investigator, who was waiting nearby. After the investigator provided a more complete explanation of the study (Appendix G), women were given assurance that they would not lose their position in the queue for the physician, and that their responses would be kept private. In addition, they were told how the data would be used. The women were again asked if they wished to participate (Appendix H). All of these women agreed to participate. Despite the often vague, noncommittal response to the invitation to participate, the women at the end of the interview frequently made positive comments about the interview. Some actually said that they liked to give their opinion and were glad to participate. Four of the nine subjects from the clinic indicated this by returning to extend the interview after having seen their physician. Each subject was shown where the investigator's name and phone number was on the explanation of the study. They were asked to contact the investigator if they had any friends or relatives willing to meet with her. None of the women interviewed at the clinic contacted the investigator.

A second means of accessing the target population was through the students who had participated in the design phase. Each was asked to contact friends and relatives who met selection criteria and to ascertain whether they would be willing to meet the investigator. If they were, then the

student was to contact the investigator and a time when the student could introduce the investigator to her friend would be set. Many of the target population have no phone and limited literacy. Therefore, personal introductions were considered the most reliable means of ensuring contact. None of the students provided subjects for the study. It was probably unrealistic to expect individuals in a state of status transition and coping with changes in their personal relationships to further strain these bonds by asking their friends to participate in a research study.

In the third and fourth approach the investigator used her informal personal network to contact individuals that might meet inclusion criteria. Six of the seven interviews conducted with individuals contacted through this method met inclusion criteria. In the third approach, the investigator contacted individuals who she personally knew. Using the same format outlined above, she explained the study and the use of data obtained from the study. She obtained verbal consent to participate, and arranged a convenient time and place of meeting. Before beginning the meeting, questions about the study were solicited and answered. After again receiving verbal consent the discussion began.

In the fourth approach, the investigator contacted persons who knew women who met the inclusion criteria. The individuals of this group were given a preliminary explanation of the study by the contact person and were asked if they were

willing to meet the investigator. The investigator contacted the names provided and, using the same method described above, conducted interviews. The investigator made it very clear, to the potential subjects, that their decision regarding participation, and their comments, would be kept confidential. She specifically stated that this information would not be shared with the individual who first approached them. This was done to prevent the women feeling undue pressure to participate in order to please the person who suggested their names.

The use of multiple access routes was planned to reduce the time required for data collection and to give the study a broader sampling base. The investigator found that interviews conducted outside the clinic were not as inhibited by the time factor. This allowed the investigator to explore in some depth ideas that had surfaced in clinic interviews but, because of time constraints, had received limited attention.

In this manner, a convenience, nonprobability, snowball sampling method was utilized to obtain a sample. In total twenty-two interviews were conducted. Despite efforts to screen participants it was impossible to know fully if a woman would meet all inclusion criteria. The order of data collection recommended by design phase participants placed the collection of sociodemographic data to the end of the interview. This meant that a number of interviews were conducted on women who failed to meet inclusion criteria,

making the interview data unusable for this study. Fifteen met inclusion criteria. Of the seven that did not, six had completed grade twelve and one was employed and had an income well above the levels received on social assistance. Of the fifteen, nine were contacted through the clinic and six through the third and fourth methods outlined above.

Ethical Considerations

Ethical approval was obtained from the University of Manitoba School of Nursing Ethical Review Committee prior to the implementation of this study. Written approval was obtained from the director of the local community college program before contact was made with nursing instructors and students. Written approval was obtained from the director of the health clinic to conduct the interviews at the clinic. A thorough explanation of the study was provided to the nursing staff at the clinic to ensure their understanding and cooperation before clients were approached.

In the design phase undue pressure to participate was prevented by having the instructor leave the room before the investigator explained the study to the students and requested their participation. The names of those participating and their responses were not shared with college staff. In addition, the importance of confidentiality and anonymity was explained, and members of the class were requested to not

share information outside the discussion. Written consents were obtained before interviews began (Appendix J).

In the study phase undue pressure to participate was reduced by arranging for subjects to be approached by an intermediary, whenever possible, who obtained their oral consent to meet the investigator. The nature of the study, along with the right to withdraw at any time and to not answer any particular question, was explained to all subjects. The means by which confidentiality and anonymity would be maintained were also explained. A written explanation of the study was offered to each participant. After questions were solicited and answered, informed oral consent was obtained. Consent was confirmed in writing at the end of the interview. All subjects voluntarily participated. Codes were assigned to each respondent and at no time were their names associated with the interview data. Only the researcher and thesis advisor had access to the raw data which was stored in a locked drawer. A summary of study results was offered to all who participated (Appendix K).

No experimental conditions were involved in this study and no harmful effects were anticipated. However, four possible negative effects on participants were anticipated. These included: fatigue, anxiety related to the recalling of unresolved previous experiences, the undermining of a woman's self esteem, and an increased fear of labour. Each was dealt

with carefully to ensure that no lasting negative effects resulted from participation in the study.

Since the interviews were quite lengthy, breaks were suggested and in two cases the interview was continued at a second meeting. No portion or segment of any interview was allowed to last more than 2.5 hrs.

A number of the women interviewed had not resolved their experiences of labour and delivery as evidenced by the anger associated with telling their story. These women seemed to have a need to talk in great detail about their experience. The investigator listened and allowed these women to work through the experience without suggesting that much of what was said was not on topic. The women frequently provided their own explanations and insights into the reason for their troubling experience. Sometimes they asked the interviewer to explain why incidents had occurred. The investigator answered questions regarding the process of labour and explored ways the woman could ensure she received more explanation next time. The interviewer did not move onto another topic until the woman indicated she wished to do so.

To prevent threatening a woman's self-esteem the investigator made use of a number of approaches. She made it clear that the CEQ was flawed and that she really wanted their help in correcting it. The need to change it extensively before using it in the general population was emphasized. The women were not asked if they understood items themselves but

rather were asked if they thought their friends or relatives would understand. The data was collected orally and no reading was required. This prevented embarrassment related to limited literacy. In discussing the CEQ the investigator also offered a number of alternative words to overcome difficulties related to the vocabulary of the questionnaire. The interviewer was careful not to become defensive about criticism of nurses, research, or the tool. She laughed with them over what they termed as "silly" in the questionnaire and in the interview process. These efforts were very successful and even the woman who at the beginning of the interview referred to herself as a dummy left 2.5 hours later buoyant and offering to meet again. Many stated that they thought that this kind of work needed to be done and were pleased to have helped.

Increased fear of labour was mainly a problem with women expecting their first child. Many of the students in the design phase felt that only limited information should be given to "first timers" to prevent frightening them. The CEQ contained much information that was not generally shared and which was viewed as "scary". Understanding this, the investigator watched carefully for signs of fear. Explanation and teaching was done where appropriate even if this meant not being able to collect as much data. Information on prenatal classes was also given.

If any serious concerns had arisen through the interview process, a referral to appropriate community resources would have been made with the subject's consent.

When considering the ethical implications of this study, the investigator was particularly influenced by authors interested in the research of women such as Ann Oakley (1981), Janet Finch (1984) and Hilary Graham (1983). These investigators have focused on the problem of ethics in the research process. They suggest that traditional survey methods may be inappropriate and inadequate for some studies and recommend changes that allow the goal of truly grasping the subjects point of view to be met. Traditional survey method categorizes life experiences imposing relationships on events, and restricting responses to set predetermined categories. These relationships may not represent the subject's reality. If one is not truly representing the subject's reality (with the use of the survey method), then one is misrepresenting them. Therefore Oakley (1981), Finch (1984), and Graham (1983) recommend in-depth interviewing.

Oakley (1981), Finch (1984), and Graham (1983) view the relationship between the investigator and subject differently from the scientific ideal of the uninvolved impartial investigator. They accept that the investigator is the data collecting tool and as such must be involved. Oakley (1981) and Finch (1984) describe a collaborative approach between the investigator and the participants. They recommend a more equal

relationship between subject and interviewer, than the traditional approach, and suggest the interview process should be mutually beneficial. They suggest that the collaborative approach is not only more ethically acceptable but also produces better research by providing data of higher quality which more accurately reflects the phenomena being studied. This is due to the data being collected in a manner that is more likely to elicit the actual feelings and attitudes of the subjects. Finally, use of the data is also an ethical issue. It is the moral obligation of investigators to fulfill the trust placed in them by the participants by ensuring that the data is used constructively and in a manner consistent with the goals of those being studied (Oakley, 1981; Finch, 1984).

The investigator attempted to use a collaborative approach using language that was mutually understandable as well as letting the subjects have some control over the direction of the interview. The design was flexible to allow for individual needs and to encourage the subjects to share their understanding in their own way. Although the investigator felt she was benefitting the most from the interviews it was her impression that the women who participated also benefitted. Some resolved, at least in part, previous experiences. Some gained knowledge of childbirth and their rights as patients. All were encouraged to demand more explanations when dealing with members of the medical system. The experience of participating in the interview seemed to

increase or reinforce their value as individuals and as women. Thus the reciprocity of benefit was evident in the exchange of information as well as in using an approach which allowed the women to tell their stories in a manner that enabled them to develop new insight and understanding. At a more global level it was anticipated that the study would be of benefit to women of lower socioeconomic status in general because its findings should provide insight into the attitudinal characteristics and use of language common to this group. This could influence health care delivery, education of nurses and future research among this population. The study will more specifically influence the CEQ and its future use in research among women of lower socioeconomic status.

Setting

Subjects were recruited for the design phase from a local community college, and for the study phase from an inner city health clinic and the community of Winnipeg in general. The community college was chosen because of the unique nursing program offered at the college which targets the population of this study. The students, therefore, were considered to be very similar to the subjects of the study phase and capable of assisting in the design.

The health clinic was chosen because many of its patients met the inclusion criteria. The community clinic is a modern,

well-equipped, free standing clinic located in the core of the city which provides a variety of services including a day hospital, day-care, counselling, instructional classes, outreach programs, as well as medical and dental care. A pharmacy and medical laboratory provide additional services. The clinic staff are interested and supportive of research which focuses on their cliental. Many of the clients attend the clinic for maternal child care. They often spend one to three hours waiting to see the physician, having tests completed and their prescriptions filled. This allowed time for interviewing while the women were on site. These factors combined to make the clinic an excellent study setting.

The city of Winnipeg was chosen because it is a relatively large city with a population from a variety of socioeconomic backgrounds. The core area is where the largest percentage of people on social assistance live, although, low cost subsidized housing has been built throughout the city in an attempt to reduce problems associated with high density housing projects. Despite these attempts, the majority of social assistance recipients live in the core area. Although this study drew most of its sample from the core, the researcher did not wish to eliminate persons living elsewhere. Therefore, inclusion criteria did not specify a particular area of the city.

Instrumentation

Four tools were used for data collection -- the Childbirth Expectation Questionnaire (CEQ), the overall impression sheet of the CEQ, a general interview guide, and a sociodemographic data gathering guide (Appendix A, L, and M). The CEQ was developed by Janet Beaton and Annette Gupton in 1988 to measure women's expectations of labour. The other tools were developed by the investigator and underwent considerable revision based on the results of design phase.

The instrument to be evaluated in this study was the CEQ. It consists of thirty-six items rated on a five point Lickert scale. There are four subscales: coping with pain, nursing support, support from partner/coach and medical intervention. Each item was constructed to represent one of the three domains of attitude measurement: cognitive, emotional or action tendency. The first draft of the CEQ was piloted by Beaton and Gupton on over 200 women attending prenatal classes. These women were primarily from the middle class. A high level of internal consistency was found for the total questionnaire (alpha=0.83). The subscales attained alpha values of 0.72 to 0.78. Through item analysis, any statement that correlated poorly with either its subscale or the total questionnaire score was identified and was either deleted or reworded. A revised CEQ was drafted and an additional 100 women were sampled. The Alpha coefficient for the revised CEQ

was .81. The Alpha coefficient for the four subscales were: coping with pain .82, support of partner/coach .77, nursing support .75, and medical intervention .67.

The investigator designed the other tools used in the study. An overall impression sheet of the CEQ (Appendix L) was developed as a result of the design phase. It was used after the review of the CEQ to ensure that certain topics were explored if they had not spontaneously emerged during the conversation. It was also designed to provide a means of summarizing the interview. The impression sheet focused on general aspects such as length, format, suggestions for additions as well as the potential usefulness of a changed CEQ.

The general interview guide used in the design phase was devised by the investigator after reviewing the interview schedule used by Beaton and Gupton during the developmental stage of the CEQ. For the study phase, the general interview guide used in the design phase was modified to incorporate the findings of that phase. The primary focus of this guide was the subjects' expectations of birth and the accuracy of these expectations if they had experienced childbirth. The roles of the nurse, doctor, coach and patient were explored. A secondary focus of the interview guide concerned the participants' attitude about the sharing of information with pregnant women. This information was obtained primarily through discussion of what they would tell someone close to

them and what they thought was important to learn during pregnancy. If time constraints demanded, the guide was shortened by deleting or discussing minimally questions 4, 5, 7 (see Appendix L, guide 2). These questions specifically focused on their expected emotions and activities during the pre-hospital and hospital phases of childbirth and were considered the least important.

Sociodemographic data thought to impact on the subject's expectations was collected. This information was used to ensure that subjects met inclusion criteria and to assist in the analysis of results. Information was solicited regarding age, primary language, child bearing history, level of education, income and length of residence in Canada. One factor which was not included was the subject's enjoyment of reading. The investigator discovered during the course of the study that this may have been useful in analysis of the results. All four instruments were used consistently throughout the study.

Design and Procedure

An exploratory descriptive design was chosen. This design is particularity suited for investigators seeking to portray the characteristics of situations or groups in order to gain insight, and increased knowledge, in a topic area where limited research has been conducted (Holm & Llewellyn, 1986;

Wilson H., 1985). Furthermore, one of the uses of exploratory research is "to test and refine data collection methods" (Polit & Hungler, 1987, p. 529).

In-depth interviews are recognized to be an excellent method of obtaining accurate and detailed information, and are particularly appropriate when the study population has limited education (Polit & Hungler, 1987; Shelley, 1984; Wilson, 1985) as this overcomes problems which arise from functional illiteracy. The in person interview method of data collection was chosen because the information desired was of an in-depth nature and one of the inclusion criteria for this study was having completed less than a grade 12 education. Partially structured, or semi-standardized interviews were planned in order to permit the investigator the flexibility to probe freely and to spend as much time on each predetermined topic as was appropriate (Holm & Llewellyn, 1986; Wilson, 1985). This design also facilitated a collaborative approach. The researcher and participants worked openly and cooperatively together sharing their ideas and perceptions. Each interview was conducted in essentially the same manner. Individual situations were considered, and the interviews adjusted accordingly.

The purposes of each phase determined the design, procedure, and analysis of the data.

Design Phase: Design, Procedure, Analysis, and Findings

The four purposes of the design phase were: 1) To generally improve the investigator's ability to relate to and understand the perceptions and language of women of lower socioeconomic status. 2) To specifically examine the CEQ, identifying possible problems with its conceptual base and its use of language. This included obtaining synonyms for all problem words that were identified. Problem words were any words that participants could not understand, understood but felt uncomfortable using, or used but had a different meaning than that intended in the questionnaire. 3) To collaborate on appropriate content to be included, the order in which data should be collected and the approach to be used in the study phase. 4) To gain access to subjects for the second phase of the study.

All interviews were conducted according to an interview guide (Appendix L). The interview began with a review of the study purpose and answering questions. The consent and sociodemographic forms were completed. Taping of the interview was then requested. Tape recording of the interviews had been planned to increase the accuracy of information recall. This plan, however, was abandoned when the participants in the design phase preferred not to be taped. Notes were taken throughout the interviews. Immediately after the interview was completed the notes were reviewed and clarifying additional points added.

The interview proceeded with a sentence by sentence review of the revised CEQ (Appendix A) with the participants. During this review, words and concepts which presented problems were identified and suggestions for changes were solicited. A general discussion of issues related to childbirth followed. The interviews concluded with a discussion of appropriate order and approach of data collection in the study phase.

In total, six students were interviewed -- three individually and three in a group interview. The individual interviews allowed greater exploration of personal experiences as there was a more chance to delve into personal feelings and attitudes. Students interviewed individually did not, however, have the support or stimulation of their classmates comments. The major advantage of the group interview was its stimulating atmosphere. Responses by one student encouraged and generated discussion among the others. Two disadvantages of group interviews were noted. Occasionally the influence of one student on another seemed to result in hesitation by another to voice an opinion. The greater problem was the increased time required by the participants. The group interview took two hours and some questions in the interview schedule were only briefly discussed. An interview of an individual could be completed in an hour and a half without limiting the discussion of any questions. In addition, during the group interview there was less time to explore any one individual's

ideas. Both the individual and group interviews proved effective and useful to the investigator.

Throughout the interviews open-ended questions met with little response. Probing was needed throughout the interview to ensure that responses were obtained and understood by the investigator. Probing should be neutral and should not bias the subject's response (Polit & Hungler, 1987). However, the recommended form of probing often did not work as it would with a middle class population. The phrase, "Could you tell me a bit more?" would often elicit a shrug and required more specific, focused questions to stimulate a discussion. The investigator avoided, however, leading questions. For example, "Would you prefer yes/no questions?" would have been leading. A non-leading alternative was used, for example: while showing them examples of a number of alternative question types the investigator would ask, "Which type of questions would you prefer?"

The data collected in the design phase was analyzed. All the suggested alternative wordings to the responses to the CEQ were compiled and listed for use by the investigator in the review of this tool in the study phase (Appendix L). Whether the suggestion was made once or repeatedly it was included. The responses to the general interview were reviewed and probes categorized. These were used to rework the interview guide. This resulted in the guide being transformed from a list of open-ended questions to a more specific, detailed

tool with many probes to ensure completeness of response. In contrast to the plan to include all suggestions for the CEQ and general interview guide, the investigator intended to determine the order and approach of the study phase by using majority opinion. However, the design participants unanimously favoured one order and approach.

The design phase subjects proved to be good informants. Although the students were slightly older, had higher education levels, and were involved in upgrading their academic qualifications and language skills than study phase subjects, they acted and spoke in a similar manner to the subjects of the study. This provided the investigator with opportunities to develop an appropriate interviewing style and language. The informants were unable to clearly articulate the differences between women of lower and of middle socioeconomic status, but were able to identify problem words and phrases and assist in the development of alternative wording for both the CEQ and general interview guide. Given the difficulty the respondents in the design phase had with open-ended questions, the investigator chose a semi-structured interview method with careful questioning to elicit detailed responses for the study phase.

Participants in the design phase indicated that all data should be collected and recorded in writing by the investigator during an oral interview. They recommended not tape recording. They also said that even requesting permission

may create hesitancy to participate. The design phase participants indicated that women would find talking about their own experience to be least threatening and this would "warm them up" for the CEQ. The CEQ was considered "cold" and its evaluation a formidable task. This, they reasoned, would only be done if the subjects of the study phase were already committed to the interview. Sociodemographic data was considered to be too personal to be collected until the end of the interview. The informal wording of the sociodemographic questions was approved of by the women (Appendix M). One stated "I like the way you put that" and indicated the phrase "living with a guy". Another commented that the questions were down to earth.

Finally respondents unanimously agreed that the written consent form should be signed at the end of the interview. They believed that requesting women to sign any form at the outset of the interview would reduce the likelihood of participation. Their comments indicated that the women would prefer to be anonymous and that being asked to sign a consent would raise anxiety. The investigator wondered if this was related to their life experiences.

Study Phase: Design, Procedure and Analysis

The purposes of this phase were: to gain a better understanding of the childbirth expectations of women of lower socioeconomic status, and to specifically examine the CEQ for

use within this population. The examination of the CEQ focused on:

1) the method of administration
2) the readability/understandability of the language
3) the structure of the questionnaire
4) the relevance of the concepts
5) alternate and more acceptable methods of administration, language, structure and concepts.

The investigator incorporated the suggestions made in the design phase into the study phase. The interviews began with an oral explanation and answering of questions. Oral consent was obtained. The general interview was conducted using the revised interview guide (Appendix L). After the review of the CEQ, the overall impressions sheet was used to solicit a general evaluation of the tool, a brief discussion of additional topics that might be added to the questionnaire and to summarize the interview. The sociodemograghic data was collected. At the end of the interview the participants were requested to complete the written consent (Appendix I), as recommended by the students in the design phase. A number of study subjects were hesitant to sign a consent form, even at the end of the interview. They were satisfied with the explanation that it was: "To show my teacher that I really have done this interview. To show that I have told you what the study was all about and to prove that you are willing to have everything that we talked about included in my work".

Subjects were told that if they did not want to sign, their data would not be included in the study. All subjects then willingly signed the consent.

In the study phase the initial contact with the women occurred as described in the section on subject recruitment. A conversational manner, using the informal language of the participants, was used throughout the interview to help the women relax and to encourage them to speak freely. All material was presented and collected orally. The collected data was hand recorded by the investigator since this approach was recommended by the women in the design phase.

Taping was not discussed with participants of the study phase until the end of the interview. At this time each woman was asked if she would have allowed taping. All stated they would not and some made very negative body gestures strongly indicating that they were opposed to the idea. Hand recording during the interview did not seem to hamper the discussion. As with design phase interview notes were completed in greater detail immediately following the interview to ensure accuracy. Given the amount of nonverbal communication, the use of notes was probably more effective since the nonverbal could be noted with ease and without comment as would have been required if taping had been used for data recording.

The investigator used the list of appropriately phrased questions and probes constructed in the design phase to guide the general discussion of childbirth expectations in the study

phase. When the CEQ was discussed the investigator read it aloud and unmodified, with the subject. The investigator watched for nonverbal signs of understanding. In order to avoid embarrassment of the subject the investigator quickly used the list of synonyms constructed in the design phase (Appendix L) and asked which they preferred if there was any indication of lack of comprehension. Each subject was asked if they had other suggestions. This facilitated the discussion of the item and possible changes to the questionnaire.

The data were analyzed using qualitative methods. The interview data from each respondent were photocopied twice and each unit of data was marked with the respondent's code. The interviews were read in their entirety and threads, or themes, were identified and listed. One set of photocopies was then cut into units of data according to the question number. The CEQ questions were then sorted into subscales.

The units of data from the general interview were read question by question and analyzed for relevance to the CEQ. Many responses were of a mixed nature and only a portion was directly applicable to a CEQ subscale. The relevant portion of the responses was placed with the appropriate subscale using the second photocopy. Each question from the general interview was then read repeatedly to determine the spectrum of response. The response categories were counted to provide an indication of the frequency of an opinion or idea. The categories were then combined into larger classes of concepts.

For example one category would be financial concerns during pregnancy while the larger class would be concerns during pregnancy. After working with the subdivided data from the general interview the investigator reread the general interviews in their entirety to ensure the threads previously listed were accurate and to examine the material for ones missed.

The interview data from the review of the CEQ provided information of two types. The first was of a general nature including thoughts about the method of administration, language, tone, format and structure. This was combined with information from the overall impression sheet for analysis. The second was content information related to the subscales of the CEQ.

The procedure for analyzing the first type of data was to read the data from the review of the CEQ and the overall impression sheets in its entirety and group the data according to the categories identified in the original purposes of the study phase. On examination of the data some of these overall categories required subdividing. For example, during the analysis it became apparent that structure included components related to the instructions, response format, and length of questionnaire.

The procedure for analyzing the second type of data was to divide the items into their subscales and incorporate the relevant responses from the general interview. Each subscale

was read in its entirety to determine general attitudes. The responses to each item were read individually and examined for the linguistic and conceptual congruency with the original intent. All suggestions for changes were recorded and frequency determined.

An example of how data were analyzed comes from the CEQ. In reviewing the CEQ it was noted that words ending in "ing" presented difficulty, although some of the root words were understood by the subjects. Therefore the problem was not lack of familiarity with the root word. To determine whether the difficulty lay in the use of present participles, the investigator reviewed the CEQ. It was found while some of the words presenting problems were present particles others were not. Therefore, the category was expanded to capture all problem words where the root was understood. This category became vocabulary problems associated with derivatives which was a subsection of problems with vocabulary.

To summarize, qualitative methods were used to analyze the data. This means that interviews were compiled, repeatedly read, categorized and organized for presentation. The subscales of the CEQ were used whenever possible to categorize the data into themes. The four subscales of the CEQ are: support of partner/coach, nursing support, coping with pain, and medical intervention. When data did not fit into these subscales, new categories were formed. This approach was considered the best method of reducing the data while still

capturing the thoughts and feelings expressed by the women during the interviews. Information obtained in both the general interview and the item by item review of the CEQ (Appendix A) was used to address the purposes of the study.

The analysis provided the results which are the basis of the next two chapters.

Limitations

This study has several limitations. These include the sampling method and size, as well as other factors which became apparent during the course of the study.

The snowball convenience sampling method may result in a bias in the data because this method can not produce a random sample. In addition, the small sample size increases the chance of bias and reduces the likelihood of a representative sample. Nonrepresentative sampling does not give each member of a population equal opportunity for inclusion. This type of sampling has less generalizability and results must be applied to the population with caution. The representative nature of this sample was enhanced by identifying extraneous variables and controlling for their impact. The identified variables were; lack of understanding of English, cultural orientation, socioeconomic status, educational achievement, and age. The inclusion criteria limited the variability of these factors and by so doing reduced their effect (Polit & Hungler, 1987).

Other variables identified were: parity, gestational stage and willingness to access medical services. These variables were accounted for by ensuring a wide variety within the sample. Primiparous and multiparous women were included as were women at various stages of their pregnancy. The sample was collected at a health clinic and in the community, in the hope of including women who were seeking medical assistance as well as those who were not. These measures reduced the problems associated with convenience sampling while not eliminating them altogether. Therefore, findings of this study must be considered indicative but not predictive of the attitudes of women of the lower socioeconomic population in Winnipeg.

In collecting the socioeconomic data the investigator failed to include enjoyment of reading as a variable. Women who had read widely seemed to be more articulate and have a greater vocabulary. The enjoyment of reading may be a more useful indicator than educational level in determining appropriate approaches and instruments as educational level has been shown to correlate poorly with reading skill (Farkas et al., 1987; Irwin & Davis, 1980; Mohammed, 1964). Failure to ask each respondent whether they enjoyed reading meant that the correlation of this factor with level of understanding of the CEQ could not be examined.

Being limited to a single contact with participants meant that the investigator was under severe time constraints. Although this was addressed by giving breaks and having two

sessions where possible, the depth of some aspects of the discussion was none the less restricted. In addition, a single session may reduce the rapport necessary to obtain true insight into a woman's attitudes and beliefs. The investigator used a collaborative approach to overcome this problem and to ensure a high quality of data. The respondents appeared to answer with frankness. However, the investigator recognizes that their responses may have been affected by the investigator's lack of familiarity with the background of each woman.

Assumptions

Although this was not a pure ethnographic study, the investigator accepted and adopted an ethnographic attitude (Ragucci, 1972; Spradley, 1985). This attitude is characterized by the following beliefs: 1) the interview is a time for learning from the people being studied, 2) the meaning of events are defined by the group being studied, 3) differences exist between varying groups within the society especially in the meaning and use of language. "The ethnographic approach is most effective for the study of groups whose members do not have the literacy and language skills characteristic of the dominant white middle-class culture" (Ragucci, 1972, p. 489).

In addition, the investigator assumed that the benefits of the collaborative approach outweighed the disadvantages and adopted an approach where the involvement of the interviewer with the subjects was considered desirable. The investigator accepted the precept that the interview process should be beneficial to both parties and so conducted the research with this objective in mind.

Conclusion

This chapter has outlined the methods used in conducting this exploratory descriptive study, the purpose of which was to determine childbirth expectations of women of lower socioeconomic status, and to evaluate the CEQ for use with this population. The inclusion and recruitment of subjects, their ethical treatment, setting, instrumentation, design, data gathering procedure, analysis and the limitations of the work have been discussed. The assumptions from which the investigator worked were also outlined. These assumptions influenced the methodology of the study and the analysis of the findings. The next chapter will discuss the finding from the analysis of the data.

CHAPTER 4: RESULTS

This chapter begins with a description of the subjects, and continues with a discussion of the findings. The discussion of the findings is divided into four sections. The first focuses on the CEQ as a whole and examines: the method of administration, the language, and the structure of the questionnaire. The second section examines the conceptual issues of the CEQ using its four subscales as a frame of reference. The third section discusses information which arose from the interviews but did not fit into any of the four subscales. The fourth and concluding section integrates the material from the prior three sections and summarizes the findings related to the relevance and readability of the CEQ for women of lower socioeconomic status.

Description of the Subjects

The fifteen participants of phase 2 ranged in age from 18 to 27 years with a mean average age of 22.5 years. Their educational achievement ranged from grade 9 to 11. Three were expecting their first child. The rest (12) had experienced childbirth. Seven had forcep-assisted deliveries with their first. Four had unassisted vaginal deliveries and one had a

cesarean section. The average age of their first childbirth was 18.2 years. Seven were of European descent, five were of Metis heritage and the three of North American Native origin. All spoke English in the home with their children and peers. A few spoke other languages to parents and grandparents. Five were either living with someone or married. Nine were living on their own and one with her parents. On these ten, seven were single and three were separated. Fourteen were on social assistance. The income level of the employed subject was similar to the other subjects. Therefore her responses were included in the analysis. One subject was able to complete only part of the interview. Her responses were included in the analysis. This resulted in fifteen responses to the general questions but only fourteen responses to the CEQ.

Overview of CEQ

All the women in the study felt there were problems with the structure, language and administration method of the CEQ. The discussion of the method of administration revolved around whether the questionnaire should be administered orally or in writing. The language difficulties were related to sentence structure, vocabulary, tone, and verb tense. The structural difficulties were related to the 1 - 5 response format, the instructions, and the length of the questionnaire.

Method of Administration

The method of administration was the first issue facing the investigator. Each subject was asked if she preferred to read the questionnaire, or to have it read aloud to her. All the respondents felt that this choice should be offered whenever the CEQ was administered. All chose oral administration. They felt that all women would prefer oral administration, and that this method should be used for all surveys.

A number of reasons were offered for their preference. They believed that oral presentation: allowed for clarification

-"I'd like it read to me, so you can explain",ensured accuracy of response

-"If [other women] don't understand most will just make up any answer",

-"They'll put any old answer if they don't understand",and increased cooperation

-"Most forms you have to think about for hours to figure out what they're asking, (shrug) won't do that for a [written] survey."

Thus oral presentation was seen as necessary to ensure that subjects understood the question being asked and provided for greater accuracy of response.

Oral administration was also seen as a means of reducing fear, as explanation and discussion would be

provided. One subjects stated: "It's [the CEQ] too scary, you need to be able to talk." Another said that the questionnaire: "should only be given when people can ask questions, not just sent out, it might scare you."

Oral administration was seen as a means of solving the problem of someone not being able to read, and not wishing to admit to it. Almost all women felt that the problem of illiteracy should be handled by offering to read the questionnaire to a woman. None felt that a person should be asked if they were able to read. The topic was seen as potentially embarrassing and requiring sensitive handling.

Finally, oral presentation was viewed as more pleasant. "This [reading aloud with discussion] is better. Who would like to sit and do it by yourself? [It's] boring, you know."

The investigator concluded that for this population the preferred method of administration was oral and that the CEQ should be administered within the context of a discussion to allow issues raised by the questionnaire to be addressed.

Language

Four aspects of the language of the CEQ will be addressed. These include vocabulary, sentence length, tone and verb tense.

Vocabulary and Sentence Structure

The language of the CEQ created difficulty. This first became evident in the examination of the introductory section. The women didn't understand the instructions because of the complexity of the vocabulary and sentence structure. They would glance at the introduction; they wouldn't read it and would then give a noncommittal response to the request to identify difficulties and suggest changes. After the interviewer read it aloud their first comments were usually about its length "putting them off." The vocabulary was the next issue raised. Many words were identified as problems. "Problem" words were either not understood, or were unacceptable. Unacceptable words were words that the women felt uncomfortable using because of their formality. Such words were identified by statements such as "I don't like that"; or "I just wouldn't say that." In the following copy of the introduction all the underlined words were identified as problem words.

Childbirth Expectation Questionnaire

This questionnaire is designed to describe women's expectation's regarding their impending labor and delivery experience. Your opinions along with those of other pregnant women will be used to try to learn more about women and childbirth.

> This questionnaire contains a number of statements, each of which says something different about your labor and delivery expectations. While no one can know for sure what will happen to them in labor, we are interested in knowing what you anticipate or expect the childbirth experience will be like for you. We are asking for your "best guess" about what will happen to you in labor. For each statement, decide how you agree or disagree with the view expressed. Think about the statement. Beside each statement you will find five words used to describe your expectations. There are no right or wrong answers. People differ in their views. Your response is a matter of your personal opinion. The information you give will be completely confidential.
>
> Thank you very much for your time and your help. Below is an example which may help you in completing the questionnaire.

Another aspect of the introduction identified as a problem was the sentence structure. The complexity of sentence structure is evident in the above paragraphs. The respondents were confused by the use of compound sentences containing many subclauses. Indicating these sentences, the subjects made

comments like: "too much", "too long", or "confusing". The only sentence identified as good was: "There are no right or wrong answers." This sentence was short, simply constructed, and contained no words which they found difficult.

The respondents did not find that the examples reduced their confusion nor helped them understand the instructions. The underlined words again indicate "problem" words.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
A.I am looking forward with great joy to the birth of my baby	1	2	3	4	5
B.I need to know more about childbirth than I possibly could	1	2	3	4	5

The answer to Example A, "Strongly Agree" indicates that you are quite certain that you are looking forward to the birth of your baby with great joy.

The answer to Example B, "Neutral" indicates that you cannot quite decide whether to agree to disagree with this statement.

The language of both examples A and B implied concepts which presented difficulty for the women. To the subjects the

wording of example A implied that a woman would have no mixed feelings about the pregnancy, that the pregnancy was planned, and that she was not frightened of labour. Most felt this was totally unrealistic but felt that they should feel like this. Thus the item immediately made them feel "put down" and uncomfortable. A few suggested "maybe that's the way rich people feel". The wording of example B was completely baffling and the respondents did not understand that it was referring to education. The examples did not clarify the subjects' understanding of the instructions because they could not identify with them and because of the problems with the words "strongly agree - strongly disagree". Alternatives to the response words were discussed. Suggested alternatives were "excellent to poor"; or "yes/no". The term neutral presented problems. Only a few understood its meaning. The rest could not understand it and although some were able to glean its meaning from the context many could not. All of the respondents suggested using an alternative word such as "doesn't matter", "don't care" ,or "maybe" for the term neutral. It was concluded that for this population the introduction and examples need to be changed. The vocabulary should be basic, the sentence structure simple, the physical length shorter and the concepts which the language implies more "in tune with" the population.

Language continued to be problematic in the item by item review of the CEQ. Sometimes the words were simply too formal

and alternative words were easy to establish. In the following example of such words alternatives are shown in brackets: "comforted" (better, happier), "presence" (around, with me), "experience" (have), "ignored" (won't be done), "helpless" (won't know what to do, will feel in the way), "intense" (a lot, bad, really bad), "discomfort" (not too bad pain), and "childbirth" (labour and delivery).

Sometimes the problem resulted from the form of the word. The subjects often understood the root word but had problems with derivatives. For examples the women identified "panicking", "encouragement", and "severity" as problems but found "panic" "encourage" and "severe" acceptable. Present participles of the verb were used infrequently by the subjects and may account for the difficulty with words like, "will be agonizing" and "regarding their impending labor". Gerunds also created problems, examples of these are underlined in the following phrases "avoid telling" "afraid of panicking" and "avoid seeking".

Other words were a problem because of their lack of meaning. Some were not concrete enough. Examples of these "vague" words were "help" and "kind". The women were unsure of how these words should be defined, and wanted specific examples before answering the item. Other terms were not understood by most of the subjects. Examples included "sought", "opinion", "experience", "avoid", "unbearable", "seeking", "anesthetic", "fetal", "monitoring", and

"immobilized". Alternatives which captured the meaning were difficult to establish because the investigator had to first discuss the meaning of the words, and then generate alternatives. Sometimes the terms and items were so complex that the investigator questioned whether the original intention had been captured in the rewording. For example item 32 read "My opinion or that of my partner coach will be sought for all major medical decisions". An acceptable rewording was difficult as the women did not understand what having an opinion in this context meant and had little idea what a major medical decisions was. The most popular rewording was "I'll be asked what I think before anything is done" which may not capture the original intention of the item. Finally some items could not be reworded. In item 25 "Forceps will be used" the term forceps was not understood by many of the subjects. Those who did know the term and used phrases like " Big metal things they pull the baby out with" and " those claw like things" to describe it. An acceptable non-frightening way of phrasing the item was not found.

These problems indicate that changes in the language of the CEQ would be necessary before using the questionnaire with women from the population from which the subjects were drawn. Further language problems and the conceptual difficulties are discussed in the section reviewing each subscale.

Tone

An issue related to the problems in the language of the CEQ was the tone of the questionnaire. The number of complex words and sentences as well as the use of language which subjects had only heard in formal situations resulted in an overall tone of the questionnaire which was described as: "too formal", "cold", "not friendly", "too clinical - needs to be more conversational" ,"like government forms - all backwards", "like G.E.D.(equivalency exams) doesn't get at heart, at emotion", "scary", and "too definite". They also had problems with the definitive tone created by the use of the future tense. All the respondents felt that the term "will" was "too sure", "too definite", "too positive" or "too strong". They suggested that it should be softened by using phrases like "I think", "I hope", "I might", or "I want". The respondents said that the tone would: reduce their willingness to complete the questionnaire "put you off, you know", and make it harder to complete because of lack of understanding, "I don't know what to say - I don't understand", or result in inaccurate data "I'd pretend I understood and fill it out."

Verb Tense

The use of the future tense created difficulty for three reasons. The first has been discussed in relation to tone. The second related to the predictive nature of the items. The concept of predicting the future was a problem as future events and feelings were considered unknowable and

unpredictable. "This is not asking what you want or like but if you know a situation - but you can't know that." They found it difficult to anticipate their own feelings and behaviour. They displayed a fatalistic view of life. For them an event such as childbirth unfolds in a predetermined fashion over which they have little or no control. Whether they would require pain medication or would feel like asking for help or would be a part of decision making depended on how severe the labour pain was, what the nurses were like and whether they were asked what they wanted. Their future responses were seen as contingent on the behaviour of others over which they had no control. The prediction of someone else's behaviour and feelings was viewed as impossible. One example of this attitude was the response to item 1: "My partner/coach will be happy and excited". All but one subject felt this was an impossible item to answer. Comments like "How should I know how he'll feel?" and "Everybody will put "3", [because they] won't know what their partner feels", reflect their difficulty with the concept of predicting responses of others. Similar comments were made in response to items seen as asking one to predict the emotions and actions of the nurses and physicians.

The third problem with the use of the future tense was related to the fact that many items were seen as current as well as future concerns. They felt that if they were asked whether they "will feel fearful" at a future time the implication was that they did not currently feel fear.

Therefore, all the subjects wanted the items relating to pain and fear to be phrased in the present tense since these were emotions experienced throughout pregnancy. For example, "I will be worried about the severity of labour pain", was rephrased as "I am worried about the severity of labour pain." This did not negate that they would feel fearful in the future, as they saw the emotions as continuing until after delivery. Throughout the review of the CEQ any item which reflected emotions which they experienced during pregnancy had to be reworded to the present tense in order to have the women discuss the item.

The future tense created problems because of its effect on the tone of the items, its challenge to the subjects belief regarding predicting the future, and its apparent negation of their current experiences. Throughout the discussion the subjects repeatedly indicated that attempts to predict the future was a waste of time and a useless endeavour. Problems with the language - the vocabulary, sentence structure, tone and tense - indicate that changes to the CEQ would be required before it could be used with women of lower socioeconomic status.

Structure

The discussion of the structure of the CEQ will focus on three aspects: the instructions, the response format, and the length of the questionnaire.

Instructions

The instructions created difficulty. The instructions required that all items to be answered. No directions were given for dealing with items which were not applicable. The subjects identified the subscale of partner/coach as potentially being such a problem. No instructions were given for handling answering items containing vocabulary or concepts not understood. The subjects were asked how they thought women would manage these problems. Some felt that women would make up answers in order to follow the directions. Others felt that women would probably leave those items out even without direction. None of the subjects thought women would ask for clarification of the instructions. Therefore, clearer instructions would be necessary to ensure accuracy of response.

Response format

The response format, strongly agree...strongly disagree, was problematic for five reasons. First, the respondent was expected to read the preamble at the top of the page and combine it with each stem.

At the top of each page were the following instructions: CIRCLE the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

	STRONGLY DISAGREE		NEUTRAL		AGREE STRONGLY
	DISAGREE				AGREE
With regard to my labor and delivery <u>experience</u>, I <u>expect</u> that:	1	2	3	4	5

The subjects had difficulty remembering to do this. They also seemed unable to hold the preamble in their memory and to automatically combine it with each stem. Added to this difficulty, or causing it, was the tendency of the subjects to have a short attention span. This limited attention span was evidenced by frequent topic changes and loss of focus on a question. The investigator was required to repeatedly remind the subjects of the preamble, restate questions and focus the conversation to ensure a given subject was fully addressed.

The second problem with the response format related to the decision making it required. Each item is written as a statement with which the respondent is expected to agree or disagree. This forcing of an opinion made all subjects uncomfortable. They seemed to feel that the items were statements of fact rather than statements about which opinions might vary. The items were viewed as stating truths and as a result those items which were considered inaccurate by subjects caused much concern. The subjects wanted these items changed as they were reluctant to disagree with an item. When

responding to an item, the respondents were not objectively agreeing with or disagreeing with th opinion stated in the item, but were instead either accepting statements as absolute truth, or as a deceitful attempt to mislead. The subjects' initial conceptual response was to answer an item with an "I know that" or "I don't know that" mode of thought. When pressed by the investigator they would consider the item further and respond in terms of an "I like that fact" or "I'm frightened or disappointed by that fact". With intense discussion they were actually able to give a reluctant admission that they disagreed with a item. They appeared to be very uncomfortable with this role as a decision maker or a judge. To disagree with an item, in this very formal questionnaire, was to question authority.

The third problem with the format was also related to the fact that the items were not viewed as opinions, but as statements of fact. The women expected that women having their first baby would read each item and accept it as reality. Some items were seen as inaccurate, such as the items related to the nurse not spending much time with a woman or that "lots" of machinery would be used. These items were considered intentionally misleading and fear producing. The women questioned why the investigator would do this. Other items, such as the ones relating to intensity of pain, were viewed as accurate but containing information that should not be shared with first time mothers. Fear producing statements, whether

accurate or inaccurate, were seen as negative. The investigator found that all the items designated as "scary" or negative by those subjects who had previously experienced childbirth, and who had children, did in fact cause concern in women who were expecting their first child. The concern of the first time mothers was displayed in a variety of ways, for example enlarging eyes, physical tensing of muscles, rising tone of voice or comments such as "Is it really like that?" "I didn't think that would happen?" Even women expecting their first baby who had formed some fairly clear expectations responded to the items as factually accurate and began to question their ideas.

The fourth problem with the format was the degree of differentiation it required. All the respondents had difficulty conceptualising a semantic differential along a gradation as detailed as five units. Most of the women found the 1-5 scale "weird" and were unable to use it. Even the few respondents who found the response format acceptable preferred less differentiation and suggested a three unit scale. Remarks such as this were made : "Why have 1-5 why not just 1-3? That's enough", "Cut to 3 or 4", "Too many options; Just agree - doesn't matter -disagree". A 1-3 format was considered easier to complete and sufficiently differentiated to encompass their feelings on any item.

The fifth problem related to the response format was the subjects' use of the neutral (3) response. The subjects often

used neutral to indicate an "I don't know" response, indicating that the subject did not know what the item meant. For example item four reads, "I will be immobilized by the pain of labour." The women said they didn't know what immobilized meant and said they would use 3 to indicate this. Thus three could indicate not understanding an item as well as not having thought about the topic or not caring one way or the other. This means that a neutral response would be hard for the investigator administering the tool to interpret. The lack of an "I don't know" category made the questionnaire difficult for these women. The subjects showed a marked reluctance to speculate about the future and frequently wished to answer "I don't know".

The response format of the CEQ was problematic for a variety of reasons. It cannot be over stressed that the subjects did not think in terms of statements of opinions, which can be agreed with or disagreed with, but instead took the items as statements of fact. The questionnaire was viewed as an authoritative document. The women were unprepared to oppose its authority. They were also unwilling or unable to work with the degree of differentiation required by the questionnaire. This in part was related to their reluctance to think about the future and their unwillingness to enter into its prediction. To ensure accuracy of response a different style of test would be needed. Deleting the use of a preamble would be appropriate. In addition items could be constructed

with response options of "Yes", "No", "Maybe", and "I don't know". Another option would be to reconstruct the questionnaire to allow respondents to choose a word that closely approximates their feelings . For example "When I think of labour I feel: Sad, Happy, Scared, Mixed Up, Excited, Calm." A number of the subjects suggested having a space for other comments to accommodate women whose response did not fit the options offered. Both of these options were preferred to the 1-5 response format.

Length of Questionnaire

The final aspect of the structural difficulties of the questionnaire was its length. The CEQ was perceived by all the subjects as being too long. All felt it was repetitive and deletions were recommended. In discussing the repetitious items some of the women said they felt this was a "put down" of their intelligence. They thought the author was trying to check their answers and thought they would not notice. While discussing the problems with the questionnaire's length it was discovered that the formality of the language and structure was really the difficulty. The respondents felt that if the repetitious items were eliminated and the language simplified then additional topics could be added. With these changes most of the respondents felt a 36 item questionnaire would be acceptable.

Summary

To conclude, the subjects felt there were problems with the Childbirth Expectation Questionnaire as a whole because of the written method of presentation, the language, and the structure. The language problems were more specifically related to the complex sentence structure, the vocabulary, the definitive tone, and the future tense. The structural problem were related to the 1-5 response format, the instructions and the length. The major problem faced in rewriting the questionnaire is not the issues which can be addressed by simplification of language but the problem that the subjects experienced in questioning the "authority" of the document and their reluctance to engage in the prediction of the future.

The respondents reacted to the CEQ on an emotional rather than intellectual level. The questionnaire tended to shape their attitudes and feelings and as a result data collected would be highly suspect. If a modified CEQ is to be used for research purposes it is important that it capture the women's actual thoughts and feelings. Possible solutions to the problems addressed in this section will be further discussed in the next chapter. The next section of this chapter will focus on the conceptual and language issues specific to each of the four subscales of the CEQ.

CEQ by Subscale

There are four subscales in the CEQ, each representing a concept. In this review the respondents' understanding of the conceptual aspect of each subscale is presented. An item by item analysis is used to address the conceptual issues inherent within the CEQ. In addition, language issues specific to each subscale are integrated into the item by item analysis. Whenever an item is quoted, unacceptable words are underlined to allow the reader to see those words in context. In the conclusion of each subscale, the investigator will examine the understandability, acceptability, and relevance of the concepts of the CEQ to the women in this study, as well as some of the faulty assumptions specific to the subscale.

Some of the general overall assumptions implied in the questionnaire appear to be that: the process of childbirth is considered very important to pregnant women, they are knowledgeable about the process, their relationships and their lives in general are stable and predictable, active participation is desirable, childbirth is a process of decision making, the process can be handled proactively (that it can be planned and prepared for) not just reactively, they think in detail about the process of labour and delivery, they formulate clear expectations about the event, and that these childbirth expectations are consistent throughout the childbirth experience.

The fact that respondents lack of clearly formulated expectations became evident as the interviews progressed. The subjects who were expecting their first baby had difficulty articulating what they thought would occur. Those who had delivered a child were able to share their expectations by discussing their experience and by comparing it with what they had expected. Their preconceived ideas about the concepts addressed in each subscale became evident through their dissatisfaction or satisfaction with their own experience. In fact, not one of the above named general assumptions of the questionnaire proved accurate for the subjects studied. While the fear they suffered suggested that they found childbirth to be important, the subjects did not view the process as particularly important and were outcome oriented.

When reviewing the CEQ the investigator found she had to depend mainly on nonverbal clues to determine if a subject was having difficulty understanding an item. The language difficulties had to be addressed before discussion at a conceptual level was possible as the subjects simply did not have any idea what many of the items meant. Once difficulties with the vocabulary were resolved there was one common and reliable indicator that the item was conceptually a "problem". This indicator was a comment by the subject that the item was "silly" or "stupid". The subjects also said that many items were general or "vague". They found specific concrete examples easier to understand. Thus through verbal and nonverbal clues

the investigator determined where delving and questioning was required to establish if an item was a "problem" at either a conceptual or linguistic level.

Subscale 1: Support of Partner/Coach

Seven of the questionnaire items include the words "partner/coach".

1. My partner/coach will be happy and excited.

9. My partner/coach will feel quite helpless.

11. I will ask my partner/coach for help.

17. I will feel comforted by the presence of my partner/coach.

28. My partner/coach will tell me what is going on.

32. My opinion and that of my partner/coach will be sought for all major medical decisions.

35. I will avoid telling my partner/coach what I am feeling.

From the discussion of these items, as well as information obtained through the general discussion, the investigator gained an appreciation of the respondents' understanding of the partner/coach concept. The discussion of this subscale was unique, in that it addressed a number of issues not contained in the seven CEQ items. These issues include: the subjects' definition of the terms "partner" and "coach", their expectations regarding the preparation of the partner/coach, their preference for who would accompany them during labour,

and their perception of what other women felt about the importance of having partner/coach support.

The role of the partner/coach was then explored through an examination of the seven questionnaire items. These items stimulated much discussion. The discussion focused on: what the subjects most wanted from their partner/coach, what they felt this person was capable of providing, and what responsibility this person had as a decision maker or information provider. Another issue explored was the communication style between the respondent and her partner/coach. The final issue addressed was the predictability of the partner/coach's emotional response.

The use the dual term "partner/coach" was viewed by most of the respondents as needlessly cumbersome and confusing. A single term was preferred. Of partner/ coach the favoured was coach which although they didn't use themselves they could understand. Some subjects preferred partner and a few liked support person. All the women thought that defining the term would be helpful. An acceptable definition was; "Coach means anyone that is going to stay with you during labour. This could be your boyfriend, partner, mother, sister, auntie, friend, husband or anyone else."

The word "partner" was understood and acceptable. However, it was viewed as formal and was not a term they would use in everyday conversation. More commonly used terms for "partner" were "boyfriend", "common law", "the guy you live

with" or "husband". "Partner" was defined by the subjects as a male who was currently emotionally and sexually involved with the woman, but not necessarily cohabiting with the woman. This person may or may not be the father of her child. Many made references to physical violence in their relationships and spoke as though this was an accepted aspect of it. One subject commented on her relationship, "I'm lucky, my boyfriend never hits me like most of my friend's boyfriends do. Sometimes he rubs my back. Sometimes he comes over and cooks for me." Some of the subjects had terminated relationships because of the violence.

For the respondents, a partner was not generally viewed as a permanent part of their lives or responsible for parenting. Many of the women spoke of a number of partners since their first pregnancy. At the time of the study only a few seemed to be in a fairly permanent relationship. A smaller group had experienced a relationship that had lasted more than 3 years. When discussing their first pregnancy only a few had maintained contact with the father of the baby until the time of delivery. Many of the women had worried that the pregnancy would change the relationship with their partner. "I worried about how he [the baby's father] would be, you know if he'd accept him or reject him [the baby]". A scenario known to all the subjects and experienced by many was a partner who was initially interested in the child but who later rejected both the mother and child. The statement of one subject was typical

of many: "being a mom means taking care of it [the baby] all by myself". While they seemed to hold a permanent relationship with shared parenting as an ideal, they did not expect this for themselves and accepted a succession of relationships; unequal responsibility for child rearing was considered to be normal.

Only a few respondents had their partner with them in labour. These women only expected that their partner be with them. Most did not expect him to attend classes, read, discuss, practice or in any way prepare for the event. A few said they had talked about labour with their partner prior to the event. All the women thought it would be nice to have a partner who was prepared and supportive "like the movies", but did not really think it was possible.

"Coach" was a term all the respondents understood and found acceptable. Although the term "support person" would have been acceptable some of the subjects, no other term was heard to describe coach except the phrase the person who is "going to be with me when I'm in labour". The subjects defined coach as anyone other than the partner or hospital staff who would stay with them during childbirth. The coach might be a male but was usually a female, a member of the woman's family, or a friend. To be a coach no specific training or personal experience was considered necessary. It was, however, considered desirable. The term had a connotation of someone encouraging the expectant mother, and not of someone telling

her what to do from the position of knowledge. The coach did not have any obligation to prepare the woman for labour, although in a few cases the person providing prenatal information was also the coach. As with the partner, the coach was not expected to attend prenatal classes with the expectant mother. The subjects did not think such behaviour was likely, although they considered it very nice, saying that they would like it to occur.

A few of the subjects asked a person to come with them at the last minute. While this person was not chosen in advance, and was completely unprepared, he/she was nevertheless was called a coach. Subjects did not find having last minute coaches satisfactory and made comments like the following: "You need a set coach [a specific person], you know so then they're not shocked - they'll stay calm - they won't overreact".

In discussing whom they preferred to have accompany them in labour, different attitudes were expressed. A number of respondents stated that they would like a mother or aunt to be with them during childbirth, in addition to, or instead of, their partner. One said, "Grandma makes the best coach. She stays with you, holds your hand, tells you what to do, helps you. Husband is in and out". Another said, "I'd rather have mom if she was in town. Or both [husband and mother]."

A second group specifically stated they preferred to have their partner. One subject stated, "With my first my auntie

was with me. She helped a lot. With this one my boyfriend is coming. Better, he'll encourage me better." In reality, the presence of a partner was often not possible. The most common reason was that the partner was no longer involved with the woman at the time of delivery. One woman whose husband had left her after she became pregnant said, "I wish my husband would be there. Mom will be with me,(pause) I'll feel lonely even with mom. I wish my husband was there." Another woman talked of her boyfriend with whom she was no longer involved, "I wanted his [the baby's] dad with me, just to be there, to comfort me, to tell you it was going to be o.k.". A few spoke of relationships which had been off and on throughout the pregnancy. In most of these cases the women asked someone to be their coach and arrived at the hospital with this person. For a few, their boyfriend arrived during labour but was refused admission. These women were upset by this hospital policy and made statements like "I wanted the father of the baby, but <u>they</u> wouldn't let him come in."

Finally, there were a few women who would have elected to have their partner with them, but the partner was unwilling to participate. "He said if he had to sit through all that [the labour] he'd never fuck me again. He thought it'd be gross."

Having discussed the subjects' personal preferences the investigator explored their perceptions of how women as a whole viewed social support. Two views were clearly evident regarding the desirability of having a partner/coach with them

in labour. Each subject believed that her viewpoint was just common sense and universally held. One group held the opinion that all women wanted to have someone with them during labour and delivery. One woman said, "Everybody else had somebody with them, a husband or a boyfriend or somebody. I felt alone. I wanted that too. Everybody does." This group of women viewed the absence of a partner/coach as evidence of lack of social support: "I felt so alone, I didn't have anyone who would come", or of conflict: "My mother gave me money but wouldn't come, we didn't get along". The topic was seen as sensitive and embarrassing. Questionnaire items about the topic were considered to contribute to a feeling of loneliness and fear. Therefore, these women felt that the questions about the partner should be grouped together to allow women without a partner/coach to omit section of the CEQ. This would help prevent "making somebody feel bad because they don't have anyone."

A number of subjects suggested a very different attitude toward the presence of a partner/coach. They felt the decision to have someone with you in labour was a matter of individual choice. It was seen as quite common for a woman not to wish to have someone with her. "Half want someone and half don't." This group believed that the decision not to have a partner/coach was socially acceptable and that the items referring to this topic would not have any negative impact except if the woman attempted to answer the items as this was

would skew the results. Interestingly, of the women in the study only one actually said that she did not want a coach/partner with her. "I wanted to be by myself. I didn't want anyone to see me in pain." Perhaps the desire not to have someone present is less prevalent than these participants thought.

The conceptual issues inherent in the CEQ items of this subscale (support of partner/coach) were: the role of the partner/ coach, communication between the expectant mother and her partner/coach, prediction and importance of the partner/coach response. These are examined in the following item by item analysis.

The primary role of the partner/coach was one of comforter and "security blanket". The subjects agreed with the concept of item 17 : "I will feel comforted by the presence of my partner/coach.". However, they preferred to use "better" and "around". The presence of the partner/coach was seen as a means of reducing and controlling the fear of being alone. This fear was named as a concern by almost every subject:

-"It's scary to be alone."

-"I was terrified with being alone."

-"I worried all the time about being left alone - that they wouldn't call mom - that's what happened. I didn't want to be left alone - that's scary."

-"I don't want to be left alone. I didn't want to be by myself."

-"It would be lonely without them. Nobody beside you would be scary."

-"I'm afraid of being left alone."

-"I wanted someone with me all the time, I was afraid something would happen. I wanted someone to keep me from feeling lonely."

-"Having someone with you makes you feel better.Wouldn't want to be alone. It eases your mind."

-"You want people familiar with you around, you know, to support you, to tell you you can do it."

The partner/coach role was further explored through the discussion of item 11, "I will ask my partner/coach for help." The term "help" created difficulty. Many of the subjects asked, "what help could they give?" These women could not understand the item. Other women with persistent questioning by the investigator explained what "help" meant to them:

-"Keep you calm - to sit and talk to you - not to rub your back or anything."

-"They aren't there to help. They're there for moral support."

-"Everyone is scared, they're [the partner/coach] someone you know, a familiar face, to hold my hand, talk to me, encourage me, to get the nurse, to keep the family

informed, not to stop you from having drugs, that would cause a fight."

-"Maybe holding your hand, getting things, talking to you, and rubbing your back."

Only one suggested a role that required knowledge of the process,

-"You need someone there all the time - need someone to help you breath."

In discussing what "help" meant, the subjects made it clear that these actions were secondary and less important than staying with them.

Discussion of the role of the partner/ coach as information provider was provoked by item 28 which reads, "My partner/coach will tell me what is going on". The women interpreted this item to mean that their partner/ coach would tell them how they were progressing during labour and what was going to be done. Although the subjects found the language understandable and acceptable, the conceptual aspect of the item elicited two very different responses. The majority of respondents found the idea completely unimaginable and considered it outside the partner/coach's role. These women felt that a coach, and particularly a partner, could not tell them what was happening, since they were seen as having the same or less understanding of the process as the woman in labour. They made comments like:

-"How would they know?"

-"No, he doesn't know either, that's the doctor's job."

-"Who's to say they'd know what's going on."

A smaller number of subjects saw information provider as part of the partner/coach role and wished him to fulfill this function. However, none of these women had taken steps to ensure this occurred. Their feelings were evident in the doubtful tone they used when rewording the item, "I hope my partner/coach can tell me what was going on." Both groups expected the nurses and doctors to be the primary providers of information. Interestingly, even those women who, during pregnancy preferred not to know the details of what would occur in labour, wanted to be kept informed during the actual event. All the subjects concurred with the woman who said, "It's important to know what's happening all the time you're in hospital, but especially in labour."

Item 32: "My opinion or that of my partner/coach will be sought for all major medical decisions" resulted in a discussion of decision making - the role of the partner/coach in this process as well as what constituted a major medical decision. All the subjects had difficulty with the complex form and vocabulary of this item and suggested rewriting it to read something like this: "I'll be asked what I think, before anything is done." The subjects felt decision making was primarily the right of the doctor, and to some extent the expectant mother, because "she's the one having the baby." Most of the subjects seemed to want to be kept informed of

decisions rather than actually make the decisions. None of the women felt that the partner, and especially the coach, should make decisions. "They can make suggestions but shouldn't make decisions, it's not them having the baby." In rewriting item 32, all the women removed the portion referring to the partner/coach, and did not provide for their input, even as an adviser.

Many of the subjects seemed unaware of the number and kinds of decisions that were made during labour and delivery. What was considered a major medical decisions was difficult to determine. Many of the women had no idea what it meant and would not even attempt to give an example of a medical decision. Other women hesitantly offered these suggestions: receiving painkillers, life and death decisions, choosing whether the mother or baby would live. The questionnaire itself shaped at least one respondents thoughts on the subject. She said that her ideas had changed, "Before going through this [the CEQ] a major medical decision was having a cesarean or if you're going to die. Now I think it is shots and cesarean and other things." With probing it was found she would include having an I.V., forceps, or induction, as examples of major medical decisions. She did not consider an external fetal monitor in this category. Perhaps this was because it was viewed as noninvasive. One woman said emphatically that she wanted to be included in decision making. When asked for examples of decisions which she thought

women should be allowed to make, she suggested deciding what to eat, and whether to breast feed or not. She said that decisions about childbirth were up to the doctor. This highlights the need to clarify what subjects mean when they respond to items in order to ensure an accurate understanding of the data collected.

A discussion of the communication between the expectant mother and her partner/coach was stimulated by two items (11 and 35). The phrase "asking for help" (item 11) elicited two opposing views. Some stated they would ask for help and made comments like:

- "How else will they know what I need?"
- "He can't read my mind."

Their comments were made in a incredulous tone of voice. The second group stated that they would not ask, but would wait until the person offered assistance. One said "He will do what he wants to. I'd rather have someone ask me than have to ask for help." These women also would not ask the nurses for help but wait until it was offered. The second group preferred to see the item written, "I hope my partner will offer me help". Both groups thought everyone shared their approach to seeking assistance and acted as though the specific questioning by the investigator was very strange.

The second item related to communication was item 35, "I will <u>avoid</u> <u>telling</u> my partner/coach what I am feeling." For the word avoid, they preferred "I will tell..." or "I won't

tell..." The small amount of discussion generated regarding whether sharing of feelings is appropriate was probably due to the fact that this item was at the end of the questionnaire. As with the previous item, two clearly distinct views were expressed and proponents of each view again thought their idea was universally held. The majority believed that women would share their feelings with their partner/coach and provided reasons for doing so. Some felt the partner/coach should know how the laboring woman was feeling, and made comments like this:

-"I'd let them know then they could help",

-"If you can't share, he shouldn't be there. Women should be told in class to share, it's important".

Other subjects felt sharing experience was inevitable since labour was so stressful and painful that women were unable to contain themselves and would be compelled to share their feelings. Sharing for these women was seen as a means of reducing stress.

Some women supported an opposing view and agreed with the item. Their reasons were varied:

-"Some might not tell because its private."

-"You might not tell because feel stupid, or embarrassed or anything. You should be more clear - spell out the reasons."

-"No, I wouldn't tell, because they [partner/coach] don't care. They'd just say there's nothing they can do about it."

The supporters of the second attitude seemed to believe that there was no value or benefit in verbalizing one's experience unless the recipient of this information could effect change in the situation. Sharing feelings was not seen as a means of relieving stress or growing closer emotionally with the person.

For nurses, understanding the differences in communication styles helps to prevent automatically interpreting responses such as not asking for help or not sharing feeling, as proof of a poor relationship or inadequate social supports. The subject's understanding of support was different from the usual highly interactive behaviour seen as support by the middle class. A woman's situation and her understanding of her situation is needed to decide whether social support is lacking. For many of the subjects, lack of social support was a problem. They talked of not having anyone to come with them or the person with them not really wanting to be there. Although some considered lack of sharing to be synonymous with lack of support, a number did not agree with this idea.

In addition to discussing the sharing of emotions the investigator explored with the subjects the prediction of emotions. A strongly held feeling that events and emotions can

not be predicted was evident throughout the interview. It was particularly obvious when discussing two items. Item 1: "My partner/coach will be happy and excited", was in understandable and acceptable language, but difficult at a conceptual level. Most felt strongly that they could not predict their coach/partner's feelings. Comments were made such as:

-"You won't know what your partner feels, you don't really, everyone will put 3 [neutral]."

-"You can't know, you can't answer for someone else."

Some felt the that the item was confusing because it not only suggested predicting another's feelings but also described the feelings unrealistically. "It doesn't make sense really, maybe he'll have mixed feelings, I don't know how he'll feel." Some questioned the importance of the items, saying:

-"What does it matter, whether he's helpful is more important."

-"Why does it matter, you should have things about being supportive, I can tell you if he's willing to come but not if he's happy and excited."

Item 9, "My partner/coach will feel quite <u>helpless</u>", was also difficult for most because of the requirement to make a prediction about another person's feelings. Some again wondered why it mattered. Most also preferred the phrase "won't know what to do." The subjects' reluctance in predicting others' behaviour and feelings is

symptomatic of their reluctance to predict the future in general.

Implicit in the above two items is the partner/coach being highly involved in the event, and that his response to it is important. A discussion of the value to the partner/coach of attending childbirth resulted from these items. There was little evidence of thought concerning the effect of the experience on the partner/coach. Only two subjects said they had considered the issue. One felt that attending the birth would be "good" for the father. She went on to speak of issues of bonding. The other expressed concern for his response and welfare saying: "I thought a lot about his fainting - how he'd act, if he'd be o.k." For the majority of the subjects the impact of the event on the partner/coach was a non-issue. Most of the subjects made comments about the partner/coach being present as a service to the mother. He was there to help her deal with her overwhelming fear of the event. This apparently self-centered attitude, and the notable lack of concern for the welfare of the partner/coach, may be due to the lack of a strong relationship with the partner/coach. However, it may also be a reflection of the fact that the subjects saw labour as a negative experience and did not see the process as important or of value to anyone.

The subjects felt labour was something they had to go through to have a child. They frequently made comments about wishing they could skip the whole thing and the unfairness of

the lot of women. Many expressed resentment toward the father of the baby, "It isn't fair. He didn't have to go through anything." None expressed views that suggested looking forward to the event, or valuing it as the beginning of their relationship with the child. Since the subjects saw little value in the event for themselves, it is not surprising they saw the issue of value to the partner/coach as unimportant.

The failure to place a value, or importance, on the event of childbirth for the subject or her partner/coach relates to a general assumption in this subscale, namely that the partner/coach plays a significant role. An even more basic assumption within this subscale is the existence of a partner/coach. Associated with this is the implied assumption that the partner/coach has taken prenatal classes, and is the father of the child. The women's suggestions reflect a different set of assumptions. They would include questions asking: whether a woman had a partner/coach, whether she wanted one, and whether the partner/coach was expected to stay with the mother throughout the labour and delivery. They would also include concrete examples of his behaviour.

For most subjects the role of the partner/coach did not include providing information, making decisions, or acting as a liaison between the woman and the nurses. Most felt they could not predict their partner/coach's feelings. Differences between subjects were evident in their attitudes toward asking for help, and sharing of feelings. The role of the

partner/coach, as perceived by the subjects, was primarily to stay with them to help relieve loneliness and fear. Although the subjects' perceptions of the partner/coach's primary function is congruent with the CEQ, the overall conceptual basis of this subscale is not congruent with their view of the role of the partner/coach.

Subscale 2: Nursing Support

The subjects' comments during both the general discussion, and the review of eight CEQ items, provided the material for understanding their expectations of the nurse.

2. The nurses will be kind to me.
3. I will avoid seeking help from the nurses.
6. I will feel reassured by the nurses' presence.
7. The nurses will spend little time with me.
8. My plans for birth will be ignored by the nurse.
24. The nurses will offer me encouragement.
27. I will receive personal attention from the nurses.
29. The nurse will allow me to be an active participant in decision making.

All the ideas raised in the general discussion fell within the concepts contained in the CEQ items. Therefore the discussion of this subscale will be done largely through the item by item analysis. The conceptual issues inherent in the CEQ items of this subscale were; role of the nurse, the nurse's attitude

toward patients, and the communication between the expectant mother and nurse.

In the general discussion of their perceptions of the nurse, the subjects were asked whether they had thought about what the nurses would be like and what they would do. Subjects who had given birth were also asked if their expectations of the nurse had been accurate. The subjects initial response was that during pregnancy they had not given much thought to the nurse's role in the childbirth process. They had no specific ideas about the function of the nurse.

-"I didn't think about it, I knew they'd be there."

-"I thought there would be a nurse and a doctor, that's all, so I didn't worry."

Those with previous hospital experiences used this in formulating expectations regarding nursing care in childbirth. For example, one who had been in the hospital for surgery stated that the nurses had been "pretty nice then." She went on to explain that they had asked what she wanted and had explained what was going on. She concluded that the labour nurses would be the same. Another said that before her first child she had gone on a hospital tour and the "nurses were really nice. They made you feel good about going in (shrug), I didn't think about it much while I was pregnant."

The women revealed more specific expectations about the nurse after much encouragement: "Be there, comfort you, tell you where you're at, be polite, be concerned." These

expectations were couched in terms of hopes. "I hope the nurse would be there for me. (with questioning) I hope the nurse would stay with me, tell me what to do, tell me what is happening."

All the women agreed that the primary role of the nurse was to provide support through her physical presence. Item 6, "I will feel reassured by the nurses' presence", was conceptually relevant to all the subjects. However, they preferred the words "safer" and "around". It is interesting that the subjects reworded a similar item about their partner/coach (#17), and chose the term "better." Where the partner/coach offered a means of dealing with loneliness, the nurse was viewed as providing security against their fears of complications.

The subjects saw the role of the nurse as providing security. Most of the subjects thought the nurse would be in their room almost continuously throughout labour and delivery. Item 7, "The nurse will spend little time with me", was difficult linguistically and conceptually. As discussed in section 1 items were viewed as factually accurate. Therefore, at the conceptual level, the item was depressing and frightening. It was exactly opposite to their hope of having the continuous presence of a nurse. Some of the subjects remembered the nurses being with them most of the time "The nurses were in and out all the time." They felt the item was intentionally frightening and misleading. The formal structure

of the item also made it confusing. The most common rewording was "won't be around much". A few of the subjects said the item was accurate. They recalled the nurses as leaving them alone and were angry about it.

-"They left me by myself. If I knew that would happen I would have made sure some one was there."

-"They should tell you they are going to leave you alone. They should make sure you have someone."

All the subjects thought this item would increase fear.

All the respondents viewed the nurse's role as one of providing care or help. Help was seen as synonymous with care. All hoped they would receive help during their labour and delivery. Item #3, "I will avoid seeking help from the nurses", which was reworded as "I won't ask the nurses for help", was understood to mean that a woman might not want help. The item prompted comments such as: "Strange question, couldn't answer. Why have it in here? Most people want to have help." "Why ask this, nurses are there to help." The idea of not wanting help was beyond the comprehension of some of the subjects, and considered foolish by the rest. Only one woman said that she might not ask for help if the nurses "aren't good - if they're rude or laugh at you."

One of the ways the subjects hoped the nurse would help them was by being encouraging. Item 24, "The nurse will offer me encouragement," was reworded to read "I hope the nurses will encourage me." The item was conceptually pleasing to the

subjects and congruent with their hopes. To the subjects it meant telling them that they "could do it, everything would be alright, and the baby would come soon." It was considered more specific and easier to answer but the same as item 2 "The nurses will be kind to me".

The role of the nurse, as well as that of the doctor and client, in decision making was discussed through examination of item 29,"The nurse will allow me to be an active participant in decision making." Item 29 was not understood on either a linguistic or conceptual level. The investigator felt many were considering the whole concept of decision making in childbirth for the first time. Finding an acceptable rewording was difficult. Each of the following suggestions captured the different types of relationship the women wanted with the nurse with regard to decision making. The favorite rewording was "I hope the nurse will help me make decisions". Most subjects did not see themselves as independent decision makers. They wanted to be told when a decision was needed, to have their options outlined by the nurse, and then to be assisted in making a decision. This group wanted the nurse to be a partner in decision making. They assumed the nurse would then act according to their jointly made decisions. Another group saw the focus as being one of listening, and preferred the rewording: "I hope the nurse will listen to what I want to happen." They simply wanted their ideas to be considered when decisions were made. They did not feel they would make the

decision. A small group had a slightly different focus. "I hope the nurse will ask me what I want." They too wanted to "have a say" but would not voice their ideas unless approached for them. Finally, a few women said they wanted to make decisions on their own. They were concerned that the nurse provide them with their range of options, and then ask and allow them to make decisions. This last group was unable to offer an acceptable rewording.

All the women had difficulty stating what decisions might be needed and felt the nurse was responsible for being sure the expectant mother knew what decisions needed to be made. Thus, part of the role of the nurse was information provider. The nurses were seen more as a bridge between the expectant mother and the doctor in the decision making process. The doctor was viewed as having the responsibility for decision making, with the mother having some rights since she was having the baby. The nurse's role in decision making was not raised by the subjects during the general discussion of the nurse's role. This suggests that the subjects' prenatal expectations of the nurse did not include the concepts captured in the item - the nurse as a gatekeeper in the decision making process.

Many of the subject's prenatal expectations did include ideas on the nurse's attitude. One woman was able to clearly articulate her expectations of nurses, "I thought the nurses would tell you what's going on, listen to you, be patient.

They didn't talk to me, I never felt they really cared, they were just doing a job. In discussing items 27 and 2 other subjects' hopes regarding the nurses attitude became clearer.

In item 27, "I will receive personal attention from the nurses", the term personal provoked much discussion. All, who knew the word, felt it suggested the nurse would talk to them. For some it also meant "being friendly" and "doing little extra things for you". "Personal means the nurse knows your name, asks you if you want anything. Not in the room all the time but deals with you like an individual - not routine." All wanted to receive "personal" care although they were unsure if they could really expect it. To remove the term was to make this item the same as other items. "Personal adds a lot. If you leave it out it's the same as 24" (offer me encouragement). The subjects who did not understand the word "personal" saw the item as redundant and suggested it be removed.

The subjects hoped the nurses would be kind, and liked item 2 "The nurse will be kind to me." All of the respondents understood the language. The difficulty that some of the subjects had with this item was its "vagueness" They were unsure if kind referred to specific actions or to the attitude of the nurse. Many subject felt kind should be replaced with a more specific concrete word or that examples should be added to illustrate the term. For example "the nurse will be kind, she will help me in and out of bed, she will explain what is

going on." If the item is to reflect attitude then one suggested example was

-"The nurse will not yell at me."

-"I hope, the nurse will speak to me in a nice way".

Communication between the expectant mothers and the nurses was an issue raised in the discussion of many of the items. Some of the items already discussed were also related to the issue of communication. Item 3 addressed the issue of the women's asking for help. Most of the women felt they could ask for help, although some felt they would wait until help was offered. Item 27, related to personal attention, was interpreted as also being an issue of communication, since personal attention was defined as "the nurse talking to you". Item 29,"The nurse will allow me to be an active participant in decision making." concerned the role of the nurse as a gate keeper to decision making. It was viewed by the respondents as an issue of the nurses telling them what was occurring, talking about alternatives, and asking for and listening to their ideas.

One item will be discussed exclusively in terms of communication. Item 8, "My plans for birth will be ignored by the nurse", was considered more negative but still the same as item 29. The subjects found the suggestion that the nurse would ignore them as frightening. They reworded the item to read "I hope the nurses will ask me what I want", or "I hope

the nurse will listen to what I want." All the women wanted the nurse to listen to them. The phrase "plan for birth" was incomprehensible to all the subjects. They did not believe one could plan an event like childbirth. One woman expressed it well: "You can plan your holidays but you can't plan having a baby". Through discussion, the investigator was able to help them understand, and realize that they did have plans regarding their labour and delivery. Their plans were expressed in terms of hopes, were generally not clearly defined, and lacked specific details. "I hope to have freezing (an epidural)", or "I hope my boyfriend is with me". None of the women had strategies for ensuring realization of their hopes/plans. All seemed to feel that the event was outside their control. After their first experience a few of the women made an effort to ensure some control with their second. For one this meant attending prenatal classes, while for another this meant asking someone in advance to be her coach.

Throughout the item review the subjects suggested deleting the planning and independent decision making aspects, as well as all frightening items. Their suggestions for additional questions were related to making the concepts of the subscale more specific and concrete. Some of the suggestions were:

-"I hope the nurses will listen to me."

-"I hope the nurses will be understanding."

-"I hope the nurses don't put me down."

-"I hope the nurse doesn't yell at me."

-"I hope I am given choices like what to eat and how to feed the baby."

-"I hope the nurses spend lots of time talking to me."

-"I think the nurse will explain what is happening."

-"I think the nurse will stay in the room all the time, so I am never alone."

-"I think the nurse will do what the doctor tells her, like give me shots."

In examining their suggestions for the subscale - nursing support - it was evident that the subjects have a different view of the role of the nurse and the childbirth process than the one evident in the CEQ. The basic assumption of the questionnaire was that an expectant mother has: knowledge of what occurs in hospital, plans for her childbirth, formed detailed expectations about the nurses' behaviour and attitude, an understanding of birth as a process of decision making, an understanding of the concept of gate keeping, and the desire to be actively involved in decision making. These assumptions were not accurate for the subjects. Their understanding of decision making and of the nurses' role and power was at a basic level. The subjects displayed a great deal of trust in the nurse, expecting she/he would be supportive, kind, provide information, and act as an adviser. The expectation was that the nurse would reduce their fear.

The nurse was viewed as a safety net protecting the labouring woman from "something terrible happening."

The subjects' perception of the meaning of nursing support was congruent with some of the items of this subscale. However, other items proved to be conceptually incongruent. The underlying assumptions of this subscale, regarding the role of the nurse, the nurse's attitude toward patients, and the communication between the expectant mother and nurse, account for the incongruence that existed between the views inherent in some of the items and the subjects perspective on what nursing support meant.

Subscale 3: Coping with Pain

4. I will be immobilized by the pain of labor.
5. I will be able to cope with labor.
12. I will worry about the severity of labor pain.
15. I will be afraid of panicking.
16. I will experience discomfort but not unbearable pain.
18. I will feel intense pain.
22. I will be afraid of being a coward.
23. I will be able to relax during labor.
26. The pain of labor will be agonizing.
30. I will be scared when I think about the pain of labor.
36. I will be embarrassed by my behavior.

During the general interview the subjects identified the pain of childbirth as a major source of concern during pregnancy. A more detailed discussion of this topic occurred in the review of the eleven CEQ items of this subscale. All the ideas raised fell within the concepts contained in the CEQ. Therefore the discussion will be done through the item by item analysis. The conceptual issues inherent in this subscale were: the expected level of pain, and its impact on emotions and behaviour.

Three items specifically requested the respondent to rate the expected intensity of labour pain: item 16, "I will experience discomfort but not unbearable pain", item 18, "I will feel intense pain", and item 26, "The pain will be agonizing." All the women had difficulty with the idea of predicting their pain with the degree of accuracy suggested in these items. Most of the women stated that prior to experiencing childbirth they had thought about the pain in general terms: "I never really thought about the pain or how it would happen - just thought would hurt." Some of the women thought it would be like "menstrual cramps" or "not such a big deal." Some thought it would be very painful. All who had been through labour agreed that the pain was intense. "I had no idea it would be so bad - I was scared."

The pain experienced during the actual delivery was unexpected. Most found the actual childbirth to be extremely painful and expressed disappointment. "I thought I'd be

smiling, like the movies, when the baby came out, I was crying in pain and couldn't hold the baby because I was so tired." The tone of voice was one of irony mixed with deep disappointment. Only two subjects felt that their preconceived ideas were worse than their actual labour and delivery. Both these women had an epidural.

Items 18 and 26 were conceptually congruent with the experience of most women. Despite this the women objected to including them. The content, frequency, and unfamiliar language of all three items was considered frightening. The subjects suggested having only one item which read, "I think the pain will be bad" or " I don't think the pain will be really bad". However, they preferred not to include any reference to the degree of pain.

Eight items dealt with the impact of the pain on emotions and behaviour. Two items focused on being fearful about the anticipated pain: items 12, "I <u>will</u> worry about the <u>severity</u> of labor pain" and item 30, "I <u>will be</u> scared when I think about the pain of labor." Most of the subjects identified with the idea of being afraid of the pain. One woman commented, "Everybody told me it would be bad, I was scared." A few said they had not worried about the pain, "I wasn't scared of the pain because I didn't know the extent of it." Most of those afraid of the pain tried to control their fear by not thinking about childbirth, "I just put it out of my mind." However, as their pregnancy progressed many could not avoid thinking about

it. One said "I thought about it every day at the end especially once it was overdue." When discussing their fear of pain it was apparent that the expectation of receiving pain medication helped most of the women cope. A commonly expressed view was "I'm scared of the pain. I want to have something, I don't want to feel it, at all." Another said, "I hope the medicine will take the edge off, or I'll go crazy with the pain". A few women did not realize that pain medication was available and they tended to have greater concern about the pain. One said "I thought you went in and just went through it and had the baby. I was scared, I didn't know nothing about pain killers." None of the women could understand the use of the future tense in these items. Whenever they thought of the pain they experienced fear. Therefore they believed the items should be phrased in the present tense, "I am scared when I think about labor pain" or "I am worried about how bad the labor pain will be." The subjects did not think that the use of the present tense negated the fact that they would be fearful of pain during labour. In addition, all the women thought that one item would be sufficient, as the content was frightening.

It was widely expected that the pain would impact on their activity in labour. The degree of impact of pain on activity was proportional to their expected level of pain. Those who expected a high level of pain thought they would not feel like walking, and a few of them thought they might not be

able to talk and make their needs known. Others who expected the pain to be relatively minor anticipated remaining active. Therefore, item 4 "I will be immobilized by the pain of labor" was conceptually congruent with some of the subjects feelings. The item was linguistically a problem and was reworded by the subjects in a number of ways. The most common was, "I think I'll stay in bed because of the pain." However, most of the subjects wanted the item deleted as they felt it was negative and would needlessly scare expectant mothers.

Item 23, "I will be able to relax during labor", was a problem for most subjects. The term relaxed was seen as being free of physical and emotional tension. Most felt it was completely unrealistic. They preferred to substitute calm for relaxed. The term calm was understood as not showing the tension one was experiencing. Although they could conceptualize staying calm the women expressed skepticism of this actually occurring. Most did not anticipate being calm. Comments like these were made;

-"I thought I'd swear and scream",

-"I'm pretty hyper, I can't stand pain, I might have to be held down."

Only a few had thought they might stay calm during labour.

-"I thought I'd be brave."

-"I hoped I'd be quiet."

None of the subjects who had experienced labour thought they had remained calm.

Item 5, "I will be able to cope with labor", was seen as closely related to the above item. Most found the term "handle" more acceptable but some preferred the word "cope". Coping or handling a situation was discussed at length. The terms were defined in a variety of ways. For some it meant doing well, "doing pretty good, not just barely getting through," or "take it without screaming, means you did good job." For others it was neutral, meaning getting through by any means. "It means just getting through - going through whatever way you have to. If you have to scream - scream. If you have to have medicine - take medicine. Just get through." Some defined it in relation to taking medication:

-"it [the item] sounds like I can do it [labour] on my own, without medicine or anything."

-"be able to take it, do alright. Can take medicine and everything. Do o.k. then you can handle it."

When asked if they had handled/coped well some of the women said no: "I screamed, freaked out", or "I cried and cried." One who said yes, shrugged, and then she "I'm here", indicating that surviving was coping. With the variety of definitions it is difficult to state what a response to this item would mean. None of the women gave any examples that would indicate that they would evaluate their coping in intellectual terms such as making appropriate decisions or obtaining information. All their references were to the physical and emotional aspects of coping.

Three items were closely related to the previous two items and were seen as essentially the same by the subjects. Item 15, "I will be afraid of panicking." Item 22, "I will be afraid of being a coward." Item 36, "I will be embarrassed by my behaviour." The subjects did not see a conceptual difference between items 15, 22, or 36. Many felt the items did not accurately capture their feelings, and were not relevant conceptually.

-"I didn't think about being embarrassed, coping or acting stupid because I thought having a baby was relatively easy."

-"I never thought about how I'd act."

Although fear was viewed as common to all women, it was seen as generalized and not as specific as the items suggest. A number of the women recommended deleting the items, as they might increase fear and suggest that women should be concerned about panic, cowardice, and embarrassment. If the item was not deleted then the preferred alternative wording was "I wonder how I'll act in labor."

Subtle differences in the understanding and use of language were evident when the changes to the items 15, 22, and 36 were discussed. In item 15 those who preferred "losing control" saw it as a weaker term than "panic". Others felt "losing control" was the stronger term and preferred panic. All the women preferred which ever term they viewed as less severe. In item 22 some of the subjects would have changed

"coward" to read "chicken", however others strongly objected because "chicken" was slang and was too informal a word. Item 36 relating to embarrassment evoked two opposite responses. One group stated they never thought about embarrassment and felt it had no part in the questionnaire. "I didn't even think about this before labour. I was never embarrassed, everyone else was screaming, so there was no need to even think about that." The other group stated they had worried about embarrassment. Most named a number of situations that would provoke the response. One particularly articulate subject captured their comments, "I was embarrassed by being in the stirrups, being examined, having an enema, being prepped, all the things done to you. Lots of people are shy and worry about it." Only a few said they had thought about embarrassing themselves when they thought of labour. "I thought I might scream, I hoped I wouldn't, it was so embarrassing." It was the investigator's impression that these items were sensitive and that more women thought about it then were willing to admit. The subjects wanted it clearly understood that women shouldn't be made to feel embarrassed and that the items focused on the wrong aspects of worry and embarrassment.

This subscale - coping with pain - was a sensitive issue for the subjects. While some items were conceptually congruent with their beliefs, others were not. Underlying assumptions in the CEQ created problems. One assumption of this subscale was that expectant mothers are concerned about their behaviour,

and that staying in control is an important issue. Another assumption reflected in the items is that embarrassment is primarily a result of one's behaviour and not the circumstances of a situation. The subjects did not identify with these issues. Other assumptions of this subscale are: pain is consistent throughout labour and delivery, the degree of this pain can be anticipated and fear is related primarily to this anticipated pain and not other factors. Suggestions for changes were made to increase the congruency between the concepts of the items and the women's experiences. Suggestions for change include: deleting and combining many items in order to reduce the unnecessary raising of fears, adding items about embarrassment related to exposure as well as items related to fears of complications, and not understanding what is occurring. Although they considered the issue of pain, fear and embarrassment to be highly sensitive and likely to cause anxiety some saw benefit in addressing them. "I screamed and was totally out of control because the pain was so unexpected. If you did this [completed the CEQ] it would make you stop and think." To ensure that women were not frightened they suggested the topic of pain be handled through personal discussion and only briefly addressed in the CEQ.

To conclude, many subjects were afraid of the pain but had not clearly formulated expectations about its degree or impact. Most expected to cry but had not thought more specifically about what how they would act or whether they

would be embarrassed by their behaviour. Most expected to receive medication to control the pain. All who had experienced childbirth did receive pain medication with their first, and most expected to so with their second birth. All the women objected to the number of items concerning pain as they felt it would unnecessarily increase fear. The attitude of the women and the questionnaire showed conceptual congruency regarding pain of childbirth as a major concern to pregnant women. However, some of the CEQ items were incongruent conceptually with the views held by many of the subjects, especially in the realm of coping with pain.

Subscale 4: Medical Interventions

This subscale was closely linked to the previous ones. Medical procedures were discussed in both the general interview and in the review of the ten CEQ items related to this topic.

10. I will be required to have routine procedures even if don't want them.

13. There is little chance that I will end up having a cesarean section.

14. Lots of medical equipment and machinery will be used.

19. I will have a childbirth free of medical intervention.

20. I will be up walking around for most of my labor.

21. I will want to have fetal monitoring.

25. Forceps will be used.

31. I will refuse to have any procedures I consider unnecessary.

33. I will use anesthetics and/or pain killing drugs.

34. The doctor will make most of the decision.

The concepts inherent in this subscale are: the role of the doctor, the role of the expectant mother, and her expectations regarding specific medical interventions. Responsibility for decision making was a theme which ran through all three concepts. Almost all the data collected fell within the parameters of the subscale. Therefore most of the information will be discussed in the item by item analysis which follows the presentation of more general information.

Prior to their first childbirth almost all the subjects had only a vague idea of what would occur in the hospital during labour and delivery with regard to medical interventions. "I don't know what they'll do. I try not to think about it." After some probing it was found that, while most had little knowledge of specific procedures, they had formed a picture of what would occur. Almost all the women expected their doctor would be present during most of the experience, that he would examine them a few times during the process, and that he would order medication appropriate to their needs. Labour and delivery was viewed as a relatively private time with only their doctor, a nurse, and possibly a partner/coach present. "I thought there would only be one

doctor, one nurse and me." Many of the subjects worried about being exposed and embarrassed during medical interventions:

-"I didn't want anyone to see my bellybutton sticking out."

-"I don't like my private parts being seen, I worried about it."

The women recalled their experiences and talked about which aspects upset them. Receiving interventions such as I.V.'s, shave prep., enema, monitor, and being required to fill out many forms were accepted by most as part of the process and did not cause concern. The lack of explanation did however, cause much concern.

-"They never told me nothing. I didn't know they were going to break my water or put on the monitor."

-"I didn't think I would be examined like that, I didn't know what dilate was. They'd check and say 'dilated something' and go . . . didn't know what was going on."

-"I thought I'd ask when I wanted something for pain. They just gave it when they thought they should. They just told me to turn on my side, they didn't tell me I was getting an epidural."

A second cause of concern was the lack of privacy and the number of staff providing care.

-"I was embarrassed by the swinging door. People were in and out all the time."

-"I didn't know there would be lots of students. No one told me students would be there. No one asked if it was o.k."

-"I didn't think about the number of doctors - it bothered me - I didn't know I could refuse."

-"I was embarrassed about the thought of being seen, I didn't realize there'd be so many examinations or all the different doctors or nurses. I had female doctor through the pregnancy. I didn't want a man."

Some subjects suggested their lack of knowledge about medical interventions helped them not to worry about the issue prior to the event.

-"I was totally unaware I'd be poked and prodded by all those doctors - so I didn't worry. I thought I'd have one nurse, one doctor and they'd check me once in awhile, never thought so much."

-"I didn't worry or think about it. I didn't know I would have monitor, medication, I didn't realize extent of it."

The role of the doctor was explored through the item by item review. Item 34, "The doctor will make most of the decisions" explicitly addressed the issue of doctors as the prime decision maker. Three types of response were given. The first, and most common, strongly agreed with the item and even suggested strengthening the wording by changing the item to read "Doctors should make most of the decisions." The second type agreed with the physician making decisions but wished to

qualify how this was to be done. They suggested that discussion or explanation should occur before the physician made the decision. This did not remove the responsibility of decision making from the doctor but addressed the problem of inadequate explanations which many experienced. The third type of response was expressed by only a few subjects. These women wanted to be decision makers. Through discussion it became evident that this group still expected the doctor to make the "critical" or "life and death" decisions. The women in this third group stated that prior to their first child their response to item 34 would have been the same as the first or second responses. "With my first I just expected the doctor to make the decisions, but you change, you know." To explain their change they recalled their childbirth experience, repeated exposure to the health care system, and contact with individuals who encouraged assertiveness.

A discussion of the expectant mother role in deciding on procedures was stimulated by a number of items. Item 31, "I will refuse to have any procedures I consider unnecessary", was difficult linguistically. The item required much discussion before it was understood by the respondents. The general attitude was that there were no unnecessary procedures. They did not see it as their role to judge whether something was necessary, and recognized that they did not have the knowledge to make such a decision. "You can't know what's unnecessary, particularly with the first. Doesn't make sense.

When you're pregnant you go along with whatever the doctor thinks is necessary." The women's comments reflected their trust in authority. The researcher wondered if some of the irritation displayed in answering this item was due to the implicit threat to their belief in labour being a self-determining event, and their belief in the doctor as decision maker. Most felt the item should be deleted. If it was not deleted they preferred an alternative wording which focused on explanation rather than decision making "I want all things explained before they are done."

Item 10, "I will be required to have routine procedures even if I don't want them", also examined procedures and the degree of control which the women expected. The subjects agreed with the concept of the item, as they expected to have "some things done" as a standard part of childbirth. During their first pregnancy none of the women knew what would occur. Many said they were surprised by the monitoring, the number of examinations, the number of staff, and the requirement to have an I.V.. When asked to define more specifically the term "routine procedure" a variety of responses were given. The responses fell into two categories. The first defined "routine" as "everything" as long as no complications arose. They included: the paperwork, fetal monitoring, I.V., episiotomy and forceps. The second viewed it in relation to decision making. This second group included activities that were done "without a decision being needed". They gave

examples including: I.V., enemas and examinations. The second group did not view receiving medication as routine, as they felt it required a decision by the doctor. As with item 31, the subjects viewed routine procedures as beyond their scope of control. They saw them as a necessary aspect of childbirth and used phrases like "they know best" to explain their acceptance. The women expected to have a passive accepting role. They did not expect to be consulted, but again expressed the desire to be kept informed. To avoid the term "routine procedures", the subjects suggested rewording the item as, "I think some things will be done when I go to the hospital." They deleted the phrase, "even if I don't want them", as it was seen as needlessly frightening.

All subjects' expectations included the presence of a physician directing their childbirth and some level of intervention was desired. Therefore, item 19, "I will have a childbirth free of medical intervention", was conceptually incongruent with their wishes. It was difficult to discuss because the subjects did not know the meaning of "medical intervention". The closest term that could be found that expressed "free of medical intervention" was "natural childbirth". This latter term was defined in three ways. The first group defined it in terms of procedures, and felt it meant having "nothing" or no interventions. They included: no painkillers, no freezing in the back, and for most no I.V.. As one stated "it's like having your baby at home, everything

else is medical." Using this definition, natural childbirth was rejected by all the subjects. None wanted to have their baby at home. They acted horrified at the suggestion and felt it was extremely dangerous. "You wouldn't want it at home - nothing to save you or the baby if something goes wrong". The second group defined natural childbirth in relation to control, and said it was having the baby "the way you want to." For these women painkillers, or anything else, was acceptable if the woman wished it. One specifically mentioned not having to have examinations or fill out forms: "It's not having to answer all the questions, not all the doctors, not all the machines, not the I.V. ... painkillers if you want. Like hopping into bed and having just what you want." The third group defined natural childbirth as having the baby vaginally. Natural was used in contrast to cesarean delivery. Therefore the use of forceps did not affect the designation of a vaginal delivery as natural. The fourth group could not conceptualize or define "natural childbirth." All the groups had difficulty with the idea that the decision to have their childbirth free of medical intervention or "naturally" was within their decision making role. The women recommended the item be deleted, as no alternative wording expressing the concepts of this item could be found.

The subjects' expectations and knowledge of specific interventions became evident in the review of the remaining seven items in this subscale. Item 13, "There is <u>little chance</u>

that I will end up having a Cesarean section", and item 25, "Forceps will be used", were considered by all the subject to be outside their decision making roles. These decisions were seen as within the realm of the physician's responsibility. Many suggested that the need for either of these interventions was outside anyone's control, including the doctor's.

-"Nobody knows - you can't know -unless you've had one before. It depends on if the baby's big. You don't know till it's time. Even the doctor doesn't know."

-"You can't know beforehand. You can't decide anyway."

Most of the subjects would simply delete the items. - "Can't answer, I don't think it's a question to ask or answer."

-"Stupid, leave it out."

-"Why ask, you can't know, its scary."

Some of the subjects suggested modifications:

-"I hope I won't need . . .",

-"I hope they will tell me before they do . . . "

These comments reflect their wish to be kept informed of ongoing decisions. At a linguistic level both items presented a challenge. In item 13 the term "cesarean" was known by all the women, but many found the inclusion of the word "section" confusing and recommended that it be removed. Most did not know what the term c-section meant. Therefore it would not be an acceptable alternative. No acceptable non-frightening alternative was found for the word forceps.

Item 14,"Lots of medical equipment and machinery will be used" asked the respondent to predict the amount of equipment that would be used in providing care. All the respondents stated they had not given much thought to this aspect prior to their first delivery. The item created an image of the physical environment. Machinery had the connotation of farming and was considered inaccurate, while "lots" was seen as needlessly frightening for a first time mother. For women who had experienced childbirth the item provoked much laughter. For first timers it proved frightening. Even though the experienced subjects frequently made reference to all the "stuff" that had been a part of their labour they recommended the following rewording: "Medical equipment will be used." The investigator concluded that the subjects were willing to have items be somewhat more positive than what they had experienced in order to meet their objective of preventing fear.

Most of the women agreed conceptually with item 33, "I will use anesthetics and/or pain killing drugs." The use of medication was one intervention most women had considered. A few did not realize that the event was painful and did not know medication was an option. Some knew a great deal and were able to tell the interviewer the whole range of options while others just knew something was available. Freezing in the back, their expression for an epidural, was well known among the subjects as was gas by mask. Childbirth without medication was not a popular goal and most subjects agreed with the item.

A few agreed with a qualifier. They planned to use medication if they were unable to manage without it. Their commitment to a medication free birth was not strong;

> -"I thought I'd try without anything, if it gets bad I won't stick with it. . . . No I won't feel bad if I need something."

A few women were encouraged by their partner or coach not to use medication.

> -"My boyfriend doesn't want me to take medication, I'll have it naturally unless the pain is too much, I'll try the breathing, I guess it depends on how big it is."

All who were interested in a medication free childbirth had been exposed to education through reading, prenatal classes, or instruction in traditional native practices which included breathing techniques. Some had practiced the breathing and some had not. Generally breathing techniques were considered an adjunct to medication and not a replacement for it. Those who had experienced labour generally thought breathing techniques were ineffective. All who had experienced childbirth had received medication.

Although this item did not present conceptual problems it was difficult linguistically. "Anesthetics" was the problem word. The subjects thought it had something to do with "putting you to sleep", but weren't sure. Only one thought it might be "freezing the back". All recommended deletion of the term. Some also wished to see the phrase "pain killing drugs"

changed because they felt it would cause fear. Alternatives suggested included: "medication to stop the pain" and "drugs to make me feel better."

Item 20, "I will be up walking around for most of my labor" was understood by all the subjects. The only recommendation for change was to change "will" to "hope to." Some of the women felt that the item was misleading as monitoring did not allow walking, while others felt that the pain would restrict them.

Item 21, "I will want to have fetal monitoring", was difficult for the women to understand. The women liked the idea of having their baby checked, saying it made them feel safer. However some didn't want continuous monitoring. Every subject thought the wording of the item needed to be changed. A number of alternatives were suggested. Many simply wanted "I want to have my baby's heart checked", while others thought "I want my baby's heart rate checked all the time with a machine" would be better. All felt the item might need to be explained. Some thought it could be compared to ultrasound which they felt most women had experienced.

This subscale like the others is based on a number of assumptions. These include the assumption that: prediction of future events is possible, childbirth is a process which involves decisions, interventions are selected not determined, expectant mothers are knowledgeable about interventions and decisions, and finally that they can and want to influence the

decisions and choice of intervention. These assumptions were in conflict with the beliefs and concerns of the subjects. During the discussion it became evident that many women found medical procedures to be frightening. A woman who had not known about the artificial rupture of membranes said, "I worried that they would hit the soft spot when they broke my water." Part of the cause of this fear was a lack of explanation, "They never explained nothing, they just started the induction, gave me needles and everything without telling me what they were for." The subjects wanted items included related to explanation and teaching. They suggested listing possible procedures rather than using global terms like "routine". The women thought this would provide more accurate data and would educate women about what happens in the hospital. They also suggested including items about the expected number of personnel, their doctor's involvement, and ways to ensure privacy and limit the number of students. The subjects wanted the wording of items changed so that the focus was on their feelings about interventions occurring, rather than on whether these interventions would occur. This reflects their belief that the decision is outside their control.

In conclusion, the subjects' belief that prediction of the future is impossible was evident throughout the review of this category. The data also showed that, while they stated they wished to have a role in decision making, they perceived that their capacity to do this was limited. Many decisions

were not recognized as such and were seen as beyond their influence. Many interventions were viewed as either mandatory routine procedures, or within the exclusive jurisdiction of the physician. The subjects indicated that before their first childbirth they had expected their physician to be the major decision maker, to be present throughout much of their labour, to examine them, to provide information on their progress and to deliver their baby. Most had expected that routine procedures would be conducted as part of the process of childbirth. These included medication for the pain and other undefined procedures. They did know that some things would be done to them in the hospital. Most of the women had little knowledge and had little given to them during pregnancy. The subscale as a whole failed to capture their concerns regarding embarrassment, explanation, examinations, and the number of personal involved. Conceptually, many of the items of this subscale were incongruent with the beliefs of the subjects.

Issues Not Captured by the CEQ

To gain insight into how the subjects understood and communicated their ideas about childbirth a general discussion as well as a review of the CEQ was conducted. In this discussion women were asked to explain what they thought, or had thought, having a baby would be like. General, as well as specific questions were asked. Much of the information

collected related to the four subscales in the CEQ, and this material has been discussed in the previous section. Some significant concerns however, arose that were not captured by the CEQ and these are the focus of the following discussion.

This information is included for three reasons. First, it addressed one of the purposes of the study. This was to gain a greater general understanding of the childbirth expectations of women of lower socioeconomic status. Second, by providing this insight it allowed the CEQ to be seen in context, providing a background into which to fit the CEQ. Third, data which did not directly relate to the CEQ was included to provide insight into changes needed to make the tool more relevant for this population.

Below are three figures. The first displays the subjects' childbirth concerns. The second pictorially illustrates the CEQ. The third demonstrates the relationship between the first two diagrams.

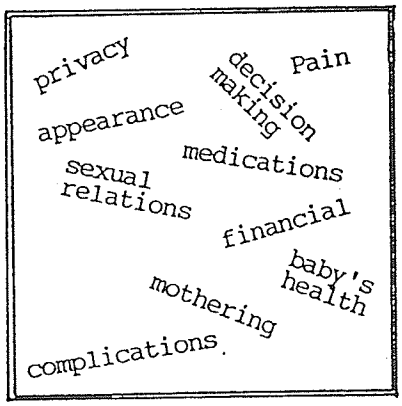

Figure 2. Childbirth Concerns

Figure 2 shows the concerns that the subjects expressed regarding childbirth. These concerns are not organized in priority; rather, they are placed in the order they were related by the women to the investigator. Their conversations were often in a stream of consciousness style - a disjointed collage of images and emotions. They would jump from one topic to another, and would sometimes contradict themselves.

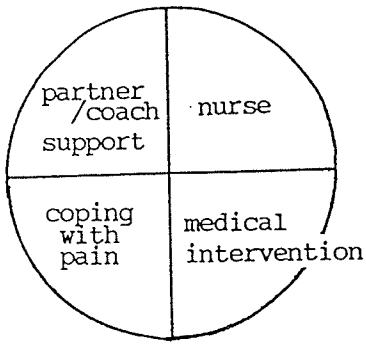

Figure 3. CEQ

Figure 3 shows the CEQ as a pie with its four distinct topic areas.

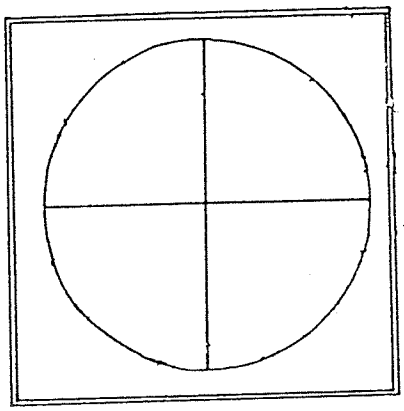

Figure 4. CEQ Superimposed on Concerns

Figure 4 combines figures 2 and 3 to give a pictorial image of the relationship between the subject's concerns and the CEQ's four topic areas. The CEQ captures and organizes some of the expectations of the subjects. The rest of the expectations provide the background against which the CEQ can be understood. In the next chapter the diagram will be expanded when general recurring themes are discussed.

Source of Knowledge

It was assumed by the investigator that the subjects' expectations regarding childbirth were influenced by the information they had received. The subjects' source of knowledge about childbirth was therefore, viewed as relevant. For the majority of respondents their mothers, "aunties", and friends, were their primary source of the information. Generally it was accepted that it was the mother who should tell her pregnant daughter what to expect. Three subjects who were telling pregnant relatives or friends about childbirth said they were doing so because the mother was not doing so. For many of the subjects their mother was a primary source of information. Friends were also involved in providing information. One subject stated that she "had a friend who had a baby three months before me, so I asked her how she knew when [to go to the hospital] and how it had been. She told me it went alright." Many subjects said that what their family and friends had told them was confusing or frightening. One

woman stated she didn't know what to think since "lots of people have told me different stories about how long it [labour] lasts and what it's like." Another said, "People tell you stories, it scares you more, you know." Some of the subjects felt that they received very little information from their family and friends.

-"Mom told me. She didn't tell me much. I knew she had a hard time and thought I would too."

-"I was never told nothing, everyone backed off, afraid to scare you."

Generally women who said they had received very little information felt this was negative when it came time to cope with labour and delivery. However it was accepted that information had to be carefully selected so as not to increase fear.

A secondary source of information was a prenatal course. Of the subjects who attended only one had completed the course. The others attended only a few classes. All the women who attended prenatal classes saw films of childbirth. They felt however that they learned very little from this experience, stating that it was frightening or unrealistic. Comments were made about the films were:

-"Not realistic - don't show exhaustion - all have big grins (shrug). I said give him [newborn son] to Mom, I was really tired, too tired to hold him."

-"I saw a film - didn't watch all of it - It was scary, you know."

-"Films aren't the same, everyone's smiling and happy, just not the way it is."

None who had experienced childbirth felt that prenatal classes prepared them for the experience. "Anything prenatal taught me I forgot, [childbirth classes] are so different from what really happened." Most of the subjects would not recommend classes for this reason. However, one who agreed that they weren't realistic said she would recommend them "it doesn't help much but it does help you stay calm during pregnancy."

A third source of information available was written material. This was used very little by the subjects. Only one stated that she had read about childbirth. When asked how extensively she had read she responded "a lot." This subject had a detailed knowledge of the process, but was uninformed about certain aspects. For example she was unaware of the appropriate time to go to the hospital or that in order to use breathing to control pain, practice was necessary. This woman's information was not sufficient to ensure she understood what was occurring or receive sufficient explanation during labour and delivery.

Whatever their source of information, the women interviewed had generally gained only a minimal understanding of the details of labour and delivery. Through careful questioning the investigator was able to gain insight into

what the subjects did understand about childbirth or in their language "having a baby." Using their language the investigator asked questions like:

-"What do you think about when you think about having a baby?"

-"What do you think having a baby will be like?"

-"What were you most worried about?"

-"What did you think about most?"

-"What did you think actually having the baby would be like? You know the actual labour and delivery."

These, and the questions regarding what should be added to the CEQ, revealed that their frame of reference could not be limited to the actual physical process of childbearing. They talked about their concerns related to the pregnancy, life after the baby's birth, as well as the process of labour and delivery itself.

Concerns of Pregnancy

Pregnancy was a time of mixed emotions and many concerns. Some concerns related to the changes caused by the pregnancy, such as changes in appearance, lifestyle changes and the health of the unborn baby. Many were embarrassed by their appearance. For some this was due to the fact that their appearance was an indication to the world that they had "done it." Others talked of wanting to be able to wear tight jeans

and look like everyone else. Only a few said they were happy with their pregnant appearance or that it had not mattered.

Lifestyle changes was another topic the subjects named as a concern during pregnancy. All the respondents knew that they should not drink, smoke, or take drugs, and that they should eat "right" and take care of themselves. Many stated that they felt guilty throughout their pregnancy because they hadn't done all these things. One subject said she didn't stop smoking and that she had "felt bad all the time". Her baby was a good weight and healthy, and she now questions the validity of these health recommendations. The acceptance of the effect of maternal behaviour on infant health was indicated by statements such as:

> -"One of my friends is pregnant, she already has two kids, she does drugs, and last weekend she got really drunk - falling down and everything - her parents didn't do nothing, I wonder how the kid will turn out."

Although the health of the baby was seen as somewhat dependent on the mother's behaviour it was also widely accepted that it was largely outside one's control.

The greatest concern for all the subjects was the health of the unborn child. "I think most about if the baby is o.k. then about the pain." All the women stated that they frequently wondered whether their baby was healthy and if it would be normal. "I worried about if the baby would normal, inside and out." They specifically mentioned being concerned

about mental retardation and physical handicaps. Some were particularly concerned about the hereditary factor in the baby's health. All those who were able to identify relatives with health problems wondered whether the child would inherit them:

-"I worried if the baby would limp like my mother."

-"My major concern was that my baby would be blind or deformed. My husband used drugs. I didn't know how it would effect [the baby]."

The women did not seem to be able to decide if problems were likely to occur. They seemed unable to conceptualize statistical probability and did not seem to draw comfort from something being uncommon or unlikely to occur.

Concerns After the Birth

During pregnancy the subjects were not only concerned with issues related to pregnancy - appearance, lifestyle and the baby's health - but also were concerned with issues related to their life after the birth. The major aspects of this area of concern were: deciding whether to keep the baby, the impact of having a child on their relationships, the motherhood role and financial worries. Some talked at length about the difficulty of deciding whether to keep the baby. One subject recalled the turning point in her decision to keep the baby, "I was really mixed up. Then Dad bought something for the baby and I decided nobody was going to hate me so I would

keep the baby . . . If I knew what it would be like, I wouldn't have." For some, keeping was directly linked to the baby's health and these women said they would give the baby up if it wasn't healthy. Other subjects disagreed stating they felt it was wrong to make the decision to keep the baby based on the health the child.

The subjects also talked of wondering what effect the baby would have on their relationships. They were particularly concerned with the negative impact on their partner or future partner and friends. Some assumed that the baby would have little impact but most saw a potential for negative impact. A few felt that the baby would improve their relationships. A specific aspect of their concern revolved around sex. A number of the women said they had wondered if they would "stay stretched out." Apparently this was a common "joke" that many of the subjects had heard. Some found out through reading or inquiry that it was not accurate while others did not find out until after the delivery that it was untrue.

Their concerns regarding the motherhood role varied. One group felt they had little to worry about. This group talked about being prepared through experiences such as looking after siblings or babysitting. They saw being a mother as a very similar activity.

-"I wasn't worried about caring for kids. I had lots of experience with kids, from the time I was little; Mom's

alcoholic. I knew what to do with kids. Sometimes I had her friends' kids as well. Once I had a baby for days."

-"I'm not worried, thought I'd be a good Mom. I always liked kids especially babies ... my sister had lots of problems with hers and I wondered if I would, but I didn't think I would." Also, within the group who were unconcerned about being a mother, were women who had never considered the issue: "I wasn't worried about being a Mom. I never thought about it." In addition, some subjects were unconcerned about motherhood because of their unrealistic ideas of the role. The most extreme comment, illustrating this last group, was made by a young woman living with her parents and expecting her first child. She said, "It's not like it's a really a big change. I'm not moving out or nothing, I wouldn't want to move out." Some realized after having a child that they had been unrealistic.

-"I thought it would be easier to be a Mom. I wanted to go out with my friends. I didn't want to stay home. I was really mad at the baby."

-"Having a baby is a big difference, I thought it was like babysitting."

Some of the subjects were concerned about being a mother and focused on how good they would be. Being a good mother was defined in terms of: not yelling at the baby, knowing when the

baby was sick, staying with the baby all the time, and knowing what to do if the baby cried.

-"I was scared of being a Mom - worried about it. Wondered if it cried too much if I'd abuse it, if I'd feed it enough, if I'd be a good Mom."

-"I wondered how I would manage, where the love would come from."

Some of these women also commented on the need for support.

-"It's important to have auntie at home, sometimes you don't know what to do, when the baby cries and things."

Another concern of some subjects, related to their life after the birth of the baby, was lack of money. They made comments like:

-"I worried about how I would manage, I applied for assistance before the baby was born. I wasn't sure how I'd manage."

-"I worried if once I stop [breast feeding], I'd have enough money for milk, and clothes and things ... didn't have own place and wondered when I would have. Wondered how I'd get my own place."

-"Yeah I was worried; I knew how much things cost."

Others said that money was not a concern stating:

-"No - treaty (federal assistance under a treaty with an Indian band) - they supply pampers and everything."

-"No, once people heard I got lots of things for the baby."

-"No not worried, I had lots of things already. I never run out of anything."

Concerns About Labour and Delivery

From the subjects' perspective, their concerns about the pregnancy especially the baby's health and about their role as a mother, were more important than their concerns about the actual childbirth. However, since their feelings about labour and delivery were the focus of the study the investigator attempted to keep the discussion on this topic. All admitted to thinking at times about labour, although some apparently did so very rarely. The characteristic initial response to the question "What do you think actually having a baby will be like?", was "I don't know", or "I haven't got a clue". This was often followed by a comment about pain and being frightened.

Although expectations tended to be vague in nature the subjects did formulate expectations, and had some major concerns about labour and delivery. The data collected was divided into prehospital and hospital phases of labour.

Prehospital phase

On the whole the subjects seemed only mildly concerned about the prehospital stage of labour, and had formulated few specific expectations. When they talked about this period the participants were relaxed and spoke calmly. The signs, normal stages, and length of labour, as well as what they expected to

do at home while in early labour were discussed. While at home in labour the subjects did not expect to do anything in particular. A few mentioned wanting "to be left alone and not have anybody bug me." Other subjects made similar comments to the one who thought she would: "watch T.V., eat, lie on the couch, not walk around - stomach too sore." Many did not think of being in labour at home and said they would go to the hospital as soon as labour started. Their only concern was if they would know when they were in labour and when to go to the hospital.

-"I always wondered about when to go to hospital."

-"I was a little worried about when to go - don't know nothing about that."

-"Yeah, I worried a lot about when to go."

A few felt sure that someone else would tell them when they needed to go.

-"Auntie was with me so I knew she would tell me when to go and what to do."

Some did know the signs of labour - "I knew I would leak a little and have pains in the stomach" - but did not know enough about the stages of labour to avoid going to the hospital in very early labour. Only one had expected that she would stay home until the contractions were regular, and approximately five minutes apart. All had plans of how they would get to the hospital. Only a few felt any concern over this and made comments about setting aside a few dollars for

cab fare or having an alternative person to take them. During pregnancy the subjects were generally unconcerned about the length of a normal labour. Only a few stated they had wondered "how long it would last." These few were able to correctly state the average length of labour. Most, however, only became interested once they were in labour. "I didn't really think about how long it would last until in labour - then I wondered when it would stop." Some found their labors "really long" not knowing that they were within the normal range.

A tone of idle curiosity was used by the subjects throughout the discussion of the prehospital stage. This, combined with the fact that they had not sought information, suggests that most of the subjects were unconcerned about knowing when labour started, how long to stay at home or the signs, stages, and length of "normal" childbirth. Most expected to go to the hospital as soon as they were experiencing "pains." All had clearly prepared a means of getting to the hospital. Childbirth was perceived as an hospital event; most planned and did go to the hospital as soon as their labour began.

Hospital phase

During the discussions of their expectations of the hospital period the women appeared more tense and their anxiety seemed higher. Throughout their pregnancy, pain and potential complications were the major concerns related to the childbirth process. The topic of pain, along with other

aspects of the woman's expectations, has already been discussed. Most of respondents were fearful. They expected their partner/coach and the nurses to provide a sense of security and safety. They expected their physician to be present throughout much of the experience, making decisions and directing the use of interventions. They expected to be in pain and to receive medication to control the pain. The subjects' expectation of pain alone did not seem a sufficient explanation for the fearful and anxious manner in which they discussed childbirth. The investigator believes that the subjects' attitudes regarding complications may explain their fearful and anxious manner.

The fear of complications was even more prevalent than the fear of painful labour. To probe into this concern the subjects were asked if they ever worried about something terrible happening. Everyone responded quickly. All but one admitted that they were concerned and these women seemed relieved to be able to talk about their fears of complications. The one subject who denied being concerned answered the question so abruptly that the investigator suspects that the topic was too sensitive to allow her to talk about it. Most seemed relieved to share their fears. They talked of being concerned for both the baby and themselves. They worried about either or both of them dying in childbirth.

-"What if you're faced with the decision of - save you or baby."

-"I worried, before and after the baby was born that it would die."

-"I was hoping nothing would go wrong, that it wouldn't be sick or die."

-"I was worried about dying from a big baby - sometimes I worried that the baby would die."

-"I worried that I might die, I almost did with first."

-"I worried a lot, that nothing would go wrong during delivery . . . Auntie lost a baby at birth and so did Mom, . . . A woman on the reserve died when she was having a baby."

The investigator concluded that for these women serious complications and possible loss of life were part of their understanding of childbirth. Obviously, this would influence their attitude toward the event and would account in part for the fear of childbirth and the desire for constant companionship and medical supervision so prevalent among the subjects.

One subject stated she wasn't worried "about dying - everything is taken care of at the hospital." However she, along with many others, was concerned that the baby might not be physically or mentally healthy. Other, more specific concerns, regarding the baby's wellbeing were that the baby would be: dropped during delivery or damaged by "the big metal things [forceps]." Specific concerns about their own health focused on the fear of "bleeding a lot [haemorrhaging]",

damage from "freezing in the back [epidural]", or problems resulting from "being cut down there when the baby's coming [episiotomy]." These fears seemed to arise from stories of experiences of friends and relatives, as well as T.V. and books.

-"I was worried, I read about how women die and all the other things that go wrong."

-"I was scared something would happen to him. I watch Donahue, he had a show on seizures while the baby still in the womb, and how the brain dies."

-"I saw them slap a baby on T.V. - I worried that it would hurt it."

Summary

The subjects' understanding of childbirth included issues related to: pregnancy, life after the birth, and labour and delivery. Their understanding was general and emotionally based, as opposed to specific and technical in nature. For the subjects the meaning of childbirth and the concerns related to it were far broader, and from a different conceptual perspective, than what is captured in the CEQ.

Conclusion

The subjects had difficulty with the CEQ for a number of reasons and many changes were recommended. The reasons for the

problems, suggestions for correcting them, and the value of a modified CEQ are the focus of this conclusion.

Reasons for Problems

The first problem identified was the written method of administration of the CEQ. An oral style was preferred by the subjects. The benefits of an oral method of administration included avoiding problems with illiteracy as well as providing an opportunity for clarification, discussion and learning.

A second difficulty involved the questionnaire's structure. The CEQ was seen as having unclear instructions. The response format - a major aspect of structure -presented many problems. It required reading a complex and distant preamble, and combining it with each item. It required the formulation of an opinion about the future and predicting it's occurrence with very subtle degrees of differentiation. It also required, at times, the opposition to authority, as represented by the CEQ, by the respondent. Recommendations for change included: reducing repetitive items to a single question, providing direction regarding the answering of items not considered pertinent to the respondent, changing the response format to either one of yes/no or descriptive words, and removing the lengthy preamble.

A third area of difficulty was the language of the CEQ. A low congruence was found in the way the subjects expressed

themselves, and the wording of the CEQ. Complex vocabulary and sentence structure, as well as the tone and verb tense, combined to create the problem. Some of the specific problems with the vocabulary were caused by using terms which were of an unfamiliar form, an unacceptable formality, or of a vague, technical or too difficult nature. Suggestions for change included using: basic vocabulary, simple sentences, examples, the present tense for emotions experienced during pregnancy, and beginning items with the phrase "I hope" or "I think". These changes would improve the understandability and readability of the items as well as making them more acceptable in tone.

There were only seven items where none of the subjects identified problem words. These were items 1, 2, 11, 20, 28, 30, and 34. In all other items there were words that some of the subjects either could not understand or were uncomfortable using. Almost all (11 - 14) subjects identified these words as problems:

Avoid	Seeking	Medical
Intervention	Fetal	Monitoring
Agonizing	Severity	Section
Active participant	Decision making	Consider
Sought	Medical decision	Impending
Questionnaire	Anticipate	Plan for birth
Expectation	Childbirth	Procedure
Immobilized	Routine	Reassured

Panicking	Anesthetics	Birth
Neutral	Presence	Encouragement
Opinions	Offer	Quite helpless
Spend little time	Forceps	Little choice

Many (6 -10) subjects also found these words to be a problem:

Unnecessary	Unbearable	Embarrassed
Confidential	Cope	Discomfort
Comforted	Presence	Refuse
Intense	Personal	Behaviour

The following items were so difficult for the subjects that it was difficult for the investigator to establish concretely all the words which were problematic.

13. There is little chance that I will end up having a cesarean section.

16. I will experience discomfort but not unbearable pain.

25. Forceps will be used.

29. The nurse will allow me to be an active participant in decision making.

31. I will refuse to have any procedures I consider unnecessary.

32. My opinion or that of my partner/coach will be sought for all major medical decisions.

34. the doctor will make most of the decision.

It was also difficult to establish whether the problem was in the language or at the conceptual level.

The fourth area of difficulty with the CEQ was on the conceptual level. The problem was that, while the four subscales were relevant to the subjects, the amount of detail, and some of the specific concepts within the subscales, were not pertinent. The women expressed their ideas as hopes, and were reluctant to predict the possibility of their occurrence. The questionnaire was more detailed and more clearly articulated then were the subjects thoughts. Within each subscale there were items which caused the subjects to reflect for the first time on that aspect of the experience. The subjects frequently said "I never thought about that." The subscales were not basic enough, and many assumptions were evident in the items. For example, it was assumed that someone would accompany a woman in labour, therefore no item asked if the respondent expected to have a partner/coach. In addition, the CEQ failed to capture the broadness of the concerns that the women had about childbirth. A very significant omission was the lack of items related to issues of complications and fear.

In figure 5 the level of congruency between the subjects and the CEQ is illustrated. Figure 5 depicts which items are incongruent at a conceptual and a language level. Where they intersect, or overlap, the items were difficult in both spheres. Diagrams 2 and 3 indicate the items which were linguistically congruent. The numbers within each sphere represent the items of the tool.

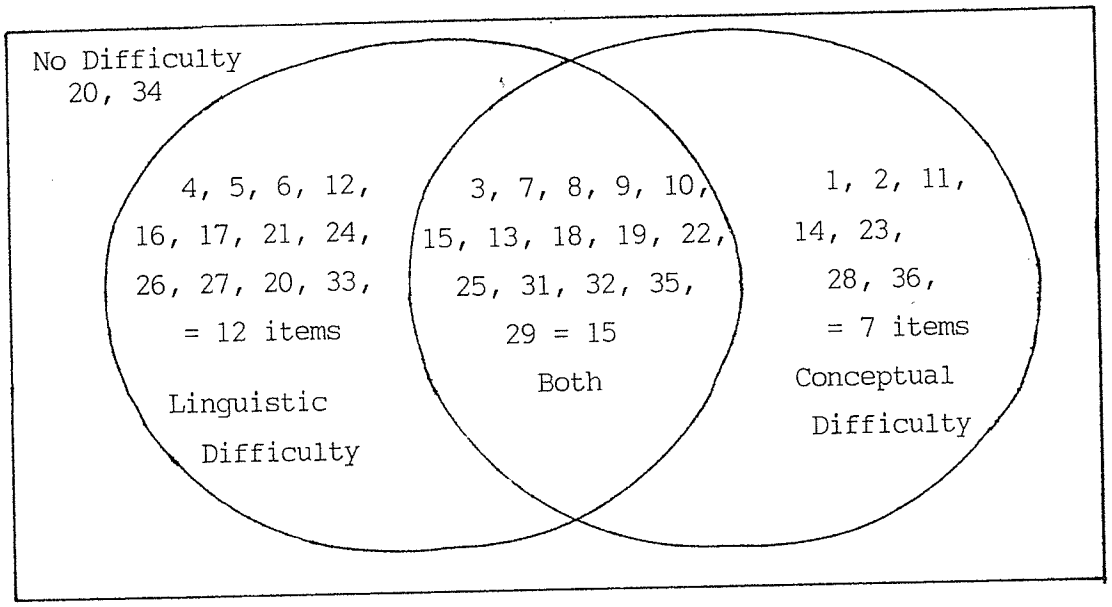

Figure 5. Congruency/Incongruency of Items

An underlying problem with the CEQ is its being based on a number of assumptions which are not accurate for the study population. The CEQ makes many assumptions some of which have been outlined in section 3. Basically the CEQ, which was developed by using a middle class population, assumes that the respondent will be articulate, well educated, that she will have a strong command of the English language, a knowledge of labour and delivery, and some understanding of the childbirthing practices in Canadian hospitals. It also assumes she will engage in preparatory thinking before an event, formulate expectations, be comfortable with prediction of the future, and believe in the right to - and wish to - make decisions about her care. Specifically the CEQ assumes that

pregnant women can and do formulate specific detailed expectations of childbirth and that they will willingly predict the likelihood of these expectations being fulfilled. The subjects repeatedly said that future events cannot be predicted. Many of the subjects had a fatalistic attitude to life in general. They did not understand the active formulation of expectations and the prediction of the future. The decision making model which suggests that the course of childbirth can be influenced by decisions made by those involved was foreign to them. Equally foreign was the concept of their taking an active role in making decision. Decisions, to the subjects, were reactive rather than proactive in nature. The fact that the assumptions of the CEQ do not reflect the beliefs and practices of the women in the study explains the basic incongruence between the questionnaire and the subjects. In its present form the questionnaire was not readable or understandable and it was only partially relevant.

Suggested Changes

The subjects believed the questionnaire should be modified to be more acceptable linguistically and conceptually. Many suggested adding topics to the questionnaire, to make it more complete and to encourage women to think about these subjects. They suggested adding items about embarrassment, loneliness, and risks to the baby. Another woman suggested adding content on emotions.

-"I didn't know I'd have strong emotions, it's good to think about ... how to know when to go to the hospital, something about maybe something serious happening, and maybe something like when I am in labour I won't be embarrassed to be examined."

Other topics suggested were financial worries, how to identify when the baby was sick pre and postnatally, marital strain caused by the pregnancy, bonding of whole family, postpartum "blues", frustrations of early care such as breast feeding problems, coping with crying, and parenting. One subject said,

-"There should be more about relationships and the effect of the baby on them. Lots fight a lot more when they're pregnant and when the baby comes. Lots break up."

When reminded that the questionnaire was about childbirth she responded that "there is more to having a baby than just having it and I think you should include those things."

Value of a Modified CEQ

The next issue explored was whether a modified CEQ would be of value. In response to questions about the value or effect of a modified questionnaire the subjects stated that it would make women think. Some thought this was negative as it would increase fear. "Makes you think more. Better not to think too much." However, many others felt it was positive.

-"I would have understood labour more if I had done this."

-"I would have thought more. You need to be able to ask questions."

All of the subjects were concerned that even a modified CEQ could cause fear, and should only be administered when there was time to explain and discuss it. "It's o.k., as long as somebody's around to answer [questions] and discuss more."

The subjects saw the value of the tool as an educational device, and not a measure of the woman's expectations. They saw it as providing information and insight into issues that they might not have considered. One woman, who had little knowledge about childbirth and had found having her first baby to be extremely upsetting, said the CEQ was,

-"Really good, it makes you think, makes you realize the medical side and you'll have pain and going to hospital ... It makes you think about the pain, support person, painkillers, nurses, doctors. It tells you that you can have painkillers to help you, tells you will have to make decisions."

To conclude, the subjects generally felt a modified CEQ would be a useful tool.

In the next chapter a modified questionnaire based on the subjects suggestions is presented. In addition, the recurring themes which emerged from the interviews will be discussed, with reference to the relevant theories and the research findings presented in the literature review. Finally, the

implications of the findings for nursing practice and research will be explored.

CHAPTER 5: DISCUSSION

This chapter begins by summarizing the study as described in chapters 1 - 4, and is followed by a detailed discussion of the findings in relation to both past and future research. It is divided into four major sections. The first section provides an overview of the first four chapters of the study. In the second section major themes of the analysis are discussed in relation to the theories and findings of previous research. In the third section the discussion focuses on the conceptual framework of the study as a means of explaining the results, and a revised CEQ incorporating the findings is presented. In the fourth and final section of the chapter the implications of the study's findings for nursing practice as well as for future research are addressed.

Overview

The goal of this exploratory descriptive study was to gain a better understanding of the meaning of, and the language used to discuss, the event of childbirth by women of lower socioeconomic status. The study was directed by two purposes. The first was to explore in a general sense the childbirth expectations of women from this population group.

The second and more specific purpose was to examine the Childbirth Expectation Questionnaire (CEQ) for appropriateness and acceptability of the method of administration, language, structure and concepts for women of lower socioeconomic status. When problems were identified by subjects they were asked to provide suggestions for modification to the questionnaire.

The theory of the "social construction of reality" (Berger & Luckmann, 1967; Elias, 1971; Hayes-Bautista, 1978) provided the conceptual framework for the study. This theory proposes that there are subgroups within a given society and that each social grouping views life events within the context of their own experience. The group's understanding and explanation of an event is communicated through a "common" language. The theory suggests that communication between social groups may be problematic because of differences between the groups both in their understanding of an event and in their use of language in discussing it.

The CEQ was designed using data obtained through interviews of middle class women. It was assumed, by the investigator, that the questionnaire would then reflect the attitudes of the middle class at both a conceptual and linguistic level. Based on the social construction of reality theory it was anticipated that women of lower social economic status would have difficulty with both the concepts and

language of the CEQ and that they would experience problems responding to it.

The nonprobability sample of fifteen subjects was selected through a convenience 'snowball' method. All subjects were of lower socioeconomic status as measured by education and income. All had less than a grade 12 education. All but one were receiving social assistance. The one who was employed had an income comparable to the other respondents. All were born in Canada and spoke English in their homes.

The subjects were interviewed by the same investigator using an interview guide. During the first portion of the interview, the general interview, each subject was asked about her expectation and experience of childbirth. This discussion was followed by the detailed review of the CEQ and concluded with a summary of the subjects' general impressions of the questionnnaire. Fourteen women completed both portions of the interview, whereas one other woman completed only the first portion of the interview. Demographic information was collected at the end of the interview. Respondents were provided with copies of all forms which they were free to read. However to avoid problems of illiteracy the investigator read all forms aloud and completed them with the subjects. Notes were taken throughout the interview. Immediately following the interview, the notes were reviewed by the investigator and details added to reflect what was said during the discussion.

Data were analyzed using qualitative methods. Frequency of responses were determined to establish prevalence of ideas to assist the investigator in determining if a given attitude was more or less commonly held by the group. The sample was not randomly selected, therefore its representative nature could not be established. Thus, application of findings to the population from which the subjects were drawn must be done with caution.

The conceptual framework of the 'social construction of reality' provided an explanation of the results. It was found that the subjects had both a common language and understanding of what it means "to have a baby." The CEQ was difficult conceptually and linguistically for them. Many modifications were suggested.

Themes

The following section will focus on the major themes which were identified during the analysis. These themes were fear, fatalism and communication problems.

Fear

The most dominant theme was fear. This theme wove like a thread throughout both the general discussion and the review of the CEQ. The relationship of fear to the subjects' expectations is illustrated in figure 6. This figure further

develops the illustrations of the subjects' expectations found in chapter 4 (figures 2 & 3), and shows how the 'thread' of fear interweaves and is related to every aspect of their expectations.

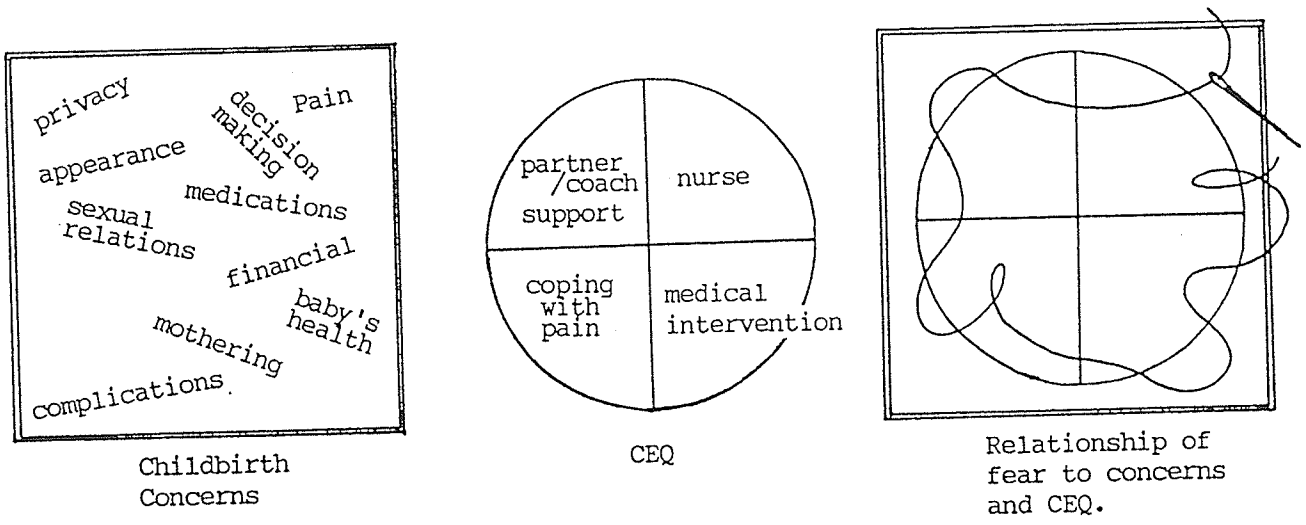

Figure 6. Concerns, CEQ, & Relationship of Fear

The following discussion of the theme of fear addresses the topic by focusing on four aspects: causes of fear, prevalence of fear, responses to fear, and the results of fear.

Causes of Fear

The subjects considered fear of childbirth to be universal; "Everyone is scared". Fear of childbirth among women has been identified by many investigators (Areskog, Uddenberg, Kjessler, 1981; Beaton & Gupton, in press; Clark, 1975; Friedman, 1974; Hubert, 1974; Klusman, 1975; Leifer, 1980; Vellay, 1972). While research supports the universality

of fear, it does not support a common cause of fear among women of all social groups.

Identified causes of fear during pregnancy include concern about: pain, death, the baby's health, medical interventions, maintaining control, the spouse's response, financial matters, parenting responsibilities and changes to the existing family. Some fears, such as concern for the baby's health, are shared by all women and seem to be independent of class. Other concerns have been associated with a specific social class by many researchers (Butani & Hodnett, 1980; Homans, 1982; Hubert, 1974; Nelson, 1983; Reid, 1983; Westbrook, 1979). Issues important to the middle class were identified as fear of: loss of control, excessive medical interventions, loss of self esteem, being helpless, and reproductive inadequacy. The women of the middle class were also concerned about having a pleasurable, fulfilling experience. By contrast, woman of lower socioeconomic status were found to be concerned about avoiding pain, complications and "getting through" the birth. Medical interventions including pain medications were desired by women of lower socioeconomic status (Cave, 1978; Nelson, 1983; Reid, 1983). These findings were supported by the results of this study. The investigator, however, would add fear of being left alone, and fear of the unknown to the list of concerns of women of lower socioeconomic status.

The degree of fear has been linked to socioeconomic status. Research indicates that during pregnancy the working class subjects were more apprehensive about childbirth than were their middle class counterparts (Nelson, 1983; Westbrook, 1979). Glazer (1980) reports that anxiety during pregnancy correlated negatively with age, education, income level, and length of marriage suggesting that women of lower socioeconomic status could be expected to be more fearful. Norr et al. (1977) also note that, "higher status women worry less about birth" (p. 265). Although the literature suggested that fear is more common to the women of lower socioeconomic status no reason was provided. The investigator believes that the increased fear among this social group is, at least in part, explained by the reality of these women's lives. Poorer childbirth outcomes -- higher infant mortality, morbidity, low birth weight, congenital malformations as well as failure to thrive and difficulties in family adjustment -- have been documented in this social group. Removal of children from their homes as well as family violence are familiar events for this group of women. The subjects in this study would be aware of these outcomes and family situations and this may explain the high levels of fear experienced.

In addition, the social reality and knowledge of this group of women would include the experience of contact with the dominant culture -- the middle class. It can be assumed that how they and their social circle have been treated and

how they had felt during these situations may impact on their feelings about having a baby. Since doctors and nurses are of the middle class having a baby would necessitate contact with the dominant culture. Women of Metis and Native culture would be likely to be particularly affected as the outcomes of this group are the poorest and their experiences with the dominant culture often very negative. Thus the reality of these women's lives is very different from the reality of middle class women. The different life experience may explain the greater fear experienced by women of lower socioeconomic status.

Although fear was common during pregnancy it was even more severe during the actual childbirth experience. All the subjects that had experienced childbirth recalled their labour and delivery as a time of fear. A typical comment was, "I was scared all the time." For these women fear was the strong, pervasive and dominating emotion of childbirth. These findings are consistent with Hubert's (1974) statement that the onset of labour began a "Protracted period of bewilderment and fear" (p. 44). One factor contributing to this problem is the lack of explanation provided by medical staff. The problem of inadequate explanation prenatally and during the childbirth process has been noted by many (Graham & Oakley, 1981; Homans, 1982; Hubert, 1974; Leifer, 1980; Lunenfeld et al., 1984; Nelson, 1983). A finding of this study, which supports the work of Nelson (1983) was that women of lower socioeconomic status expected the doctor to be the information provider.

Both in Nelson's (1983) study and this study a major complaint of subjects was the inadequate information offered during labour and delivery. Many women, in this study, told stories of not being informed about procedures such as internal examination, rupture of the membranes, attachment of a fetal monitor, giving medication or administering anaesthetic. These stories were coupled with statements about how frightening it was not knowing what was happening. "I was scared, I never knew what was going on."

Fear is heightened by the expectation of pain, complications, technical procedures and the unknown. It is reduced by being in hospital under the care of professionals who are able to intervene as needed. According to the women in this study the role of the partner/coach, nurse and doctor were all seen in relation to reducing fear. It was hoped that their constant attention would prevent anything dreadful occurring. Like Hubert's (1974) subjects, the women in this study wanted reassurance and understanding from those around them. Supporting Hubert's (1974) and Nelson's (1983) work was the finding that almost all the women wanted someone with them throughout the childbirth and for many the preferred person was not their partner but a close female relative or friend.

Prevalence of fear

Early in the general discussion the women were asked what they thought it would be like to have a baby. The characteristic response was that they didn't know. Most

appeared offhand and unconcerned. Their nonchalant stance appeared to support Hubert's (1974) finding that "The majority of girls, when interviewed during their pregnancy, showed no real dread of labour"(p. 44). However, the investigator found this casual manner changed to one of obvious anxiety when the more detailed questioning occurred. Most subjects then spoke openly of being "scared". Some traced their fear back to when they first realized they were pregnant. Others stated their fear began later and grew as the pregnancy progressed. A few of the women claimed to have never thought about labour. However, when specifically asked if they had thought about complications during labour and delivery, they talked about their fear about the possibility of dying and problems with the baby's health. All the subjects had some concerns related to childbirth. Most women fearfully anticipated childbirth throughout their pregnancy while a few displayed little of this emotion until they began labour. While this finding does not support Hubert's (1974) claim, it is consistent with Nelson's (1983) and Glazer's (1980) findings of a high degree of fear among women of lower socioeconmic status.

Throughout every aspect of the general discussion the theme of fear prevailed. No topic was unaffected by the impact of this emotion. It was, however, even more pervasive during the review of the CEQ. The questionnaire was considered frightening for conceptual and linguistic reasons. The specific content that was considered frightening has been

discussed in chapter 4. Generally any item considered to have negative implications was seen as frightening. This included items that were seen as accurate, such as those which referred to severe pain, as well as those which were seen as inaccurate, such as the item that conjured up the picture of "large machines everywhere". All the women objected to the number of items concerning pain as they felt it would unnecessarily increase fear. Unknown words and words which had previously been associated with a negative meaning were considered frightening. 'Impending' was such a word. The subjects who did not know the word found it frightening, while the women who did know it associated it with the phrase "impending doom", and also found it "scary". All the subjects felt the CEQ would need to have the frightening items changed before it would be appropriate for use prenatally. The subjects emphasized the importance of preventing fear and all their suggestions for modification were based on this premise.

Response to fear

In this study the response of the subjects to their fear was to attempt to "sweep it aside", "put it out of my mind", "not think about it". Most did not seek information, believing information would increase their fear. Even the few subjects who displayed information seeking behaviour did not clarify what they had read. This resulted in their having inaccurate or incomplete knowledge. The general attitude of the subjects

can be characterized by the familiar saying, "What you don't know can't hurt you."

This attitude and behaviour differs considerably from the response of women in the middle class. While they speak of trying not to worry about it, they openly admit to thinking about the upcoming event (Beaton & Gupton, in press). Middle class women seek knowledge through reading, discussion, and attending prenatal classes. These women's attitude of facing their fear, can be characterized by the saying "Knowledge is power."

Perhaps the explanation of the observed difference lies partially in the difference in the meaning of the word knowledge for each group. Knowledge for the middle class means control and power. It has been the accepted means of obtaining career goals and status in society. Childbirth preparation through the acquisition of knowledge seems logical. Many researchers have noted the high correlation between socioeconomic status and attendance at prenatal classes (Beck et al., 1980; Davenport-Slack & Boylan, 1974; Glazer, 1980; Nelson, 1982b; Norr et al., 1977; Reid, 1983). The consumer, feminist, and 'back to nature' movements, which were all based in middle class values, have contributed to this group becoming hearty supporters of childbirth preparation courses as Nelson suggests (1982b).

By contrast, knowledge holds a very different meaning for women of lower socioeconomic status. Knowledge is not seen as

a means of obtaining power and control. By definition their involvement in formal education is more limited, and for many less rewarding. For the women in this study knowledge of childbirth, as presented by prenatal classes and the CEQ, seemed to emphasize their lack of understanding. The subjects' reflections on prenatal classes paralleled their comments about the CEQ. Prenatal classes, like the CEQ, were viewed as fear-producing because of the content and the language of the classes. One subject made this comment: "Prenatal classes should tell you that everyone is different. They should tell you it's painful and then talk about emotional not just physical things that scare you." Some of the subjects stated that they had gone to a few classes, but then stopped because they were "scary". Many comments were made that indicated that the women could not understand what was going on. "I couldn't understand what they were talking about and everyone had a partner." Thus the knowledge acquired at prenatal classes did not provide them with insight but instead heightened their awareness of how little they knew and how alone they were. The classes served to escalate their sense of fear and if anything decrease their sense of safety as they threatened their coping mechanism of avoidance. Furthermore, the classes did not address their preexisting fears and were therefore unable to effectively reduce the women's fear of serious complications. This failure seriously reduced the usefulness of prenatal education for the subjects.

Another explanation for the differences in the women's response to fear is related to the difference in the nature of their fears. As mentioned above, middle class women are concerned about issues of control and in having a meaningful experience. They focus on the process. The women of lower socioeconomic status are outcome-focused. Women of lower socioeconomic status view childbirth as an event to "get through" (Reid, 1983); "to be endured" (Hubert, 1974; Nelson, 1983), not one to be anticipated and valued for itself as middle class women do (Nelson, 1983; Beaton & Gupton, in press). The women of lower socioeconomic status strongly believe that childbirth could end in serious complications or death for the mother or baby. They quite literally feel it is a matter of staying alive. Vellay's (1972) claim that a woman's fear for herself has been "greatly attenuated with the progress in obstetrics . . . she no longer feels her life is in danger" certainly is not accurate for women of lower socioeconomic status. The nature of their fears may partially explain their response of rejecting knowledge. These women's fears were profound in nature and came out of their experience of a life. As discussed earlier life for this social group is one where greater obstetrical risks occur. As such the subjects' fears were not easily assuaged. Thus their emphasis on prevention of fear was a natural and understandable response.

Indeed, the message from the interviews was that the most important value for these women was the prevention of fear. This value was emphasized in the answers given to the question, "What would you tell your sister or a close friend about labour and delivery?" All made comments about not frightening the expectant mother, just as Nelson's (1983) subjects had. A few however, had a clear idea of what they would share. Most would not volunteer information but would wait until the person asked questions. They talked of being honest in answering her questions. However, they also said they would not tell an expectant mother certain things considered frightening. Examples of what was considered frightening were: information about procedures such as I.V., rupture of the membranes, the examinations, as well as how labour and delivery actually felt. Information about the actual amount of time their doctor would be present, and the number of staff, was considered useful but potentially frightening, and so would not be shared by most of the subjects. Most felt that information about when to go to the hospital and the average length of normal labour would be helpful. Since these would not cause fear they were considered appropriate to share. In general, the women seemed uncomfortable with the idea of telling someone else about childbirth. They preferred not to share concrete details of the experience and thought excessive information was frightening. It is interesting to note that many of the women

in retrospect thought knowing more would have reduced their personal fear and, like working class subjects previously studied (Hubert, 1974; Nelson, 1982a, 1982b, 1983), felt that they could have been better prepared. However, most felt the responsibility for preparation was someone else's and made comments suggesting the doctor would tell an expectant mother what she needed to know.

The prevention of increased fear was extremely important and the importance of not frightening expectant mothers was repeatedly mentioned. Their comments about the usefulness of the CEQ, the problems with prenatal classes, and what they would tell others reflected this concern.

Results of fear

The results that arose from this fear were interrelated. Fear accounted in part for both the lack of preparation and the negative nature of the childbirth experienced by the subjects. Fear influenced the subjects' preparation for the event in two ways. First, since information was avoided to prevent escalating fear, it resulted in an ignorance about labour and delivery. This lack of knowledge in turn meant the women were incapable of formulating clear ideas about the event. Secondly, to prevent fear many subjects actively avoided thinking about the event. This compounded the problem of ignorance, and further inhibited their development of clearly formulated expectations.

According to Janis (1958), fear has an important function in helping an individual prepare for upcoming events. Fear induces anxiety which, if at an appropriate level, will result in realistic expectation formulation. If, however, the anxiety is inappropriately low or high, then inadequate anticipatory thinking occurs, and appropriate expectation will not develop.

Persons with low anxiety levels have been observed to deny and trivialize the forthcoming event (Janis, 1958). Among the subjects of this study the most common response to anxiety was denial. Most tried not to think about the event. Statements supporting this decision and suggestive of the use of suppression were:

-"You're better off not knowing."

-"It's not good to think about it [labour and delivery]."

-"I try to put it out of my mind."

A few said that they had never thought about labour prior to the event. Others made statements showing great trust and dependence on their coach which seemed to relieve them from worrying, thinking and learning about labour. Most women did little anticipatory thinking. This may be partially due to their unstable life circumstances and their lack of a sense of control. The general focus of most of the group was the immediate. Few revealed a sense of planning for the future in their general lives.

Individuals with high anxiety display excessive worrying and are unable to use information to formulate realistic

expectations (Janis, 1958). A few of the subjects seemed to fit this category. Their willingness to think about labour seemed to result from, and further fuel, their high anxiety and concerns. The few who demonstrated a willingness to think about the event by their reading or attendance of some prenatal classes were unable to use the information to formulate realistic expectations. Even within this 'thinking' group there was a strong feeling that it was better not to think about childbirth too much because it would increase fear.

Based on Janis' (1958) theory, the women in this study demonstrated behaviors consistent with anxiety levels that would inhibit with their ability to develop appropriate expectations. Certainly the lack of specific preparatory thinking was evident in almost all women. It was evident throughout the interview that they were considering many issues for the first time. The investigator concluded that although the subjects had some expectations, fear of childbirth affected their ability to develop clearly formulated ones. Other investigators have also found that this socioeconomic group tends to have poorly developed expectations but have not necessarily linked these to fear (Hubert, 1974; Nelson, 1982b, 1983).

Fear also impacted on their actual experience of childbirth. Among the subjects who had experienced childbirth there was an universal dissatisfaction with their labour and

delivery. In response to the question, "How did labour and delivery compare to what you thought it would be like?", all spoke very negatively about the experience and gave a variety of reasons. The most frequently named were: the severity of the pain, lack of privacy, the lack of explanations, the attitude of the nurses and doctors, and a general disappointment in the experience. The subjects found the range of emotions they experienced bewildering. The overwhelming fear, the loneliness, and the exhaustion of labour and delivery were especially difficult for them. The emotional upheaval added to their negative feelings about their experience. Although these women generally had few clearly formulated expectations they did have general hopes and ideas about the event. Their disappointment and negative feeling resulted from their un-met hopes and the unrealistic nature of their loosely formulated ideas.

When discussing their negative feelings about their delivery experience, many said they felt that the prenatal and the media presentation of the event had been misleading. Janis (1958) states that both high and low anxiety individuals will experience increased dysphoria after the event. The results of this study seem to support the suggestion that these women experienced anxiety levels which interfered with both their preparation for, and experience of, childbirth. Additional research supporting this correlation between anxiety, the use of denial, and the lack of explanation with a negative and

difficult childbirth experience includes the findings of Horsley (1972) and Lunenfeld et al.(1984).

Summary

Fear was a theme which wove like a thread throughout the subjects' discussion of what it meant to have a baby. The subjects feared: the pain, being alone, the unknown, and complications. They feared for their own life and the life of their child. Labour and delivery was an issue of survival. Their fear seemed to be pervasive in nature and without the balance provided by the excited anticipation characteristic of the middle class. Childbirth for the subjects was clearly a negative event which they anticipated with concern and fear and over which they felt no control. This leads to a discussion of fatalism, the second theme of the study. Fatalism coexisted, and was associated, with the theme of fear.

Fatalism

Fatalism implies an inevitability of the course of events and the acceptance that life events are controlled by an external force. It has been associated with people who feel they have little power. This attitude is known to be more common among people of lower socioeconomic status (Kumar & Tripathi, 1986; Powell & Vega, 1972; Rotter, 1966; Wallston et al., 1983; Yuchtman-Yaar & Shapira, 1981). Many researchers have suggested that women of lower socioeconomic status

believe in external control and are fatalistic about childbirth (Homans, 1982; Hubert, 1974; Nelson, 1983; Norr et al., 1977; O'Connell, 1983) The results of this study supported the findings of previous researchers.

The subjects' fatalistic attitude was evident in their comments about their pregnancy, childbirth, obtaining information, desire to make decisions, desire for interventions, and in their evaluation of the CEQ. Their fatalistic attitude influenced the formation of their expectations. It also had an impact on the issue of communication which will be discussed as the final theme.

When discussing their first pregnancy all but one subject stated that it was unplanned. Many made statements indicating that subsequent pregnancies were also unplanned. They often shrugged and made the comment: "It just happened." No one mentioned failed birth control or the seeking of birth control information after their first child. Hubert (1974) and Homans (1982) also found that, among their subjects, pregnancy was an unplanned event. Pregnancy seemed to be regarded as an occurrence outside their control or responsibility.

Labour and delivery were also discussed in terms of being outside one's influence as indicated by these typical comments: "It happens just the way its gonna happen"; "No one can know what will happen." Quotations found in reports from other investigators were very similar to the subjects of this study: "Why worry, you can't do anything about it" (Hubert,

1974, p. 44); "It'll come when its ready" (Homans, 1982, p. 250). Thus the findings of this study were congruent with previous research.

O'Connell (1983) believed a link existed between feelings of control and information-seeking behaviour. He states, "Since these women do not have much expectancy of control, they may be less likely to ask questions" (O'Connell, 1983, p. 164). The idea of obtaining information to allow formulation of a clear picture of what would occur was not part of her subjects' preparation for childbirth. The subjects tended not to seek out information even about non-threatening topics; for example, what early labour was like, and how to decide when to go to hospital. Instead they depended on someone else being available to tell them, or thought they would somehow "just know". The lack of desire for concrete information seemed related to the fact that they did not feel that knowing would change the course of events: "You can't know what will happen. You can't plan, there's no point."

Partially as a result of their fatalistic attitude, the women in this study had few clearly formulated expectations. The women were considering many issues for the first time, and the expectations that they did hold were difficult to unveil. With the women who had experienced childbirth, the clearest understanding of their expectations came through listening to their experience and exploring with them how this differed from their preconceived ideas. Determining the expectations of

the women who had never had a child was more difficult because their comments were often vague and non-committal. The subjects were largely unaware of their expectations and had difficulty articulating their thoughts and feelings. This lack of anticipatory thinking can be attributed at least in part to their fatalistic attitude. In comparison, Beaton and Gupton's (in press) study of middle class women demonstrated that they were able to clearly articulate their expectations. Although their subjects expressed the idea that not everything could be predicted, a pervasive feeling of fatalism was not evident in their responses.

As discussed in chapter 4, the concept of decision making in childbirth was foreign to many of the subjects. The women had difficulty conceiving of their role in decision making. This concept was problematic because they saw labour as an inevitable process. Discussing it with them was difficult because their deeply held belief in fatalism conflicted with the idea of a variety of optional courses of action. The women preferred to be kept informed of decisions rather than make them. This is congruent with a belief in external control.

The desire of the subjects to have medical intervention supported the findings of previous research on similar populations (Nelson, 1983; Reid, 1983). All wished to have the active involvement of their doctor as well that of hospital staff. They believed these people should take care of the decisions. Since others were responsible they saw no need to

be knowledgeable about specific interventions before the fact. They assumed that those who were responsible for deciding and administrating the procedures would explain what was occurring. Thus it might inferred that the desire for medical intervention is congruent with and stems from their acceptance of an external control.

A fatalistic attitude was reflected in a basic problem which the subjects repeatedly identified in the CEQ, namely the predictive nature of the questionnaire. They found it difficult to conceptualize the idea of predicting the future and felt it was a waste of time. They did not believe anyone could or would want to participate in such an activity.

Fatalism is an attitude widely held among women of lower socioeconomic status. In this study it was evident in the women's comments about pregnancy, childbirth, obtaining information, decision making, interventions, and the CEQ. The impact of this attitude, in relation to expectation development, has been discussed. Fatalism would also likely discourage discussion of any hopes and thoughts about the future, thus inhibiting the women from putting their feelings about the future into words. The investigator was aware that many of the subjects were struggling with communicating as though the interview was the first time they had formulated the words to share their ideas. This leads to a discussion of the third and final theme, communication.

Communication

Previous research has documented the problems of communication between women and the medical establishment. Graham and Oakley (1981) have related communication problems to differences in power between the medical establishment and women in general. It could be expected that this problem is much worse for women of lower socioeconomic status. The investigator found that the subjects of this study were reluctant to clarify information which they had heard or read. To add to their difficulty these women start from a much lower level of understanding. Hubert (1974) found that the lack of communication made the women's low knowledge level even worse. Since more knowledgeable individuals often incorrectly assume that the other person shares their understanding of a subject, the lack of power and understanding combine to act against the occurrence of effective communication. The findings of this study, as well as previous research (Farkas et al., 1987; Homans, 1982; Hubert, 1982; Zion & Aiman, 1989), suggest that communication between women of lower socioeconomic status and health professionals in the medical system is anything but effective. Adding to existing problems is the fact that social classes understand and use language differently.

Conceptual Framework and the CEQ

The conceptual framework used for this work was the theory of the social construction of reality (Berger & Luckmann, 1967; Elias, 1971; Hayes-Bautista, 1978). It proposes that social groups differ in their experience of reality and use language in different ways to express their reality. Items based on assumptions of one group will elicit confusing data if administered to another group. Either the questions or the responses may easily be incorrectly interpreted, raising serious doubts about the validity of results. The problems of differences in understanding of terms creates problems in using a single tool to study different social groups.

The relevance of the theoretical framework became obvious immediately after the interviewing began. The investigator found that her instinctive use of language was different from that of the subjects. It was necessary to remember that different assumptions were being made by the investigator and the subjects. This necessitated continuous verification to ensure she was understanding the subjects' meaning and intent. Reid (1983) also found differences in the biases and assumptions of the researchers and subjects in her study of the childbirth attitudes of lower socioeconomic women conducted in Glasgow.

Analysis of the interview data also supported the relevance of the theoretical framework. It was found that the CEQ was partially congruent with the subjects' understanding of childbirth, but was incongruent in language, format, and method of administration. Extensive changes to the CEQ were suggested. The subjects' perception of childbirth differed from their middle class counterparts as represented by the CEQ. Likewise the language used to discuss the event was substantially different between the two groups.

In chapter 4 the problems with specific vocabulary and concepts in the CEQ were discussed. The term partner/coach will be discussed to illustrate the differences between social groups in their use and understanding of words. The term "partner/coach" in the questionnaire might be assumed to refer to the concept as understood by the middle class. The partner/coach is usually assumed to be the father, who has a deep emotional stake in his relationship with the mother, and the child. He is expected to have attended childbirth preparation classes and to be able to assist with knowledge and confidence during labour. His role involves assisting with breathing and relaxation exercises, timing of contractions, keeping the expectant mother informed, as well as helping with decisions such as when to go to the hospital and whether to have medication in labour.

The investigator found a totally different interpretation to be assumed by the subjects. They saw the partner/coach as

someone who would sit by them and comfort them by their presence. This person, usually a female relative, would not possess any knowledge of the birth process beyond her own prior experience, and would be expected to offer no knowledgeable opinions. She was neither a partner, since she was not the a father or husband, nor a coach, since she would offer no advice. She could be more accurately termed a companion. While the role of the coach may be seen as passive it may reflect a different concept of how one shows support. It suggests that for the subjects the need to talk and give direction is not a necessary part of providing comfort.

The basic difference in the understanding of the term resulted in the subjects considering many of the partner/coach items foolish and bewildering. Examples of items which were immediately identified as problems included: "My partner/coach will be happy and excited." "My partner/coach will tell me what is going on." "My opinion or that of my partner/coach will be sought for all major medical decisions." Other items at first did not appear to create difficulties at a conceptual level. One example of such an item was "My partner/coach will offer me help." After some discussion it was noted that conceptual problems did exist. What was meant by help varied considerably between women of middle and lower socioeconomic status. What women of lower socioeconomic status considered highly involved and helpful would be interpreted by middle class women as nominally helpful or possibly passive

involvement. Compounding this difficulty was the feeling expressed by many subjects that it was unacceptable to ask for help.

The problem underlying all of the items about partner/coach was the failure of these items to be sensitive to the reality of the lives of the women in this study. Their reality is that childbirth is an event which often occurs at an early age, and one in which a partner rarely figures. When a partner/coach is involved very different expectations regarding his/her role exist. The sensitive nature of the issue of partner/coach was related to a more general response to the CEQ. The subjects' response to the concept of partner/coach and the CEQ as a whole was to feel "put down". Their tendency to view all items as statements of fact prompted statements like, "My partner/coach will be happy and excited", to be interpreted as a mockery of their situation. From the subjects' perception a condescending tone was established in the examples. The first example read: a) "I look forward with great joy to the birth of my baby" This example prompted comments about having mixed feelings and guilt for not feeling "great joy." The comment of one woman was, "I know that is the way I should feel." This clearly indicates the conflict between their experience and what they saw as ideal. The women had gained an understanding of the middle class view which they regarded as the correct or ideal one. They used this as a standard to evaluate their attitude

and experiences which they concluded were substandard and inadequate. This indicates the pervasiveness of the middle class model at a societal level. It demonstrates the dominance of the middle class in determining the norms for the society and indicates the marginal status these women hold within it. Non-adherence to the dominant model creates a sense of inadequacy, guilt, and failure. Many of the items throughout the questionnaire reinforced their sense of failure. The second example read: b) "I need to know more than I possibly could" was beyond the subjects' comprehension and reinforced their feelings of intellectual shortcomings.

In summary, the subjects' assumptions about the role of the partner/coach were not captured by the CEQ. The tendency for the subjects to assume a unique and very different interpretation of the concept of partner/coach suggests that a clarification of the definition of the term would not be adequate. The conceptual problems of items reflect a cultural difference rather than simply a lack of language skills.

Throughout the discussion of the questionnaire linguistic difficulties also created problems. The subjects feelings about the effect of the difficult vocabulary and structure was captured by one woman who said,

> -"I wouldn't fill this out. I don't mind questions but I don't like this (pause) it sort of puts you down.(long pause) This is for really educated people. Like there are

two kinds of English - regular, and what people with lots of school talk. I don't like this."

All the subjects felt changes in the method of administration, language, structure, and content of the CEQ would increase women's willingness to participate and improve the accuracy of the findings.

Research on childbirth expectations of women of lower socioeconomic status is difficult because it assumes the existence of formulated expectations. Given the lack of clearly formulated expectations, especially among primiparous women, any research on the topic potentially influences their perceptions and possibly results in the formation of expectations not previously held. The subjects in this study identified just such a process. Therefore the problem was, that in the absence of clear formulations, the act of asking questions significantly influenced their development of expectations. Research results in such a situation would be seriously affected and possibly distorted. In this population flexibility is needed in the formulation of questions to ensure one captures relevant information. Information, such as a subject's hopes for her birth, was pertinent and provided insight into the issue of expectations. The investigator came to the conclusion that the study of childbirth expectations among this population requires flexible research method and tools and necessitate in-depth interviews.

The subjects and investigator saw a revised CEQ as having more value as a teaching aid, than as a research tool. Many of the subjects stated that the CEQ made them think and they felt the CEQ, if administered carefully, would benefit all pregnant women. Many made comments about being glad to be a part of this study. They were pleased to have their opinions sought and felt this should be done more often.

Use of the tool for educational purposes does not exclude using it for research. While meeting the educational needs of the group the revised CEQ might also provide valuable information to further the understanding of the meaning of childbirth for this group. It might also be used as part of a research study examining alternative methods of providing prenatal preparation to this population.

It is unethical to conduct research in an exploitive manner where the needs and wishes of the participants are not considered. Investigators should include members of the group to be studied in the process of design and ensure that they both understand and support the purpose of the research. The CEQ was redesigned through consultation with women of lower socioeconomic status. Therefore, the resulting tool should be appropriate for use among that population. The purposes of any research using this tool would need to be acceptable to subjects of lower socioeconomic status. Therefore, in using the redesigned CEQ as a research tool, the investigator must take into consideration the educational needs of the subjects

and should be guided by those needs. Finally, the use of the data gathered in research must be carefully considered in order to prevent harm to the participant, either at an individual or group level.

Revised CEQ

Based on the need to meet education and research purposes, a modified CEQ was designed. The revised CEQ would the educational needs, identified by the subjects, as well as the original purpose, research. While this tool has not been tested, it reflects the language and content appropriate for women of lower socioeconomic status and illustrates the degree of cultural and linguistic difference between this group and that of mainstream society. It was impossible to incorporate all the suggestions made by the women who participated in the study. When adding subject areas, the investigator included themes which were repeatedly discussed but not necessarily raised by the majority of subjects. This decision was made since the time limitations of the interviews precluded extensive discussion with each subject of what additional topics should be included.

An attempt was made to parallel the contents of the original questionnaire items, when designing the revised CEQ, in order to make a comparison to the original easier for the reader of this study. If the tool is actually used, this order would need to be evaluated. In addition some repetition is

still present in this version of the revised CEQ. Again this was done to allow comparison to the original, and the repetitious questions might need to be deleted in actual use. The bracketed numbers beside items indicate the number of the parallel question in the CEQ. Some items were deleted, as no parallel item was considered appropriate. The items deleted were: the amount of equipment (14), intervention desired (19), use of forceps (25), and refusing procedures (35). Additional questions were added to expand concepts contained in the original CEQ, or to incorporate concepts not included previously. These items are easily identified by the absence of a bracketed number.

The revised CEQ has a mixed format which has implications for scoring and comparing the results to the original CEQ. Although the yes/no items could be assigned a scale and scored, the other items could not be scaled. Therefore scores indicating where an individual rated on a normative expectation curve would not be obtainable. The original CEQ allows scoring and it is anticipated that these scores will fall into a normal bell curve. Women whose score falls at either end would be considered at higher risk of the problems associated with unrealistic expectations. Such a screening purpose is not intended for the revised CEQ. The investigator intended that the tool not be scored since the primary use of the tool is educational. The results of the revised CEQ would therefore

with the original CEQ. However information gained through the use of the revised CEQ could be analyzed qualitatively and compared in a more general fashion with the findings of the CEQ and existing literature about the meaning of childbirth to middle class women.

Included with the questionnaire but on a separate sheet would be instructions for administering the tool. These instructions would include reminding the administrator to: a) administer the questionnaire orally. If the subject wished to read it independently the administrator should remain in the immediate vicinity for answering questions; b) administer only if there is sufficient time to discuss issues raised by the items; and c) provide opportunity for discussion and teaching especially when anxiety is displayed. Under no circumstances would it be appropriate to send the questionnaire home to be discussed later. These instructions along with the length of the CEQ present some problems for use. The amount of time required to administer would probably be in excess of one hour. This means that use of the tool is not a quick and simple adjunct to existing care. The investigator believes that the tool could be administered over a number of sessions so that no single session would be unmanageable in length. It might be used to help direct and focus interviews held while women wait for their prenatal checkup, or be incorporated in and help to organize prenatal classes.

An additional issue concerns the inclusion of items that address the women's hopes and desires. The original CEQ does not contain items of this nature as the focus of the tool strictly on the expectations of women. The investigator believes that expectations - what one feels is likely to occur - is important but limiting. The women in this study, perhaps because of their fatalistic outlook tended to have few expectations. They felt that what would occur would occur. The investigator found that these women did have hopes, and that these desires often indicated the kind of care they wished to receive. For example, the women generally hoped the nurse would stay with them and would talk in a kind and reassuring manner. When asked if they thought the nurses would do this, they responded with a shrug and "I don't know". By identifying the women's hopes the health care team can begin to meet individual and group desires. If the hopes are very unrealistic then teaching can be done to help them with the formulation of more realistic desires. In addition, alternative means of providing the desired care could be explored. In the case a woman hoping for the constant presence of the nurse, discussion of the role of nurses, and the fact that they are always close at hand even if not in the room, could be combined with information about volunteer coaches. The investigator believes that the inclusion of hopes with expectations would enhance the relevance of the CEQ to this population.

A Revised CEQ

What do you think having a baby will be like?

I would like to know how you feel. What do you think having a baby will be like? I want you to answer yes or no to some questions. If you have never thought about something that I'm asking - please tell me. I still want to know what you think so try to answer those questions too. There are no right or wrong answers. I just want your best guess. No one will be told what your answer was. Your answers will be kept completely personal.

Examples:

1. I think I will get something for pain during labour.
   yes_x_ no___ never thought of, before today___

If you answer like this, it means you had thought about having medicine before today, and you think you will get it.

2. I think a nurse will be with me all the time I'm in labour.
   yes___ no _x_ never thought of, before today_x_

If you answer like this, it means you had not thought about whether the nurse would stay with you before reading the question. Now that you think about it you do not think the nurse will be with you all the time.

With some questions you'll be asked which words best describe what you feel. You can choose as many as you want. A blank space is left if you want to add something. For example:

3. When I think about right after having the baby I think I will be:

a. very tired __x__	b. happy _____
c. smiling _____	d. mixed up _____
e. crying _____	f. excited __x__
g. other _____scared_____	h. never thought of, before__

If you answer like this, it means you thought about this before today and thought that you'd be tired, scared and excited after you had the baby.

Please answer all questions. Some questions might be confusing. Please ask if you want to check out what a question means.

Each of the following questions is about what you think your labour and delivery will be like.

1. I think that thinking about labour is a waste of time.
yes___ no ___ never thought of, before today___

2. I think a lot about what labour will be like.
yes___ no ___ never thought of, before today___

3. I worry about if I'll know when labour is starting.
yes___ no ___ never thought of, before today___

4. I wonder if I'll know when I should go to the hospital.
yes___ no ___ never thought of, before today___

5. I think someone will tell me when to go to hospital.
yes___ no ___ never thought of, before today___

6. I think that labour usually lasts about 12 to 14 hrs.
yes___ no ___ never thought of, before today___

7. When I am in hospital, I hope the people around me will offer me help, so I don't have to ask.
yes___ no ___ never thought of, before today___

8.(2) I think the nurses will probably:
a.talk to me_____ b.smile at me_____
c.yell at me_____ d.hold my hand_____
e.explain what they are doing_____
f.other_____
g.never thought about before_____

9.(3) I'll probably ask the nurses for help.
yes___ no ___ never thought of, before today___

10.(4) I think that labour pain will be bad enough that I'll have to stay in bed. yes___ no ___ never thought of, before___

11.(5) I think I might lose control when I'm in labour.
yes___ no ___ never thought of, before today___

12.(6) I think I'll feel safer when the nurses are around.
yes___ no ___ never thought of, before today___

13.(7) I think a nurse will be with me all the time that I'm in labour. yes___ no ___ never thought of, before today___

14.I'd like a nurse with me all the time when I'm in labour.
yes___ no ___ never thought of, before today___

15.(8) I think the nurses will ask me what I want when I am in labour. (for example - the nurse will ask if I want medicine)
yes___ no ___ never thought of, before today___

16.(10) I think I'll have to have some things done to me, just because the nurse is supposed to do them. (for example- I will have to answer some questions, have my temperature taken, have the babies heart listened to.)
yes___ no ___ never thought of, before today___

17.(12) I am worried about how bad the pain will be.
yes___ no ___ never thought of, before today___

18.(13)I really hope I won't have to have a cesarean (have an operation to get the baby out).
yes___ no ___ never thought of, before today___

19.(15) I'm afraid I'll panic during labour.
yes___ no ___ never thought of, before today___

20. I think I will leave the big decisions up to the nurse or doctor.
yes___ no ___ never thought of, before today___

21.(16, 18, 26) I think the pain will be:
a. really bad____ b. not too bad_____
c. terrible_____ d. no problem_____
e. other_____ f. never thought of, before today___

22.(20) I think they'll let me walk around during labour if I want to.
yes___ no ___ never thought of, before today___

23.(20) I think I'll feel like walking around during my labour.
yes ___ no ___ never thought of, before today___

24.(21) I'd like to have my baby's heart beat checked all the time with a heart monitor machine.
yes___ no ___ never thought of, before today___

25.(23) I think I'll be able to stay calm during my labour.
yes___ no ___ never thought of, before today___

26.(24) I think the nurses will encourage me.
yes___ no ___ never thought of, before today___

27.(27) I think that the nurse will know my name and talk to me.
yes___ no ___ never thought of, before today___

28.(29) I think the nurse will ask me to make choices.
yes___ no ___ never thought of, before today___

29.(29) I think the nurse will help me decide what I want.
yes___ no ___ never thought of, before today___

30.(32) I think they'll ask me what I want before they do anything important.
yes___ no ___ never thought of, before today___

31.(33) I hope I'll get drugs that will help the pain when I'm in labour. yes___ no ___ never thought of, before today___

32.(34) I think the doctor will make most of the decisions.
yes___ no ___ never thought of, before today___

33.(22,36) I think I might be embarrassed by:
a. the way I will act___ b. being examined____
c. being seen in just a nightgown____
d.having my private parts looked at____
e. things that are done_____
f. other_____include if feels won't be embarrassed here
g.never thought about before_____

34.(33) When I think about labour I feel:
a.scared of the pain____and other things___
b.mixed up____ c.excited____
d.other_____ e.never thought about before___

35. I am worried something really bad might happen to me during labour and delivery. yes___ no ___ never thought of, before___

36. I am worried that something really bad might happen to the baby during labour and delivery.
yes___ no ___ never thought of, before today___

37.I think my doctor will:
a.come just for the delivery_____
b.be the only one to examine me_____
c.tell me what is going on_____
d.see me often during labour_____
e.other_____ f.never thought about before_____

38. I hope someone is with me all the time
yes___ no ___ never thought of, before today___

39.I would like to have someone I know with me during labour and delivery. yes___ no ___ never thought of, before today___

40. Are you planning on having someone you know stay with you while you are in labour? yes__ no __ never thought of, before___
** If you do not plan on having someone with you please skip the rest of the questions. Thankyou. Do you have any questions you'd like to ask me? Please do.
41. Have you decided who will be staying with you during labour - boyfriend, partner, mother, friend, husband, someone else _____. In the following questions, I will call whoever is going to be with you a companion.

42.(17) When I am in labour, I think I will feel better when my companion is around. yes___ no ___ never thought of, before ___

43.(28) When I am in labour, I think my companion will tell me what is happening (for example - how often my pains are).
yes___ no ___ never thought of, before today___

44.(32) I think my companion will be able to help me make choices about what I want, when I am in labour.
yes___ no ___ never thought of, before today___

45.(35) When I am in labour I think I will tell my companion how I am feeling. yes___ no ___ never thought of, before today___

46.(35) When I am in labour I think I will keep my feelings to myself. yes___ no ___ never thought of, before today___

47. I think the main job of my companion is to stay with me.
yes___ no ___ never thought of, before today___

48.(11) I hope my companion will offer to do things for me. (for example- call the nurse, rub my back)
yes___ no ___ never thought of, before today___

49.(11) I will probably have to ask my companion to do things for me.
yes___ no ____ never thought of, before today___

50. I worry about my companion feeling:
a.bored_____ b.turned of by it all_____
c.tired_____ d.left out_____
e.upset_____ f.like he doesn't know what to do____
g.other_____ h.never thought about before_____

51.(1,9) When I am in labour I think my companion will:
a.stay with me all the time____ b.come and go_____
c.feel tired____ d.be bored_____
e.feel nervous_____ e.not know what to do____
f.other_____ g.never thought of this before_____

52.(1,9) When I have the baby I think my companion will feel:
a.happy____ b. sad_____
c.mixed up____ d.nervous_____
e.calm____ f.like he shouldn't be there____
g.other_____ g.never thought of before____

Thankyou for answering these questions. Do you have any question you would like to ask me?

Implications

While the study examines issues related to childbirth among the lower socioeconomic population, the implications of this study transcend this topic. The findings have implications related to: the nursing care of people of lower socioeconomic status, the education of health care professions, and the process of research among this populations. These implications are at a general level as well at a specific level related to childbirth.

All situations where different social groups meet could potentially result in communication problems related to the differences in the groups perception of reality as well as use of the language (Berger & Luckmann, 1967; Hayes-Bautista, 1978; Hubert, 1974; Samora et al., 1961). Nurses need to be aware of their socioeconomic origins. They also need to remember that nursing has a culture with values, a particular view of reality and common knowledge and language. The cultural values of nursing are middle class and members of the profession are recognized as middle class. Wherever nurses work, whether in the community, a clinic, or in the hospital they need to be aware of the potential for communication problems and take measures to prevent and compensate for them. Overall the implications of this study are related to communication problems and methods of preventing and coping with them.

Implications for Nursing Care

The first implication relates to the issue of communication. Differences in the use and understanding of words which occur among social groups was evident throughout the study. In this study, when the subjects did not understand a question, fear and anxiety rose. Linguistic problems can be addressed by altering vocabulary and sentence structures when delivering care to women of lower socioeconomic status. Since simple language is understandable by all social groups, when social status and linguistic ability is unknown it is better to err on the side of simplicity. This would be important when any explanation was being given whether for consent or to provide instruction. When teaching is being conducted, such as with a pre and post operative patient as well as with pre and post natal women, the nurse needs to evaluate her usual explanation and all printed material for appropriateness. If written material is used it should be reviewed line by line to ensure the patient realizes what is contained in the document.

The women in this study did not readily admit their lack of understanding or ask questions and appeared uncomfortable when asked if they understood. When a rapport was established, the subjects became more open although they remained shy. This implies that nurses cannot expect the patient to guide her in the appropriate level of instruction. The importance of building a relationship and spending time with patients is evident. The success of assessing learning needs and teaching

the patient will be at least in part determined by the relationship which has been established and the ability of the nurse to modify her vocabulary. Consent forms present a particular challenge as the usual procedure is to obtain them on initial contact. This research suggests that obtaining written consents should be delayed as long as possible. Whenever consents are signed it is very important that the nurse ask specific questions to determine if the patient truly understands what they are signing. In addition, it is very important to inform clients of their rights as these women do not know what their rights are. For example, the subjects did not know they could refuse to have students caring for them.

Another aspect of this implication is that the history taking should be delayed to allow the patient and nurse to establish rapport and until the patient has become more familiar and comfortable in the setting. When done the history should be conducted in several sessions to reduce the sense of invasion of the patient's privacy. The initial questions should not be related to the patient's home situation. All nurses need to exercise diligence to ensure they understand what the patient is communicating and that the patient understands what the nurse is saying.

Conceptual problems related to differences in basic values are more difficult to solve. Being conscious of one's own assumptions and values is necessary. Listening carefully to what others say provides insight into their assumptions and

values. Familiarizing oneself with the typical values of a social group helps but does not solve the problem since no social group is homogeneous (Hubert, 1974). Nurses need to continually be cognizant of the fact that values and norms differ among social groups.

Where individuals differ in their cultural background these differences are heightened. Although this investigator did not explicitly examine the impact of culture because of small cell sizes, it was recognized that subjects were not of homogeneous culture. There were subjects of Native, Metis and European descent. It is expected that each of these groups would have somewhat different norms.The investigator intentionally included a culturally mixed sample because the population of this socioeconomic class is mixed. Extremes of difference were controlled for with language and residency requirements. In responding to the CEQ the subjects were very similar. Individuals from all cultural groups were found to be highly fearful, fatalistic and used English very differently from the persons who constructed the CEQ.

To use norms from one group to judge another may lead to errors in assessment. For example, among the middle class acceptance of the role changes associated with pregnancy are indicated by the way women speak about the upcoming event and how they dress. It is normal in the middle class for the woman to begin talking openly about the upcoming event and to wear special clothing quite early in pregnancy. Whereas, most of

the study subjects reported that they tended to talk little about their pregnancy and stated that they preferred not to wear clothes that showed they were pregnant. Most did not like their pregnant appearance. Being aware of these differences would prevent a nurse assuming that behaviour was maladaptive simply because a woman acted differently from her middle class counterpart. It is critically important that the nurse be aware of her own values, assumptions and norms of behaviour in order to avoid automatically and unconsciously judging others by these beliefs.

The second implication, closely related to the first, relates to the sensitive nature of communication. When communicating the nurse needs to be aware of how her comments might be interpreted. The CEQ was seen by many of the subjects as a "put down" because of its assumptions; For example it assumed a high degree of proficiency in the English language. It also made assumptions about the social situation of the respondents. Nurses need to remember not to make assumptions about either of these factors. When developing a rapport, questioning must be done with sensitivity. This will establish the individual's situation without putting him/her in a defensive position. Given that women of lower socioeconomic status often do not initiate conversations, but wish to converse with health professionals, it is important for nurses to initiate communication. In this study many of the subjects stated they were disappointed in the fact that nurses had not

talked with them. They also indicated that their criteria for good care was being addressed by name and spoken to in a reassuring kind fashion. Most subjects preferred support to detailed factual information which they often found frightening.

The third implication is related to the effects of fatalism. Two of the effects of fatalism in this study were the subjects' minimal preparation for childbirth and their discomfort with being a decision maker. Nurses must not assume the degree of knowledge a patient has. Teaching should begin wherever the patient is and proceed in a fashion that will inform but not frighten.

Nurses need to assist women so they can articulate what they think and want. They must help the women by explaining what is occurring, introducing them to what decisions need to be made and informing them of their rights. They need to assist the women in making decisions and in providing the means to ensure these decisions are respected. In situations with students and other staff the nurse should be prepared to actively intercede to ensure that the patients are cared for appropriately and that their wishes are respected.

The investigator could not separate the impact of fatalism from the impact of powerlessness. A sense of powerlessness is common to disadvantaged groups. The more marginal the group the greater the jeopardy in terms of feeling powerless.

The fourth implication relates to level and style of interventions. In the case of childbirth, the women of this study wanted interventions. One of the desired interventions was not technological. The subjects wished the nurse to be present and supportive. The subject indicated that they felt safer when a nurse was present and wanted her there as much of the time as possible. When women of lower socioeconomic status are in labour and delivery the nurses should spend time sitting with the patient even if a companion is with her. The idea that childbirth is a private time to be shared by coach and mother may be appropriate for middle class women but is inappropriate for this group.

Another intervention examined in this study was the desire for medication during labour. This should not be ignored because staff prefer 'natural' childbirth. The staff should be careful not to use coercive or pressure tactics to ensure the client accepts the hospital's point of view. A thorough discussion of the benefits and problems associated with the use of medications should be conducted to allow a truly informed decision to be made by the patient. Even where research indicates a specific course of action is desirable, the staff should be careful to keep the patient informed and not simply impose their will. Although these women often hesitate to be decision-makers, it is important to consider and respect their input into the process.

Implications for Prenatal Education

Besides these implications for nursing care this study also has implications specific to prenatal education of women of lower socioeconomic status. These women tend not to use information seeking and planning as methods of coping, and are known to be infrequent attenders at prenatal classes (Westbrook, 1979). Prenatal preparation needs to more completely meet the challenges presented by women of lower socioeconomic status. This study provided some insight into how this might be done.

Nurses working with prenatal patients of lower socioeconomic status must be aware of the reasons for these women's reluctance to attend prenatal classes. The study subjects identified a variety of reasons for their reluctance to attend. Those who had not attended any classes could not see the benefit of classes and viewed them as a waste of time. This may be due to their fatalistic life attitude and their lack of belief in the benefit of preparation in affecting a future event. The difficulty of encouraging fatalistic people to attend prenatal classes that are basically future oriented can not be underestimated since such programs are basically in opposition to their life orientation. A possible solution might be to change the focus of the educational material provided to make it more present oriented. Addressing issues of interest to these women such as ones related to pregnancy and their fears and concerns about the labour would make the

content more relevant. Once these topics were discussed the women might become interested in additional information. Possibly a change in the method of delivering prenatal education is required. Relevant brief educational sessions might be conducted by nurses in conjunction with the women's visits to physicians for prenatal medical care.

For those who had withdrawn after attending one or two classes the most frequently named reason was that they could not understand what the teacher was talking about. Closely associated with this was that they found the classes frightened them. Since prenatal classes are open to anyone, instructors are faced with widely divergent needs. A means of being able to offer separate classes with more homogeneous groupings would help an instructor tremendously. Within these special classes the identified needs of the population could be met. Much of the detailed and complex information suggested to prenatal instructors in the Perinatal Resource Manual (Manitoba Health - Maternal and Child Health Directorate) and the usual content of classes is inappropriate for women of lower socioeconomic status group. Within a special class the content and presentation style could be modified to make the classes more acceptable and appropriate. Entry into the classes could be by referral by either the community nurse, physician or other professional involved in providing care to these women. This might avoid the problems that would occur in trying to publicly advertised the classes. This assumes that

those providing care understand the socioeconomic status of their clients.

Another problem identified by the subjects was that they felt uncomfortable because everyone else had a coach. A woman without a support person should not be expected to attend classes where other women are accompanied by a coach. Within a separate prenatal education system it may be possible to offer courses specifically for those without a coach. Classes where women do not have a coach should discuss the benefits of social support during childbirth with care and sensitivity. Perhaps measures could be taken to assist a woman in being matched with a coach. During the preparation of coaches, information regarding the concerns, desires and outlook of this population should be included to ensure the coach can empathize and provide appropriate support.

Once a referral was made individual interviews could be conducted by the instructor. At these interviews, time should be spent becoming acquainted with the background of the woman, developing a rapport, and finding out her particular concerns and needs. If needed, initial and basic information might be provided on a one to one basis to increase a woman's confidence and reduce her fear of appearing ignorant. Besides preparing a woman for the classes this interview might increase her willingness to explore the topic of childbirth. During this interview it might be possible to discuss the benefits of having someone with you and arrange prior to the

beginning of classes to match a women without a coach with a labour companions. These interviews, if conducted with sensitivity, should demonstrate to the woman that she will be respected and have her needs met. For a shy woman meeting the instructor and receiving a clear idea of the size and nature of the classes should make attending class more comfortable.

Small group sessions of 3-5 women would be the most appropriate. This size would allow time to meet specific needs and address concerns of individual group members. The need to provide opportunities to vent anxiety and discuss fears has been identified by Astbury (1980). Given the tendency of women of lower socioeconomic status not to verbalize concerns such discussions would require careful engineering.

The content of the classes must be specific to the needs of the participants. Although teaching breathing techniques may be appropriate in a course with a great deal of time, it would not be appropriate in courses of shorter duration since the issues of control and a medication free childbirth are not important to these women. Helping the women formulate realistic expectations would however be important, since this should reduce their postpartum dysphoria. A factor that this investigator recognizes, but could not measure, was the halo and reverse halo effect. In the halo effect a woman's difficult childbirth would result in her having more negative feelings about her mothering role than would have been anticipated. In the reverse halo effect impact of a the

difficult early mothering experiences would cause a woman to recall her childbirth in more negative terms than if interviewed at the time of the birth. Many of the subjects admitted that becoming a mother had been difficult and that they had experienced much frustration and loneliness. Further research is needed into the causes of this negative postpartum experience. Further research may also determine whether a halo effect is influencing the interpretation of events.

In order to meet the needs of this particular group the nurse must recognize the overwhelming influence that fear holds for them. If sensitive to the usual causes, responses and results of fear, the nurse should be able to carefully facilitate a discussion of labour and delivery. This discussion should focus on the expected sensations and emotions and keep procedural information to a minimum, given the research on the impact of information on expectation development (Hartfield, et al., 1982; Janis, 1958; Johnson, 1973; Lindsay et al., 1984). Addressing the issue of complications and their treatment would be necessary to meet these women's needs for reassurance. All teaching must be done in simple language and begin at a basic level. No assumption of knowledge should be made. Since oral communication is preferred and illiteracy a major problem, information should not be given in a written form. The currently used pamphlets with their technical language would not be useful. Therefore pictorial or comic style pamphlets

need to be developed. Many of the subjects could not relate to the films used in prenatal classes. They mentioned the clothing, loving husband and absence of fatigue as being unrealistic. Audiovisual materials using more socially and culturally sensitive situations and actors need to be developed.

Finally materials for prenatal instructors that are directed at this group are needed. The rewritten CEQ may be useful in providing a framework for individual sessions or in the stimulation of discussion in group sessions. The Perinatal Resource Manual (Manitoba Health - Maternal Child Health Directorate) in its introduction discusses the importance of being sensitive to the socioeconomic and cultural situations of participants. The manual however, focuses on the norms of the dominant culture. In the lists of client concerns and the content suggestions there is no indication of which approaches or resources are most appropriate for women from groups other than the mainstream. Using the guide for women of lower socioeconomic status would be difficult. Instructors working with this population need to record what they do and what materials they found most beneficial. This information then needs to be incorporated into the manual so that a more useful guide can be developed for those working with this population.

All currently running educational programs directed at people of lower socioeconomic status should be examined on a

number of factors. In situations where a clinic provides prenatal education as well as prenatal medical care, the percentage of the maternal population attending classes needs to be calculated. All classes should record attrition rates and if socioeconomic or cultural data is known, the figures need to be examined for patterns. As well the appropriateness of the language, the content, and the written and audiovisual materials needs to be evaluated to see if issues raised in this study have been addressed. If the need for change is identified then they should use the findings of the study. On going evaluations need to be conducted to establish if changes are effective.

Implications for the Education of Professionals

This study has implications for the education of health professionals in general, and specifically for the preparation of nurses. Classes on self-awareness need to be conducted to assist health professionals to recognize their values and view of reality. These classes also need to provide an opportunity for these people to explore the values and world view of other social and cultural groups. Exploring ones own and other's values would help individuals to recognize when they are imposing their views on others. It would hopefully sensitize the person to inappropriate assumptions of commonality. Nurses particularly need to be made aware of the impact of social class on the assumptions one makes and the values one holds,

as nurses ascribe to providing individualized care of a holistic nature.

Most nursing education programs already include, at a minimal level, content on the impact of culture and social factors on an individual outlook. The basics of good communication is also generally included in nursing curriculums. The inclusion of the findings of this study would therefore not involve any major changes, but would require a much greater emphasis to be placed on this content. Inclusion of the findings would assist in making the theory of the impact of social factors more concrete and should enhance a student's ability to grasp the concept.

One area that nurse educators must examine for cultural and social bias is the theories of human development and "normal" behaviour that are the basis of much of nursing curriculum. The study population on which these theories were based needs to be examined. Given that much of social science and nursing research has been conducted on the mainstream population, this investigator anticipates that many of these theories will be found to be biased towards this group. Unfortunately, this has not been clearly identified to students and the theories have been presented as normative of all groups. This has encouraged students to judge certain stereotypical responses as indicative of healthy role adaptation. These judgments may be erroneous if the stereotypical response is not congruent with the normative

behaviour of the social group of the client. The findings of this study clearly show that the childbirth experience for women of lower socioeconomic status is quite different than the experience of middle class women. Teaching childbirth as though it is a homogeneous experience is inaccurate and interferes with the student learning to provide socially and culturally sensitive care. It also may result in care being delivered which heighten the woman's sense of guilt and inadequacy at not meeting the societal ideals for a new mother. These women are disadvantaged and do not need the additional burden of not meeting a nurse's expectations.

Nurses need to be taught to examine written and oral communication for social and cultural biases. This would help them become more self-aware and capable of recognizing situations in which social class differences are interfering with communication and the delivery of care. Classroom assignments related to this would assist the student to become skilled in this area and help them apply it in the clinical setting.

The continuing education of nurses in practice is the responsibility of inservice departments as well as the responsibility of the individual. Programs addressing the biases the nurse brings to her work need to be conducted, along with the examination of all teaching and care plans, for middle class bias. Once it has been establish whether the content is appropriate, the language of all written material

for patient use should be examined. Simple, conversational English should be used. Involving nurses who are familiar with people of lower socioeconomic status would facilitate this process as they could be expected to more familiar with the language of these people. Specialists involved in literacy and in English as a second language would also be helpful in the task of not only translating materials but as consultants on broader issues.

The findings of this study need to be shared through both the inservice departments and through other mediums such as conferences, presentations to colleagues and written work.

Individualized care can be given only if the specific needs of the client are known. Socioeconomic status influences those needs. Therefore, the underlying implication of this study for nursing practice is that a client's socioeconomic status should be taken into consideration in providing care and that this must be emphasized in the education of professionals.

Implication for Research

A great deal of research has been conducted with a middle class population. It would seem that this social group is easier to access and research than are other groups. This is probably due to their: similarity to those conducting research, facility with the written language and willingness to be a subject in research. This has resulted in theories of

normative human behaviour being tested primarily on middle class individuals and therefore being class bound. Research is needed among other social groups in order to determine if current theories and norms are applicable to these groups or whether alternative ones need to be developed. Several implications for research among people of lower socioeconomic status come from this study. Some are general in nature while others are more specific.

General Implications

This study provided information important to research related to the characteristics of the study population, as well as factors related to the investigator. Characteristics of the population include: their use of language, sensitivities as well as orientation to life. The language used in collecting data must be simple, and specific examples should be provided to illustrate general terms. The subjects used a limited vocabulary and often spoke in non-standard English. Expressions frequently used were "you know" and "like". Often they were accompanied by body language that indicated that the subject wished the investigator to help her put her ideas into words. The women's thoughts tended to be communicated in a stream of consciousness manner and were not categorized in the manner of the middle class. With this communication style one needs to exercise particular care not to make assumptions, to repeatedly check to be sure that one is being understood and is understanding what is being said by

the subjects. This convoluted way of relating information also impacts on the recording and analysis of the data. This pattern of speech means that research with this population is labour intensive. Hubert (1974) suggests that research seeking to study beliefs, attitudes and expectations of women of lower socioeconomic status needs to use an intensive interview method, "since it was often a lengthy or difficult process extracting the true opinion of the women, and obtaining their confidence was an essential first step" (p. 40). Individual interviews are probably preferable to group ones since the subjects of this study were reluctant to express opinions and needed to be drawn out. Thus a group setting could inhibit the process of data collection.

Survey methods may be inappropriate for this population. Surveys assume that life experiences can be categorized and that respondents are able to understand and use the given categories in relation to their own experience. The subjects of this study could not do this and preferred to relate their experience in their own terms.

Although the investigator would not recommend using a survey method, if one was being designed it would be important to ensure the concepts and language were congruent with this population. In addition, the format of the tool would need to be examined. The Lickert scale was unsuitable for this group as was the use of strongly worded opinions. The subjects tended to view the written word as factual and not as

opinions. Even when they were shown that these were just opinions they had difficulty disagreeing with it as the questionnaire seemed to represent authority. Without an interview their true feelings would not have been recorded. Administering tools designed for another social group would be inappropriate given the inappropriateness of content, language, design and the unreliable nature of data collected by such tools. Therefore development of a single tool appropriate to all social groups is not a realistic goal given the differences between groups indicated by this and other studies (Hubert, 1974; Nelson, 1982b, 1983; Rosengren, 1961; Reid, 1983; Westbrook, 1979).

If an investigator were interested in using a written format with some subjects, a method of determining who could manage this method of administration would need to be found. Reading ability was considered a sensitive issue and asking someone if they can read was considered inappropriate. Enquiring if someone enjoyed reading or crosswords might be a means of establishing reading skill. This investigator found that those subjects who identified an enjoyment of either of these had a greater facility with the language of the CEQ and would often read ahead of her as they were reviewing the tool. As this study was an oral one this serendipitous finding was not studied. Even if a written format was used only on women from this population who had displayed strong reading ability, this investigator would recommend being present throughout its

completion. This would encourage the subjects to make comments and ask questions.

The subjects sensitivity was displayed in other areas. They were quick to pick up any hint of a slight and were keenly aware of the underlying tone of an item. Therefore the investigator found it important to ensure the tone of the interview was not condescending. Another method that proved effective in protecting the subjects from embarrassment and feelings of inadequacies was asking them, whenever possible, to respond as though for another person.

Another area of sensitivity was the order of data collection. Information such as educational level, marital status and income are indicators of socioeconomic status and is of interest to the investigator wanting to establish eligibility of an individuals for participation in a study. However, this group is very conscious of how they compare to the middle class on these measures. This may explain the sensitive nature of questions on these subjects. This investigator would therefore recommend not collecting sociodemographic data until rapport is established. This investigator would recommend not asking persons on social assistance questions about household income as the information gained is suspect and the line of questioning may threaten the established rapport. For these individuals any additional income threatens their qualification for assistance and it is

unlikely that they would admit such information to a stranger, who possibly is an informant.

Most of the subjects displayed a fatalistic non-futuristic, and private orientation to life. This impacts on research, as questions related to future events and expectations are difficult for them to answer. The subjects had problems comprehending and answering the CEQ. However, questions about past or present events, and about their hopes for the future were relevant and easier for them to answer. This suggests that the phrasing of questions and the perspective of a study needs to be examined for suitability to the study population.

Their sense of privacy also impacts on design issues such as location of the interview and using a snowball sampling method. Alternative neutral areas must be planned for those subjects who prefer not to have an investigator in their homes. In this study a local restaurant chosen by the subject proved a good alternative. The clinic was a neutral place and the use of a private room for interviews allowed them to speak freely. This investigator found she received few referrals from the subjects which may have been related to their desire to maintain privacy. Snowball sampling is not recommended with this population.

This study not only provided information that relates to the study population, it also provided information of related to the investigator. The first two factors related to the

investigator are closely linked. They are the investigators orientation to life and her approach to research. Orientation to life include many aspects. During this study the investigator found that it was important to recognize that she was of the middle class. Recognizing her class meant accepting the impact it had on her frame of reference, her attitudes, her beliefs and her perception of reality. The investigator believes it is important to understand and examine one's orientation in order to recognize biases and determine the suitability of proceeding with research among this population. Unless one can respect and value the subjects it is difficult and perhaps impossible to meet their needs. In addition, recognizing ones orientation helps to prevent imposing ones own understanding of reality on others and in so doing misrepresenting the information one collects.

Research with this population may require the investigator to set aside some of their usual behaviors. This investigator thinks that when conducting research in a group one accepts the role of a guest and respect the rules of social conduct of the study group. For example, this investigator is opposed to smoking. However she accepted the subjects smoking throughout the interview and refrained from indicating her feelings on the subject. An attitude of flexibility and acceptance was important in winning and maintaining the subjects cooperation and confidence.

It was also necessary to not allow oneself to be deterred. The groups very neutral and noncommittal response to the request to interview them was at first daunting. However the investigator found this coolness gradually disappeared as the relationship developed. Another potentially daunting aspect of this research was the time interviews took. Most of these women seemed to have difficulty translating their knowledge into language. Perhaps they are pictorial thinkers. Whatever the explanation, the result was that the investigator had to patiently help them put their ideas into words. Throughout the interview the investigator found she had to initiate and encourage the conversation. This may have been a result of the power differential between the social status of the investigator and subjects.

The approach adopted by this investigator developed from her orientation to life. Prior to beginning, the investigator examined her interviewing skills and decided that practice would be appropriate before the data collection began. This was built into the first phase. Knowing one's limitations and strengths helps to prevent problems. A person's frustration level is very individual as will be their response to conducting this type of interview. Scheduling an appropriate number of interviews per day so that a relaxed manner, free of clock watching, can be maintained, helps to build rapport and reduce both subject and investigator tension. Not wishing to

overpower the subjects, and wanting them to feel comfortable, the investigator dressed simply and casually.

Respecting the women who assisted in designing the study meant incorporating their suggestions even when they were inconvenient. For example, having the consent forms signed at the end of the interview meant that the subject might refuse and the time interviewing that person lost. Not requesting taping of the interviews meant that the research notes had to be completed immediately at the end of each interview. These and other suggestions were used so that the research approach would be as acceptable as possible to the subjects and would meet the needs of the population. The investigator found the suggestions also helped to establish rapport, reduce tension and ensure participation. Including women from the social group to be studied in the design of the research is strongly recommended.

The final factors related to any investigator are their ethical responsibilities as well as their collegial responsibilities. An ethical issue which this investigator became aware of during the study was the impact of words on the subjects. Traditionally research that does not involve invasive bodily procedures has been considered benign and harmless. The investigator found that such an assumption is erroneous. Many of the subjects clearly stated that the CEQ should not be used as it created fear. What they were saying was that words can hurt you. Investigators need to view their

work as potentially harmful and exercise care in the phrasing and nature of questions.

Those using a survey method need to be particularly careful to evaluate the tool before use. The subjects in this study felt that the review of the CEQ was good as it was on a one to one basis. The investigator made it clear that she was willing to set it aside to provide reassurance and teaching. One way of reducing potential harm is through oral collection of data. Investigators interested in this population need to examine their tools and methods and consider the desires and needs of the population identified by the subjects of this study.

All investigators have collegial responsibilities. Every investigator should provide data on the socioeconomic status of their subjects, as well as the criteria for establishing it. It should be stated what consideration was given to this factor in the design, analysis and reporting of research findings. This would provide a more complete and accurate understanding of the impact and differences of socioeconomic status. Failure to consider socioeconomic status may result in flawed research. Nelson (1982b) states that "a methodology that altogether ignores social class as a variable or avoids class analysis by combining groups of women on the basis of similar characteristics, irrespective of social class, may well lead to unsound generalizations (p. 350). In research conducted on the exclusively on the middle class it

is important to be able to recognize this so that it is recognized as representative of that group and not the society as a whole.

Specific Implications

Additional implications for research involve specific recommendations for further studies that need to be undertaken as an outgrowth of this work.

Firstly, a study to evaluate the acceptability and appropriateness of the language and concepts of the proposed revised CEQ to women of lower socioeconomic status should be conducted if it is to be used for research and education.

Secondly, the tool's reliability and consistency needs to determined by having a large number of women of this group complete it. These two studies could result in the formation of an appropriate tool for use among women of lower socioeconomic status.

Thirdly, a longitudinal prospective study using the refined tool needs to be conducted to examine the formation of expectations during pregnancy. Measurements in the few days following delivery would provide insight into how realistic these expectations were and what information the women thought would have been beneficial. A control group that had not participated in the prenatal study should be included to measure the impact of the research tool and process, on the expectations developed in the experimental group. Such a study

would increase the knowledge of expectations, their formation, as well as the impact of research.

Fourthly, and the most valuable would be an implementation study. Using the suggestions outlined in the implications for nursing care, a modified prenatal class incorporating the CEQ could be developed. The group's expectations and experience in childbirth could then be compared to control groups to provide a means of measuring the effectiveness of the modified prenatal class in the development of expectations.

Conclusion

To conclude, this study has provided much information about the expectations of childbirth held by women of lower socioeconomic status. It has specifically addressed the issue of the appropriateness and acceptability of the Childbirth Expectation Questionnaire (CEQ) to these women. Differences in the childbirth expectations between women of middle and lower socioeconomic status suggested by Nelson (1982b, 1983) Reid (1983) were supported. Differences in the conceptualization of reality, as well as differences in the understanding and use of language as suggested by Berger & Luckmann (1967) were also supported. Many implications for nursing care, the education of health professionals and research resulted from this study. These implications include the need to modify current

practices of care, education as well as the need for further study. In both nursing research and practice the impact of socioeconomic status was shown to be important.

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Appendix A

Nursing support
Intervention
Coping & pain
Significant other

Actual one used

CODE: _____

CHILDBIRTH EXPECTATIONS QUESTIONNAIRE

This questionnaire is designed to describe women's expectations regarding their impending labor and delivery experience. Your opinions along with those of other pregnant women will be used to try to learn more about women and childbirth.

This questionnaire contains a number of statements, each of which says something different about your labor and delivery expectations. While no one can know for sure what will happen to them in labor, we are interested in knowing what you anticipate or expect the childbirth experience will be like for you. We are asking for your "best guess" about what will happen to you in labor. For each statement, decide how you agree or disagree with the view expressed. Think about the statement. Beside each statement you will find five words used to describe your expectation. There are no right or wrong answers. People differ in their views. Your response is a matter of your personal opinion. The information you give will be completely confidential.

Thank you very much for your time and your help. Below is an example which may help you in completing the questionnaire.

EXAMPLE

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A.	I am looking forward with great joy to the birth of my baby	1	2	3	4	5
B.	I need to know more about childbirth than I possibly could	1	2	3	4	5

The answer to Example A, "Strongly Agree" indicates that you are quite certain that you are looking forward to the birth of your baby with great joy.

The answer to Example B, "Neutral" indicates that you cannot quite decide whether to agree to disagree with this statement.

Circle the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

	With regard to my labor and delivery experience, I expect that:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
S	1. My partner/coach will be happy and excited.	1	2	3	4	5
N	2. The nurses will be kind to me.	1	2	3	4	5
N	3. I will avoid seeking help from the nurses.	1	2	3	4	5
C	4. I will be immobilized by the pain of labor.	1	2	3	4	5
C	5. I will be able to cope with labor.	1	2	3	4	5
N	6. I will feel reassured by the nurses' presence.	1	2	3	4	5
N	7. The nurses will spend little time with me.	1	2	3	4	5
N	8. My plans for birth will be ignored by the nurse.	1	2	3	4	5
S	9. My partner/coach will feel quite helpless.	1	2	3	4	5
I	10. I will be required to have routine procedures even if I don't want them.	1	2	3	4	5
S	11. I will ask my partner/coach for help.	1	2	3	4	5
-	12. I will worry about the severity of labor pain.	1	2	3	4	5
I	13. There is little chance that I will end up having a cesarean section.	1	2	3	4	5
I	14. Lots of medical equipment and machinery will be used.	1	2	3	4	5

Circle the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my labor and delivery experience, I expect that:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
15. I will be afraid of panicking.	1	2	3	4	5
16. I will experience discomfort but not unbearable pain.	1	2	3	4	5
17. I will feel comforted by the presence of my partner/coach.	1	2	3	4	5
18. I will feel intense pain.	1	2	3	4	5
19. I will have a childbirth free of medical intervention.	1	2	3	4	5
20. I will be up walking around for most of my labor.	1	2	3	4	5
21. I will want to have fetal monitoring.	1	2	3	4	5
22. I will be afraid of being a coward.	1	2	3	4	5
23. I will be able to relax during labor.	1	2	3	4	5
24. The nurses will offer me encouragement.	1	2	3	4	5
25. Forceps will be used.	1	2	3	4	5
26. The pain of labor will be agonizing.	1	2	3	4	5
27. I will receive personal attention from the nurses.	1	2	3	4	5
28. My partner/coach will tell me what is going on.	1	2	3	4	5

Circle the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my labor and delivery experience, I expect that:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
29. The nurse will allow me to be an active participant in decision making.	1	2	3	4	5
30. I will be scared when I think about the pain of labor.	1	2	3	4	5
31. I will refuse to have any procedures I consider unnecessary.	1	2	3	4	5
32. My opinion or that of my partner/coach will be sought for all major medical decisions.	1	2	3	4	5
33. I will use anesthetics and/or pain killing drugs.	1	2	3	4	5
34. The doctor will make most of the decisions.	1	2	3	4	5
35. I will avoid telling my partner/coach what I am feeling.	1	2	3	4	5
36. I will be embarrassed by my behaviour.	1	2	3	4	5

CEQ ORGANIZED ACCORDING TO SUBSCALES

Subscale 1: Support of Partner/Coach

1. My partner/coach will be happy and excited.

9. My partner/coach will feel quite helpless.

11. I will ask my partner/coach for help.

17. I will feel comforted by the presence of my partner/coach.

28. My partner/coach will tell me what is going on.

32. My opinion and that of my partner/coach will be sought for all major medical decisions.

35. I will avoid telling my partner/coach what I am feeling.

Subscale 2: Nursing Support

2. The nurses will be kind to me.
3. I will avoid seeking help from the nurses.
6. I will feel reassured by the nurses' presence.
7. The nurses will spend little time with me.
8. My plans for birth will be ignored by the nurse.
24. The nurses will offer me encouragement.
27. I will receive personal attention from the nurses.
29. The nurse will allow me to be an active participant in decision making.

Subscale 3: Coping with Pain

4. I will be immobilized by the pain of labor.

5. I will be able to cope with labor.

12. I will worry about the severity of labor pain.

15. I will be afraid of panicking.

16. I will experience discomfort but not unbearable pain.

18. I will feel intense pain.

22. I will be afraid of being a coward.

23. I will be able to relax during labor.

26. The pain of labor will be agonizing.

30. I will be scared when I think about the pain of labor.

36. I will be embarrassed by my behavior.

Subscale 4: Medical Interventions

10. I will be required to have routine procedures even if don't want them.

13. There is little chance that I will end up having a cesarean section.

14. Lots of medical equipment and machinery will be used.

19. I will have a childbirth free of medical intervention.

20. I will be up walking around for most of my labor.

21. I will want to have fetal monitoring.

25. Forceps will be used.

31. I will refuse to have any procedures I consider unnecessary.

33. I will use anesthetics and/or pain killing drugs.

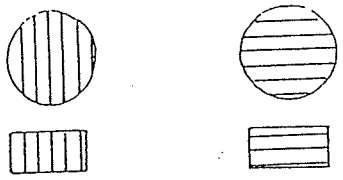
34. The doctor will make most of the decision.

Appendix B

Possible Study Results

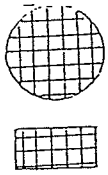
These diagrams display the various outcomes possible with regard to language and concepts as used in the CEQ and as understood by the subjects in the study. Language is designated by circles and concepts by squares. The CEQ is designated with vertical lines, and the subjects by horizontal.

For example in the key below, language, as used in the CEQ, is a circle with vertical lines:

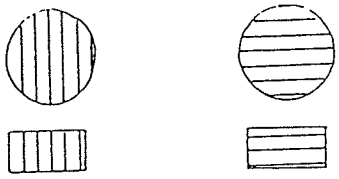


As shown below, congruence (A) between two of these is displayed by a overlapping of the symbols, resulting in a checkerboard design while incongruence (B) is the opposite.

A. Congruence

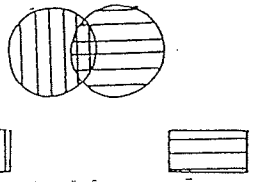


B. Incongruence

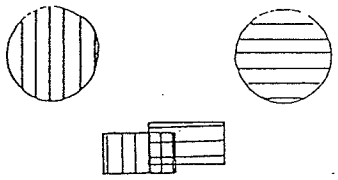


C. Partial Congruence

In the first two of the seven variations one can see that, in 1, language is partially congruent, while concepts are incongruent. In 2 this is reversed with language being incongruent and concepts partially congruent.

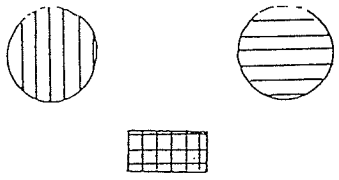


1

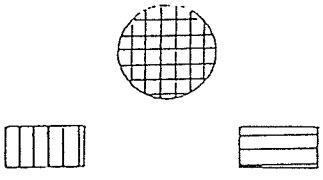


2

In the third variation language is incongruent and concepts are congruent. In the fourth the situation is reversed.

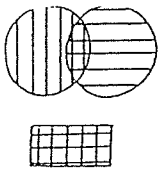


3

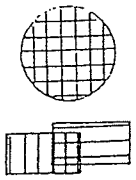


4

In the fifth variation language is partially congruent while concepts are completely congruent. In the sixth the situation is again reversed.

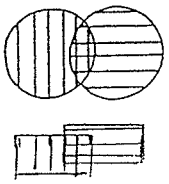


5



6

The seventh variation shows both language and concepts to be partially congruent.



7

Appendix C

To be presented orally:

Introduction to: Design Phase

Hi, my name is Sue Stanton,

I am a nurse taking my masters degree. I am interested in finding out if this questionnaire (hold up) is useful and clearly worded. It looks at what pregnant women think about childbirth and what concerns they have about labour. The questionnaire is made up of statements. Each woman is asked to consider how closely each statement reflects her own feelings, and to rate this on a scale from one to five. I'm trying to find out whether the statements are clear and appropriate for all women.

What I'd like to do is go through the questionnaire with you, and for you to tell me which words are difficult, and suggest alternative ones. Then I'd like to discuss the content with you to be sure no major areas of concern have been missed.

This will be a group discussion that will take about two hours.

I am not studying the effect of different cultural backgrounds, so I am only looking for women who have lived in Canada for at least 10 years and who speak English at home. I would be interested in talking with you whether you have children or not.

If you are willing to help in this research I would appreciate it very much. However, if you can't, that is o.k.. Your instructor will <u>not know</u> whether you participate or not so don't let that influence your decision.

I'm going to hand out a letter which I'd like you to read now. Please fill out the second page and return it to me before you leave.

Thank you for considering this request.

If you agree to participate, I'll arrange a group interview where all of the volunteers from the class will meet together for approximately two hours. If you agree to participate, you can still withdraw at any time, and you do not have to answer all questions.

I assure you that your decision to participate is entirely voluntary and will in no way effect your studies at the college. Only I will know who has agreed to help me. My records will only refer to you by a code number, not your name. Data will be available only to my thesis advisers and myself.

The results of the study may be published but only group results will be presented. No information will be released on any particular individual. A summary of test results will be sent to you if you would like them.

If you have any questions please feel free to call me. Thank you for considering my request.

Appendix D

Inclusion Criteria

The classification of individuals into socio-economic levels may be done by a number of criteria including occupation, income, education, material possessions, housing district, or any combination of them (Abramson, Gofin, Habib, Priden & Govin, 1982, Beaton, 1986, Morgan, 1983, Nelson, 1983, Westbrook, 1979). Abramson et al (1982) suggests that multiple criteria are a preferred method of establishing the socio-economic status and that the choice of indicators should be determined by practical considerations and by the conceptual framework with respect to the social and class relationship . . ." (p. 1739). As the group of women to be studied in this research project are often unemployed the criterion of education and income were most relevant.

Only female subjects who meet the following criteria will be included in this study. Those who:

1. are between 18 and 40 years old
2. speak English in the home
3. have completed less than grade 12
4. are pregnant or have delivered a child
4. are currently on social assistance
6. have resided in Canada for more than 10 years and currently reside within the City of Winnipeg.

Appendix E

This will be given to the class.

Invitation to Participate: Design Phase

Hi!

I am a nurse taking my masters degree. I am interested in finding out if this questionnaire is useful and understandable. It is about what women think childbirth is like. I am trying to find out if the content is appropriate and the words understandable to the general population. Before meeting with women in the community I want to get your thoughts and ideas about the questionnaire. Therefore I would like to go through the questionnaire with a group of you and talk about whether it's easy to read and whether it makes sense.

If you agree to participate, you will be part of a group discussion will last about two hours. If you agree to participate, you can still withdraw at any time and you do not have to answer all the questions.

I assure you that your decision to participate is entirely voluntary and will in no way effect your studies at the college and only I will know who has agreed to help me. Data will be available only to my thesis advisers and myself. In this data, you will be referred to only by a code number, and not by your name.

The results of the study may be published but only group results will be presented. A summary of test results will be sent to you if you would like them.

If you have any questions please feel free to call me. Thank you for considering my request.

Sincerely,

Susan Stanton
Ph.

Please return this portion of your invitation to S. Stanton.

I am willing to participate in this study.

yes _____ no _____

If yes, then you are agreeing to participate in a group discussion. I will contact you to confirm the data and time of this meeting.

Name _____.
Address _____.
_____.
Phone _____.

Thank you,
Sue.

Appendix F

To be read by nurse as each patient comes to the desk.

Sue Stanton is a nurse who is doing a study on what women think labour will be like. She would like to talk to you. If you are willing to speak to her, I'll call her over, and she can explain how the study works while you wait to see the doctor.

Appendix G

This will be delivered orally to possible subjects:

Introduction to Study Phase

Hello! My name is Sue Stanton. I am interested in talking to you for a few minutes. Would that be o.k.?

I'm a nurse. I'm doing a study for a course I'm taking at the university. I'm interested in finding out if this questionnaire (hold it up) is useful and easy to understand. The questionnaire is about what women think having a baby will be like. The questionnaire is a list of statements where a woman says something like, "The doctor will make most of the decisions.". You're asked if this is how you feel. What I am interested in finding out is whether the questionnaire is clear and useful for all women, or whether it has to be reworded in some places.

If you are willing, then I will read through the questionnaire with you. After each one you can tell me if it needs to be changed. Then we will talk about what words would be better. Before we start on the questionnaire, I'll ask you some things, like: what sorts of things you think about when you think of having a baby, and what do you think labour will be like. All of this will take about 1 1/2 hours. We could do it now or I could come to your home if that would be better. The time and place are up to you.

If you decide to meet with me I'd be very thankful. Even if you agree to help me, you don't have to answer all questions, and can drop out any time you wish. If you don't want to help me, that is no problem and <u>won't affect your care here at the clinic in any way.</u>

After I have spoken to a number of women I will be able to decide on how to make the questionnaire better. To help me remember what people say I will take notes as we talk. These notes will only be used by me and my teacher, who is helping me with this study.

I may publish the results of this study. I will not ever use your name. Only the results of all the comments <u>together</u> will be used. If you are interested I will send you these results.

Thank you for giving this some thought. Are you willing to participate?

If the answer is <u>no</u>, I will again thank her and leave.

If the answer ir <u>yes</u>, How about starting right now while you're waiting for the doctor. (I will then begin the

interview by giving her a written explanation of the study. (appendix H) I will encourage her to call if she has any questions or knows of anyone else who would be willing to participate.)

Appendix H

To be given to subjects:

Invitation to Participate: Study Phase

Hello! My name is Sue Stanton. I'm a nurse working on a course at the university. This questionnaire is about what women think having a baby will be like. I want to know if it is clearly worded and useful. I would like you to help me decide how I can make it better.

If you are willing, then I will go through the questionnaire with you and ask you to tell me which parts aren't clear or are hard to understand. Then we will talk about what words would be easier. Before starting the questionnaire I will ask you some other questions. Something like this: what are the major things you think about when you think of having a baby and what do you think labour will be like. All of this will take about 1 1/2 hours. Even if you agree to help me you can drop out at any time you wish, and you do not have to answer all questions. We could do it now or I could come to your home if that would be better. The time and place are up to you.

If you decide to meet with me I'd be very pleased. If you don't have time that is no problem and <u>won't affect your care here at the clinic in any way.</u>

After I have spoken to a number of women I will be able to decide on how to improve the questionnaire. To help me remember what people say I will take notes as we talk. These notes will only be used by me and my teacher, who is helping me with this study.

I may publish the results of this study. I will never use your name. Only the results of all the comments <u>together</u> will be used. If you are interested I will send you these results.

Thank you for helping. If you know about anyone else who may be willing to be interviewed, or if you have any questions, please contact me.

Susan Stanton

Appendix I

To be read aloud with informant.

Consent: Study Phase

I, _____, understand that I am being asked to help evaluate a childbirth questionnaire.

I have received an explanation of the study and have had my questions answered.

I agree to talk with Susan Stanton for about one to two hours. I know that I don't have to answer all the questions and can stop the interview at any time. I know all information will be used only by Susan and her instructor; my name will never be used but instead I will be referred to by a code number. No one else will ever find out what I answered. Whether I do or do not speak with Sue will not affect my care at Mount Carmel Clinic or any other place I go to see a doctor or nurse.

If Sue publishes this work I understand that all the information will be combined together and that no names will be used.

I agree to have my conversation with Sue tape recorded:

Yes _____ No _____

My signature below shows that I understand and agree to this meeting.

Date _____

Signature _____

Appendix J

Consent: Design Phase

I,_____, understand that I am asked to help evaluate a childbirth expectation questionnaire for use with women from the general population.

I have received a written invitation to participate and have had my questions answered satisfactorily. I agree to being in this 1 to 2 hour group discussion with Susan Stanton, which will be tape recorded. I understand that I can leave the meeting at any time, and that I do not have to answer all questions. I understand that in the data collected, I will be given a code number, and not referred to by my name. I understand that the information will be combined and, if published will only refer to the group. Therefore I understand that my name will never be used and no one will find out what I answered. I understand that, whether or not I participate, my studies at Red River Community College will not be affected.

My signature below indicates that I am informed and that I agreeto participate.

Date _____

Signature _____

Appendix K

Would you like to receive a summary of the results of this study?

Yes _____

No _____

If yes: Name _____

Address _____

_____

Postal Code _____

Appendix L

Interview Schedule - Design Phase

(Briefly review the purpose of the meeting and answer questions. Have the students fill out the consent and sociodemographic forms. Make request to tape interviews.)

By the end of our discussion I'm hoping to have a better idea of the order interviews should be done in, and ideas for changing the CEQ.

(Distribute the CEQ along with a pen and pencil to each participant.)

We'll read this questionnaire together. Please underline words and phrases that you think will create difficulty. As we go, please write down possible alternatives. Ask any questions that come to mind.

(Read questionnaire. Have them work through. Discuss findings.)

Let's look at the introduction and the instructions. What words did you underline in the instructions? What would be a better way of saying that? What do you think of the 1 to 5 choice? What's a better way of doing it? Do you have any about this page? O.k., let's look at page 1.

(Go through whole questionnaire in this manner. Then begin overall discussion)

As you noticed, the questionnaire focused on four main areas. These were: pain, support from someone else, support from the nurse/role of the nurse, interventions. What does this (name of subscale) mean to you? Could you give me a brief definition/ description?

(Move to next topic. Distribute handout phase 1)

Now let's look at childbirth in general. Please read through this list of questions and either jot down some answers or just talk about them and I'll take down notes.

(Discuss each question and then general issues)

Considering what we have just discussed, do you think that there's any important things that have been left out of the CEQ? (alternatively) If you were having a baby, can you think of other things that ought to be put in, and how important would they be?

Do you think that if the CEQ was changed, like you have suggested, that it would be useful? How? What do you think of its length? How would you administer it (orally / self administered).
You know that lots of people do not read. How would you ask someone if they could read without offending them?

I've thought a lot about how to approach this and would like your advice. When I meet women by themselves, I'd like to approach evaluating this questionnaire in the best way. How do think my interview with you today went? Do you think I should change it around?

(Request for referrals.)

You've been really helpful. I've got one last request. I'm hoping to meet women through Mount Carmel Clinic and you. If you have anyone, a friend or relative, who might meet with me for an individual interview I'd like you to check it out with them. (Discuss inclusion criteria) If it is o.k. then you could call me (show them phone number on invitation to participate - or give out) and we could arrange a time that you could introduce us. Please don't feel you must find someone. If you can, great, if not, that's o.k..

(Conclude with following)

Thank you for all your help. I hope your studies go well. If anyone wishes to have a copy of my results please fill out one of these forms (Appendix K). Remember please do not talk about who was at this meeting with your instructor. I promised that no one would be pressured into participating and I don't want people who didn't come to feel I broke my word.

Handout for Design Phase

1. When you think about having a baby what do you think about?

2. Whenever a women is going to have a baby there are some things she worries about. What are/were the major things you worry about?

3. How do you expect to/did you feel emotionally during childbirth? (early labour, late labour, during delivery and immediately afterward?)

4. What do/did you expect the discomfort/pain to be like during childbirth?

5. What do/did you expect will help the pain? (What did you do?) (early and late labour, during birth, afterwards?)

6. What kinds of physical activities do/did you expect to do during labour and delivery? (early and late labour, delivery and immediately afterwards?)

7. How do/did you think you'll act during labour and delivery?

8. How much time will/was your husband/coach be with you?

9. What do/did you want your husband/coach to do? (early and late labour, delivery and afterwards?)

10. What activities will/was the nurses be doing? What do/did you hope the nurse will do?

11. How important do you think expectations are?

12. Is there anything else you would like to add or any questions you would like to ask me?

The following incorporates suggestions from design phase.

Interview schedule - study phase.

After obtaining oral consent the interviewer will briefly outline the format of the interview and reassure the subject that she will not loose her turn to see the doctor. Encourage the woman to talk at length whenever possible. (Use form with correct tense for parity of subject)

Questions - For women having their first baby

1.Have you ever seen a baby being born (in person, film, T.V.)? ______________________________
Sat with someone in labour? ______________

2. What do you think it will be like to have a baby? (When you think about having the baby what do think about?)
no resp. ________ see notes _________

3. When you think about having the baby what things do you think (worry) about? no resp. ______ see notes __

Do you think about:
how it will feel (pain) ______________
what sorts of things could you do to help reduce pain (breathing, walking, hot showers, back rub) _________
if they'll give you something for the pain __________
how long it will last ____________________
knowing when its time to go to hospital __________
how you'll get to the hospital ______________
who will go with you ____________________
if you will be left alone __________________
if the nurses will tell you what is happening ________
if the nurses will listen to you what you want ________
being examined _______________________
being seen by the doctors and nurses ____________
how many doctors will see you ________________
if you will cope (act stupid,fall apart) ___________
if you'll show emotion (cry, yell, smile) ___________
what you will do about money _________________
how the baby is (if it is healthy) ______________
how the baby will feel during labour ____________
how the baby will fit into your life ____________
what it will be like to be a Mom ______________
what's a good mom _______________________
your appearance (being fat) while pregnant _________
how you will look after ____________________
how IT (sex) will feel after __________________
are there any other things ___________________

4. When you go to the hospital what do you think you will feel like? (frightened, excited, sad, mixed up, relieved, other) _

5. When you are in labour do you think you will feel? (happy, scared, excited, mad, uptight, lonely, other) _ _ _ _ _ _ _ _ _ _

6. Right after the baby is born how do you think you will you feel? (scared, tired, happy, mixed up, other) _ _ _

7. When you start labour at home what will you do? (walk around,go to bed, eat, visit, watch T.V., go to the hospital right away, other) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

8. In hospital while your in labour what do you think you'll do? (stay in bed, go for smoke, visit, walk around, other) _ _ _ __

9. Do you expect someone to be at the hospital with you - who? _
   Do you think it's important to have somebody there? _ _ _ _ _ _ _ _ _ _ _ _ _
   What will they do? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
   Do you think about how they will cope? (manage) _ _ _ _
   Are you worried about them? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
   Have you ever thought about this before? _ _ _ _ _ _ _ _

10. Do you think it's important to think about all these things before having the baby? see notes _ _ _ no _ _ _

11. Do you think about labour and birth much? _ _ _ _ _
   How much? (how often, once a hour, day, week, month) _ _ _ _
   When you think about it do you try not to? Why? _ _ _ _
   What things do you think about most often? (being a mom, baby's health, see above list) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

12. Do you think it is important to see a doctor regularly during pregnancy? _ __Why? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

13. What do you think makes a good parent? _ _ _ _ _ _ _ _ _ _ _
   Is how you have the baby (labour and delivery) important? _ _ _ _ _ _ _ _ _ _ _ _ _ _

14. Is there anything you'd like to tell me about, or ask me about? _

Well that's great. Let's go through this questionnaire. I'll read it out loud and stop after each sentence so we can talk about it.

If the woman has previously had a child the subject will be asked to recall her first pregnancy and respond appropriately. She will also be told that I'm interested in her answer for this pregnancy. Throughout the woman will be asked if what occurred was what she had thought would happen.

Questions - For woman who have had a child.

1.Have you seen a baby being born other than your own (in person, film, T.V.)? _
sat with someone in labour? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

2.What did you think it would be like to have a baby? (When you thought about it what did you think about?) Was it like you expected? (encourage to describe previous experiences) _
_ _
_ _

3.When you thought about having the baby what things did you think (worry) about? see notes _ _ _ no resp _ _ _ _ _ _ _ _

Did you think about:
a) how it would feel? (pain) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
b) was it like you thought _
c) what did you get for the pain _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
d) was that what/when you wanted _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
e) during pregnancy were you worried about getting something

_ _ _ _ _ _ _ _ _
f) were there other things you thought would help (breathing, back rubs, hot showers etc.) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
did they help _
g) would more info have helped _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
h) knowing when it was time (start of labour) _ _ _ _ _ _ _ _ _
i) how you'd get to the hospital _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
j) who would go with you _
did they go? _
k) if you would be left alone _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
l) if the nurses would tell you what was happening _ _ _ _ _ _
m) if the nurses would listen/talk to you _ _ _ _ _ _ _ _ _ _ _
n) being examined _
o) being seen by all the doctors _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
more doctors/staff than you thought? _ _ _ _ _ _ _ _ _ _
p) if you would cope (act stupid, fall apart) _ _ _ _ _ _ _ _ _
q) if you'd show emotion (cry, yell, smile) _ _ _ _ _ _ _ _ _
how did you act? _
r) what you would do about money _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
how have you managed _
s) how the baby was (if it was healthy) _ _ _ _ _ _ _ _ _ _ _ _ _
t) how the baby would feel during labour _ _ _ _ _ _ _ _ _ _ _ _
u) how the baby would fit into your life _ _ _ _ _ _ _ _ _ _ _ _
v) what it would be like to be a mom _ _ _ _ _ _ _ _ _ _ _ _ _ _

what's a good mom _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

w) appearance: how did you feel about how you looked during
pregnancy _ _ _ _ _ _ _ _ _ _ labour _ _ _ _ _ _ _ _ _
after _

x) how IT (sex) would feel after the birth _ _ _ _ _ _ _ _ _

y) are there any other things _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

4.When you went to the hospital what did you think you would feel like? (frightened, excited, sad, mixed up, relieved, other) _ __ How did you feel? _

5.When you were in labour how did you think you would feel? (happy, scared, excited, mad, uptight, lonely, other) _ _ _ Was it like you thought? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

6.After the baby was born how did you think you'd feel? (scared, tired, happy, mixed up, other) Was it like you thought it would be? _

7.When you started labour at home what did you do? (walk around, go to bed, watch T.V., eat, smoke, other) _ _ _ _ _ _ _ _ _ _ _ _ _ _

8.In hospital, while in labour what did you do? (stay in bed, go for smoke, visit, other) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

9.Did you have someone with you while you were in labour and delivery? - who? _ _ _ _ _ _ _ _ do you think it's important to have somebody there? _ __ Why? _ _ _ _ _ _ _ _ _ _ _ _
What did they do? _
Did you think about how they would cope? Were you worried about them? _

10.Do you think its important to think about all these things before having a baby? see notes _ _ _ _ _ _ _ _ _ no _ _ _

11.Do you think it's important to think about this sort of stuff before having a baby? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Did you think about these things very much? _ _ how much? _
Do you think it would have helped if you had? _ _ _ _ _ _
What would you tell your sister/a close friend if she was having a baby _

What are the most important things to learn while your pregnant? _

12.Did you think it was important to have seen a doctor regularly during pregnancy? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

13.What do you think makes a good parent? Is how you have the baby important? _
_ _

14.Is there anything else you'd like to tell me/ask me? _ _

Part 2 of the interview schedule for all subjects.
Review of the CEQ.

(In the following review of the CEQ alternative words suggested by phase 1 participants will be indicated by capital letters. These suggestions were then used with phase 2 participants when they clearly did not understand the item, and as well, to help stimulate discussion. A the beginning of the review of the CEQ the investigator again explained that she wanted their ideas for improving the questions. The subjects were asked to think of women, like their sister or a friend, and evaluate the clarity or the understandability of the questionnaire from that context. The entire CEQ was reviewed thoroughly. First the language of the item was discussed and alternatives solicited. This often entailed discussing the meaning of phrases and words. The meaning of the item and its relevance was then discussed.)

Lets talk about this introduction first. (read aloud introduction) What do you think of it? How's the length? Are there any words you don't like? (if none offered, provide some alternatives suggested in phase 1.) Well some women thought it would be better to use the term SURVEY or QUESTIONS instead of questionnaire. What do you think? Can you think of any other ways of wording it, or do you like it like this. (This method used throughout the review.)

Introduction:
childbirth - HAVING A BABY, LABOUR AND DELIVERY.
expectations - IDEAS, WHAT YOU THINK WILL HAPPEN,
questionnaire - SURVEY, QUESTIONS
designed - WRITTEN, SUPPOSED TO
regarding - ABOUT
impending - IS COMING, UPCOMING
opinions - IDEAS, THOUGHTS, FEELINGS
statements - SENTENCES, QUESTIONS, COMMENTS
anticipate - THINK WILL HAPPEN
views - IDEAS
opinions - IDEAS
confidential - PRIVATE, PERSONAL, WON'T BE SHARED WITH ANYONE
completing - FILLING OUT, ANSWERING
neutral - DON'T KNOW, DOESN'T MATTER, UNCERTAIN, NOT SURE, DON'T CARE
quite certain - SURE, THINK SO

A. I am looking forward <u>with great joy</u> to the birth of my baby.
EXCITED, REALLY HAPPY

B. I need to know more about <u>childbirth</u> than I possibly could.
LABOUR AND DELIVERY, HAVING A BABY

1. My partner/coach will be happy and excited.
   BOYFRIEND, FRIEND, HUSBAND

2. The nurse will be kind to me.
   NICE, HELPFUL, LOOK AFTER

3. I will avoid seeking help from the nurses.
   HOPE I DON'T HAVE TO ASK, WON'T ASK, TRY NOT TO ASK, HOPE I WON'T NEED TO ASK

4. I will be immobilized by the pain of labour.
   HAVE TO STAY IN BED, WON'T BE ABLE TO MOVE AROUND, WON'T BE ABLE TO WALK AROUND.

5. I will be able to cope with labor.
   HANDLE, DEAL WITH, MANAGE, GET THROUGH

6. I will feel reassured by the nurses' presence.
   BETTER, SAFER : BEING AROUND, IN THE ROOM

7. The nurse will spend little time with me.
   WON'T SPEND MUCH, WON'T BE AROUND MUCH

8. My plans for birth will be ignored by the nurse.
   IDEAS, WHAT I WANT, WHAT I'D LIKE, WISHES : WON'T BE DONE

9. My partner/coach will feel quite helpless.
   WON'T KNOW WHAT TO DO, WILL FEEL IN THE WAY

10. I will be required to have routine procedures even if I don't want them.
    HAVE THINGS DONE, HAVE THINGS EVERYONE HAS TO HAVE DONE, OBEY THE RULES

11. I will ask my partner/coach for help.

12. I will worry about the severity of labor pain.
    HOW BAD, HOW SEVERE, HOW STRONG

13. There is little chance that I will end up having a cesarean section.

14. Lots of medical equipment and machinery will be used.

15. I will be afraid of panicking.
    FALLING APART, TENSE, UPTIGHT, LOOSING CONTROL, PANIC

16. I will experience discomfort but not unbearable pain.
    HAVE : WON'T BE TOO BAD : WON'T BE TERRIBLE

17. I will feel comforted by the presence of my partner/coach.
    BETTER, HAPPIER : AROUND, WITH ME

18. I will feel intense pain.
    A LOT OF, BAD, REALLY BAD

19. I will have a childbirth free of medical intervention.
    NATURAL CHILDBIRTH, WITHOUT HAVING THINGS DONE LIKE SHAVE

20. I will be up walking around for most of my labour.

21. I will want to have fetal monitoring.
    BABY'S HEART BEAT WILL BE CHECKED WITH A MACHINE ALL THE TIME, BABY'S HEART BEAT WILL BE WATCHED

22. I will be afraid of being a coward.
    CHICKEN, NOT BRAVE, SCARED ALL THE TIME

23. I will be able to relax during labor.
    CALM, NOT UPTIGHT

24. The nurses will offer me encouragement.
    ENCOURAGE, HELP

25. Forceps will be used.
    BIG METAL THINGS

26. The pain of labor will be agonizing.
    TERRIBLE, REALLY BAD, AWFUL

27. I will receive personal attention from the nurses.
    STAY WITH YOU, TALK TO YOU

28. My partner/coach will tell me what is going on.

29. The nurse will allow me to be an active participant in decision making.
    TELL ME WHAT IS GOING ON AND ASK WHAT I WANT
    HELP ME MAKE UP MY MIND
    LISTEN TO WHAT I WANT
    HELP ME MAKE DECISIONS
    LET ME MAKE DECISIONS RATHER THAN TELLING ME WHAT TO DO
    ASK ME TO MAKE DECISIONS DURING LABOUR

30. I will be scared when I think about the pain of labor.

31. I will refuse to have any procedures I consider unnecessary.

TO HAVE THINGS DONE TO ME THAT I DON'T WANT,I'LL BE ASKED WHAT I WANT BEFORE ANYTHING IS DONE

32. My opinion or that of my partner/coach will be sought for all major medical decisions.
IDEA, WISHES, ASKED WHAT I WANT, ANYTHING THAT'S DONE, BEFORE NEEDLES, BEFORE THEY CUT ME, BEFORE A CESAREAN

33. I will use anesthetics and/or pain killing drugs.
FREEZING, PUT TO SLEEP, SPINALS

34. The doctor will make most of the decisions.

35. I will avoid telling my partner/coach what I am feeling.
WON'T, TRY NOT TO

36. I will be embarrassed by my behaviour.
ASHAMED, ACT, BEHAVE

Part 3 - (for all women).
Overall Impressions of the CEQ:

1. What did you think overall:
length - OK _ _ too long _ _repeats _ _ _ _ _ _ _ _ _ _ _
Is it written for anyone in particular (bias) _ _ _ _ _ _ _
Sound (tone) - o.k. __friendly __snooty _ _scary _ _cold _ too definite __suggestions _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

2. Format: Do you like the 1 - 5 setup _, or something else (show alternatives and have them choose.)
When I think about labour I am (circle one or more)
scared nervous calm accepting happy
I am scared of labour yes no why _ _ _ _ _ _ _ _ _ _ _ _

3. Add:
Do you think anything should be added to the survey? _ _ _ _
Suggestions _
(Use following as probes.)
I want someone with me in labour - yes no who _ _ _ _ _ _
I will have someone with me - yes no who _ _ _ _ _ _ _
I don't Know what to expect in labour _ _ _ _ _ _ _ _ _ _
I can ask my doctor questions _ _ _ _ _ _ _ _ _ _ _ _ _ _
I think about labour a lot _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
I think about how the baby will effect how my boyfriend/husband will feel. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
I wonder about how to know when labour starts. _ _ _ _ _ _ _
I worry about something bad happening. _ _ _ _ _ _ _ _ _ _ _
I hope I won't be left alone. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
I worry about if the baby is healthy. _ _ _ _ _ _ _ _ _ _ _
I wonder what it will be like to be a mom. _ _ _ _ _ _ _ _ _

4. Partner/coach: What term do you like - support person/coach/ partner/ companion
How would you define it _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
How about this - _ _ _ _ Refers to anyone with you and could be mother, sister, friend, boyfriend, husband, or coach.

5. Delivery: What is the best way to get you to do the survey?
_ _ _ _ written _ _ _ nurse read with you/oral _ _ _ _ _

6. How would you find out if someone could read? _ _ _ _ _ _

7. If I made all the changes that you've suggested, do you think this survey would be useful. _ _ _ _ _ _ _ _ _ how _ _

8. Is there anything you'd like to tell me/ask me? _ _ _ _ _

Thanks for all your help. I just want to ask you a few questions like: where you were born. (Do sociodemographic and consent)

Appendix M

This form was reviewed by participants of design phase, and changes were made.

Sociodemographic Data Sheet

1. Age _ _ _ _ _ _ (please state in years)

2. Were you born in Canada? yes _ _ _ _ no _ _ _ _ _

   If no, how many years have you lived in Canada? _ _ _

3. Is English the language you speak at in your home?

   yes _ _ _ _ no _ _ _ _

4. What is your cultural background?

   European _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

   Asian _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

   South American _ _ _ _ _ _ _ _ _ _ _

   African _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

   North American Native _ _ _ _ _ _ _

   Metis _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

5. Please circle last year completed at school.

   1 2 3 4 5 6 7 8 9 10 11 12

6. What is your marital status?

   Single _ _

   Married or common-law _ _

   Separated _ _

   Divorced _ _

   Widowed _ _

7. Are you pregnant? yes _ _ no _ _

   When is the baby due? _ _ _ _

8. How many children have you delivered? _ _ _ _

9. What kind of delivery did you have?

Vaginal _ __

Forcep _ __

Caesarean section _ __

Induction _ __

10. Are you receiving social assistance? yes _ __ no _ __

Please remember the above information is strictly confidential and <u>will not</u> be shared with anyone except the professors who are helping me with this study.

This was the modified data sheet, and was administered orally towards the end of the interview.

Sociodemographic Data Sheet - Study Phase

1. How old are you? _ _ _ _ _ _ __

2. Where were you born? _ _ _ _ _ _ _ _ _ _ _ _

   (if not Canada) How long have you been in Canada? _ _

3. Do you speak English at home? _ __ Any other languages? _ _ __

4. What is your cultural background? (Where did your forefathers come from?)

   European _ _ _ _ __ African _ _ _
   Asian _ _ _ _ _ _ Native _ _ __
   South American _ __ Metis _ _ _ _

5. Are you single? _ _ Living with a guy? _ _ Married? _
   Are you divorced? _ _Legal or just split up? _ _ _

   Child support? _

6. How many children have you had? _ _

7. Did you have a normal delivery _ __ or forceps _ _ _

   caesarean _ _ __

8. Are you expecting? _ __ When are you due? _ _ _ __

9. Have you taken prenatal classes? _ _ _, how many? _ _ _

10. Are you receiving social assistance/welfare? _ _ _
    If not, income range _ _ _ _ _ _

11. What was the last grade you finished at school? _ _ _ _