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The Social Construction of the Pregnancy Experience by Black Women at Risk for Preterm Birth

by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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DEDICATION

To my grandmother, Maude Farabaugh, who bore nine children, raised sixteen, and attended women and assisted the general practitioner in home births.

ABSTRACT

This study explores how pregnancy risk is socially constructed by disadvantaged Black women who have been labeled "at risk" for preterm birth and provided with preventative prenatal management. This qualitative study used an open-ended interview guide to avoid preconceived judgments about the way the women would respond to pregnancy and risk. The study explored three broad areas. The first series of questions asked what the woman knew about pregnancy. The second series asked who taught her what she knew. The third series discussed concerns or problematic situations that arose during the pregnancy.

Seventeen women were interviewed by the researcher while they attended a prenatal clinic. Seven women were assessed by the provider as at risk for preterm birth, while ten women were not considered to be at risk. Black women not at risk were included in this study to examine possible differences in how the two groups defined their pregnancy experiences.

Risk was defined in two distinct ways: by the provider and by the pregnant Black woman. The provider's definition was derived from a mathematical probability of weighted risk factors based on the patient's reproductive history and on the clinical assessment of her current pregnancy status. The woman's definition was based primarily on her experience of problematic change, then on the counsel of other Black women, and lastly on the legitimation by the provider.

All of the women conceived of their pregnancy as a normal process. For some that conception never changed; for others, it did change, and the change was precipitated by the occurrence of an unexpected event, indicated in this study as a critical moment. The critical moment is a dynamic interplay between biophysical changes, patterns of social interaction, and intersubjective reflection.

The process of the critical moment changed the woman's definition of her pregnancy from a normal event to a problematic one. The problematic situation became a transforming incident in the woman's experience of the pregnancy and in her conception of herself in relation to the problem. These findings stress the significant role of sharing between Black women in perpetuating their culture's normative expectations concerning pregnancy.

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THE RESEARCH PROBLEM

Introduction

Since the 1950's, three directions in obstetrical research and practice have been aimed at the prevention of premature births: the development of comprehensive perinatal care, the development of labor-inhibiting drugs, and the identification of risk factors to predict women at risk for preterm birth. The development of comprehensive perinatal care has expanded prenatal medical surveillance to include care providers who address the social and psychological factors that affect the health of a pregnancy.[1] Labor-inhibiting drugs, which were developed as part of the obstetrical management of the intrapartal period , can now be used to reduce the number of preterm births.[2] Some risk factors that could help to direct prevention efforts have been identified, but current risk assessment screening does not reliably predict preterm birth risk (Main & Gabbe, 1987).

Risk assessment techniques assign different numerical weights to various physical, psychological, and sociological risk factors to try to quantitatively predict the probability of preterm birth risk during the prenatal period. Using this technique, various prenatal screening tools have been designed to help identify women at risk (Papiernik, 1984, Creasy, Gummer, & Liggins, 1980, Gaziano, Freeman, & Allen, 1981).[3]

Early in the prenatal course, the physical, social, and medical factors associated with preterm labor and delivery are reviewed and each assigned a numerical value. If the

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[1] The perinatal period extends from 28 weeks of pregnancy to 28 days after birth (Neeson and May, 1986:6). This term is compared to the prenatal period which refers to pregnancy from conception to the onset of labor. The term perinatal reflects the extension of the obstetrician's responsibility in caring for both mother and fetus.

[2] Intrapartum means "during parturition", or the period of active labor and delivery.

[3] The Creasy design is the most widely distributed screening tool, since it is used by the March of Dimes. Therefore this study refers to it exclusively when discussing a screening tool.

total score is 10 or more, the woman is designated as "at risk" for preterm birth. In this case, "at risk" is defined as the potential to experience the onset of labor at least four weeks before the expected date of delivery. The purpose of early screening is to include such women in a triage system that promotes the identification of impending early labor and the immediate use of labor-inhibiting drugs to halt the process if it occurs.

The successful management of preterm labor requires that both providers and patients actively follow the preterm birth protocol during the prenatal course.[4] The seven components of the protocol are: assessment of risk, patient education, assessment of physical status, ultrasound evaluation, self monitoring at home, and treatment with tocolytic drugs and bedrest.

Four conditions provide the ideal circumstances for participation by the patient in preterm labor prevention. First, the woman must identify herself as perhaps being physiologically unable to maintain a full term pregnancy. Second, she and the provider must agree that self-care is the best way to forestall the onset of labor. Third, she must be able to recognize the signs of early labor. Fourth, she and the provider must have established enough rapport so that she feels comfortable reporting the onset of any identified sign of early labor (see Appendix B for patient instruction sheet "Recognizing Premature Labor").[5]

In clinical practice, providers often expect women at risk to have some advanced education and to readily understand the concepts and facts of preterm birth prevention. Providers may assume that such women are part of middle income families and therefore that they share a social milieu with the providers, which would facilitate communication.

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[4] Preterm labor protocols have not yet become standard practice throughout the U.S. Most of the research has been done in California, South Carolina, and Florida. The protocol in Appendix B is taken from one of the five participating institutions and is representative of the approach recommended by the panel of experts guiding the California Preterm Birth Prevention Program.

[5] The term provider refers to any and all providers who may be responsible for the patient's prenatal care. The singular tense is used for convenience with full knowledge that disadvantaged women primarily receive care from multiple providers in clinics.

As a result, providers often view women at risk for preterm birth as mildly anxious women who understand the importance and method of detecting early labor and who will immediately report indications of labor (Robertson & Berlin, 1986:7).

In fact, not all women at risk for preterm birth comply with these expectations. No research studies have yet explored the complex reasons for this lack of compliance. Further, no studies have focused on compliance by pregnant disadvantaged Black women, who do not conform to the provider expectations outlined above because of their education and social milieu. Considerable statistical information identifies Black women as having the highest incidence of preterm births (Binkin, Williams, Hogue & Chen, 1985, Bertoli, Rent & Rent, 1984, Heckler, 1985), even when other variables such as single motherhood, teenagers, and educational level are controlled. However, Reed (1986) notes that these differences in preterm birth risk between Blacks and Whites may be related to racism rather than to the reproductive habits of Black women. He identifies class inequity and ghettoization as the primary factors that limit participation in prenatal care.

Statement of the Problem

To separate out and identify the importance of some of these issues, this study qualitatively examines the social construction of Black women's "concern" for preterm birth. The study explores how pregnancy risk is socially constructed by disadvantaged Black women who have been labeled "at risk" for preterm birth and provided with preventative prenatal management. The woman's construction of pregnancy and labor risk within the context of her social world is emphasized rather than the traditional medical perspective of woman-as-patient.

This study acknowledges that a unique social dynamic may operate between a White provider and a Black patient but does not focus on this dynamic. Instead it asks questions about the Black woman's experience as defined within the socio-cultural context of her everyday world. The intent of the study is to describe the findings as discussed by

these Black women, not to assert that these findings are necessarily characteristic of all Black women.

The study is based on the premise that a particular perspective held by a social group is determined by how the social situation is defined within that group. Therefore, the study is concerned with the differing prespectives of preterm birth risk held by providers and Black women. The provider's perspective is documented by discussing the impact of preterm birth on infant mortality and morbidity, the two-fold increase in the incidence of preterm birth for Black women as compared to other ethnic groups, and historical precedents that underlie the provider's defintion of preterm birth today.

The researcher recognizes that the Black woman's construction of the situation is dependent on her particular referents for gaining knowledge and establishing meaning to problematic situations. In undertaking a study to discover that perspective, the researcher must acknowledge that there are many ways of addressing the problem of preterm birth. Providers chose a particular avenue to explore the complexities of preterm birth that produce certain consequences to both the provider's and patient's experience of pregnancy. However, the provider's perspective is only one way of knowing the problem of preterm birth; the Black woman's is yet to be revealed in this study. In order to discern that perspective, the researcher must step outside of the medical framework and demedicalize preterm birth by placing it in the broader framework of the woman's everyday world. In particular, the study asks what meaning, if any, do these women place on preterm birth risk, and how does that definition of risk relate to the medical definition of preterm birth risk.

Background

The United States began recording statistics on maternal and infant mortality by 1915 under the newly formed Children's Bureau (Vital Statistics of the U.S., 1915). In the beginning, the Children's Bureau collected limited data from eleven representative states

in the Eastern and Atlantic regions. These data provided the first uniform information on the incidence and probable cause of maternal and infant mortality and morbidity. By 1940, all states were registering births and deaths at approximately a 90% reliability rate (Vital Statistics of the U.S., 1940). However, infant mortality was not recorded by weight and gestational weeks in every state until the 1950's. This record provided the first proof of the devastating relationship between preterm births and infant mortality.

In the early 1940's, the Children's Bureau used the pediatric definition of prematurity, which was any infant weighing 2,500 g or less at birth. Public health awareness of the occurrence of preterm infant morbidity--in the form of mental retardation and physical handicaps--grew in the late 1940's (Association for the Aid of Crippled Children, 1953).[6] This focused considerable attention on determining the cause of prematurity, and so the first Federal and private money was allocated for the study of prematurity.[7] Public health officials, obstetricians, and pediatricians began to address their roles in the cause and management of prematurity (Beck, 1941, Eastman, 1947, Reynolds, 1949).

The Medical Construction of Preterm Birth Prevention

Early public health studies, stimulated by the statistics compiled on prematurity between 1950 and 1967, recognized multiple factors that correlated with prematurity but could not identify any single factor that caused prematurity (Chase & Byrnes, 1972, Chase, 1977). Most early researchers identified such socioeconomic factors as poverty, malnutrition, unwed mothers, teen pregnancy, repeated pregnancies, and urbanization as being related to premature births (Reed & Stanley, 1977). Current research affirms that

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[6] The terms prematurity and preterm may be used interchangeably as both refer to an infant born before completing intrauterine development. The difference in the two terms is found in the measure which determines incomplete development. Prematurity is based on the infant's weight at birth (a pediatric referent). Preterm is based on the estimated number of completed weeks of gestation (an obstetric referent).

[7] Money was allocated from the Sheppard-Towner Act through the Children's Bureau and from the Association for the Aid of Crippled Children, now known as the March of Dimes.

these risk factors are associated with low birth weight and identifies the additional physical factors of low maternal weight, maternal age, maternal smoking, maternal alcohol and drug abuse, and previous pregnancy loss (Gortmaker, 1979, Greenberg, 1983, Bertoli, et al, 1982). The public health effort was directed towards improving general standards of living. The implementation of this public health effort was the provision of early and continuous prenatal care for all pregnant women, the improvement of housing and sanitation, and the monitoring of immunization and pasteurization of milk products (Tom, 1982:6).

Through the years, obstetricians and pediatricians, serving as experts at national conferences, continued to define the causes of preterm birth as they determined the direction of funding for research and health care delivery (Association for the Aid of Crippled Children, 1953, Gold, 1968). In their testimonies concerning the incidence, causation, and management of preterm birth, these physician experts called upon "reasonable rationalization" to formulate research directions.[8] As the physicians addressing an unstudied problem, they relied on their clinical observations and personal judgements to formulate the "reasonable rationalization" for research directions. How much "reasonable rationalization" was based on social attitudes rather than knowledge was not distinguished during the conferences.

One such conference, the National Conference for the Prevention of Mental Retardation Through Improved Maternity Care, explored the role of "obstetrical antecedents" as causative factors (Gold, 1968). Obstetrical antecedents were defined as environmental, social, and cultural factors that reduced or enhanced the individual's potential for childbearing. This group of physician experts discussed the antecedent of

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[8] During the opening address at the Conference on Congenital Malformation and Birth Injury, L.W. Mayo, Chairman of the Association, called for the use of "reasonable rationalization" to formulate methods for reducing prematurity. Paraphrasing a Greek scholar, he directed the physicians to " 'let your minds wander in reckless abandon in the Elysian fields....' May I encourage you to do likewise in the interest of getting babies 'better born'" (Association for the Aid of Crippled Children, 1953:4).

economic status as lower class versus middle class individuals. Marital status again pointed to the single woman versus a unified household. Ethnic differences was the third antecedent which compared Black women to White women. They did not discuss such antecedents as occupational hazards, poor nutrition, lack of access to health care, and poverty. The transcripts of this conference provide an example of what occurs when taking a one dimensional view of a complex social problem. It also laid an important foundation in directing responsibility for illness causation in pregnancy at the feet of the pregnant woman.

At this conference, the highly respected Dr. Martin Stone presented "data" that divided the population into two groups: social groups determined by annual income, and racial groups divided into Black and White. This study took value-laden statements like "responsible parenthood" and under the guise of statistical fact determined that this quality occurred 18% of the time in the Black lower income groups but 85% of the time in white upper income groups (Stone, 1968:22). Further, Dr. Stone (1968) used the prematurity rate for Blacks, which is twice that for Whites, as a reason to condemn Black reproductive responsibility. These conclusions were presented to and accepted by the medical community as fact. At the same conference, Dr. Flowers (1968:35) concluded that

> "unfortunately, it is a simple matter of fact
> that a large proportion of pregnant women are
> often quite unconcerned as to the outcome of
> their pregnancy, while many unfavorable
> environmental factors hinder normal intrauterine
> and extrauterine development."

Establishing Professional Domain

The proliferation of medical journal articles on preterm birth since 1970 reflects the medical community's increasing attention to clinical research and practice in the care of preterm, low birth weight infants. This obstetrical interest developed from the process of

defining terms, establishing boundaries between pediatric and obstetric practices, and establishing professional expertise through scientific validation of preterm birth issues. Finally, the right and responsibility of the obstetrician to care for preterm, low birth weight infants was recognized in the new obstetrical subspecialty in perinatology.

In 1974, the first perinatologist was certified through Board Examination, the method of recognizing all medical specialty areas. This specialty spans both obstetrics and pediatrics, as perinatalogy is concerned with the management of pregnancies that are at risk for an adverse outcome for both the mother and infant. The goal of perinatal management is to maintain the pregnancy as close to the medical standard of "normal progress" as possible. In the medical perspective, pregnancy is never seen as a normal physiologic event, but as falling somewhere along a continuum of risk (Oakley, 1980:9). Both the pregnant woman and the fetus are monitored closely for numerous indicators of risk.

The care of the fetus became possible through the clinical application of advances in the pediatric and obstetric care and in basic advances in physiology, biochemistry, and electronics. Table 1 presents the critical advances made between 1950 and 1970 that allowed the monitoring and care of the fetus in the 1970's.

Table 1. MILESTONES IN PERINATOLOGY

YEAR	EVENT	SPECIALTY*
1950's - DECADE OF NEONATAL AWARENESS		
1950	Pediatricians entered the nursery	Pediatrics
1950	Exchange transfusions	Obstetrics
1953	Oxytocin synthesis	Obstetrics
1954	Limitation of 0_2 to infants	Pediatrics
1955	Neonatal hypothermia	Pediatrics
1956	Demonstration of human chromosomes	Pediatrics
1958	Obstetric use of ultrasound	Obstetrics
1958	Electronic fetal heart rate evaluation	Obstetrics
1959	Gray baby syndrome	Pediatrics

1960's - DECADE OF FETAL MEDICINE		
1960	Lumbar epidural anesthesia	Obstetrics
1962	Fetal scalp blood sampling	Obstetrics
1963	Intrauterine fetal transfusions	Obstetrics
1963	Urinary estriols and placental function	Obstetrics
1964	Neonatal blood pressure	Pediatrics
1965	Culture of amniotic fluid cells	Obstetrics
1966	Rubella immunization	Obstetrics/Pediatrics
1967	Neonatal blood gases	Pediatrics
1967	Neonatal transport	Pediatrics
1968	Diagnosis of fetal genetic errors	Obstetrics
1968	Neonatal intensive care units	Pediatrics

* Specialty refers to the development or primary utilization by either Pediatrics or Obstetrics. (Source: Queenan, J.T. (Ed.) 1982. Management of High-Risk Pregnancy. Oradell, N.J.: Medical Economic Co. Used with permission.)

In the early years, little physiologic knowledge existed about the mechanisms of labor. Proposed solutions to the problem of preterm births were based on clinical judgement and observations (Beck, 1941, Eastman, 1947, Gold, Faison & Wallace, 1950, Association for the Aid of Crippled Children, 1953). Dr. Nicholas Eastman (1974:343) reviewed 2,457 premature births and found a direct cause in 478 cases or 14.3 percent of the cases. These premature births were caused by operations done by physicians to terminate pregnancy due to various pregnancy complications. Eastman (1947:344) found that only 10% of patients delivered preterm due to "spontaneous premature labor." Nevertheless, Eastman and other experts cited causative factors that seemed related to preterm birth based on their observations (Eastman, 1947, Gold, 1950, Holt, 1953). According to Eastman (1947:347),

> "A more rational explanation [of prematurity] would seem to lie in the general characteristics, as a class, of those patients who habitually neglect to seek medical attention. They are, in the main, the shiftless and improvident of our populace notorious to every social worker; and their habits in general are doubtless as ill managed as their habits in relation to prenatal care."

Dr. Stone (1968), in recognizing the Eastman article as a classic, noted that "little has been added in these 20-odd years". Dr. Stone might have more accurately noted that attitudes had changed little in those 20 years, as his contemporaries attending the conference continued to make judgemental comments such as:

> "The highest premature rate occurs among that section of the population which is underprivileged economically, socially, educationally, and ethnically. This unfortunate combination of circumstances results not only in poor physical status, careless reproductive habits, and poor nutritional states, but develops and fosters a lack of personal responsibility to acquire adequate medical care at the ideal time." (Bishop, 1968:103)

Physiological / Pharmaceutical Emphasis

Physiology-based research directed toward preventing preterm labor with labor-suppressing drugs began in the 1960's. The first results of pharmacological research on the prevention of preterm labor were published in the United States in 1960 (Fuchs & Stakemann, 1960). The Fuchs and Stakemann study, which was done in Copenhagen, reported the use of high dose progesterone on pregnant study animals and suggested that it might work as well with humans. The research direction indicated by Fuchs and Stakemann is noteworthy because it de-emphasized "environmental factors" influencing the prenatal period and emphasized the management of the intrapartal period.

The search for the physiologic basis of preterm labor--by detecting uterine activity and cervical change--also focused attention on the intrapartum period. Once it was understood that no intervention can stop the progress of labor after the cervix has dilated significantly, the importance of early detection of uterine activity was recognized.

As medical researchers have yet to understnad the mechanisms which initiate labor, increasing research efforts have been directed at stopping labor when detected in its early

course. Between 1966 and 1969, eleven reports were published on the subject of preventing preterm delivery. Seven of these articles were concerned with the use of labor-suppressing drugs. As Table 2 indicates, this trend continued to escalate over the next 20 years.

Table 2. Number of Preterm Labor Articles

YEARS	PRETERM LABOR ARTICLES	DRUG-BASED STUDIES
1966-69	11	7
1970-79	79	58
1980-85	81	52

Table 2. Reflects the construction of preterm labor as physiologically based as reported in English language medical journals. (Source: Medline Search, 1986.)

Preterm Risk Assessment Screening

To bridge the gap between the theoretical statistical recognition of multiple preterm birth causes and the clinical inhibition of early onset labor, researchers began to evaluate pregnant women to try to detect statistically significant "risk" factors. They investigated the correlation between specific social, economic, and biophysical risk factors and the onset of preterm labor and birth (Creasy, Gummer, & Liggins, 1980, Gaziano, Freeman, & Allen, 1981, Papiernik, 1984, Gravett, 1984).

At the University of California at San Francisco, Dr. Robert Creasy and co-workers compiled the first scored risk index in the U.S. for the detection of preterm labor risk based on factors previously identified in the medical literature (Creasy, et al, 1980). However, the preliminary analysis of Dr. Creasy's data indicated that the tool did not sufficiently detect preterm labor risk in primigravidas; it predicted only 39% of primigravid preterm labors compared to 80% of multigravid preterm labors (Herron, Katz, & Creasy, 1982).[9]

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[9] Primigravida refers to first pregnancy, and multigravid indicates two or more previous pregnancies.

Further, many women labeled as at risk by the tool did not experience preterm labor symptoms. Perhaps the most critical point is the failure of the tool to detect approximately 20% of women who did experience preterm labor. Despite these imperfections, the tool has been widely distributed through the March of Dimes, which funded the original study (see Appendix A, Form 1). Subsequently, several modifications have been made to the original tool to try to improve its predictability of risk. At the UCSF obstetrical clinical services, one such modification of the Creasy risk screening tool has been incorporated into the prenatal clinical record (Appendix A, Form 2). However, the need to further improve the predictability of the original Creasy tool has been addressed by Main and co-workers (1987). After testing the tool in a prospective study of inner city Black women in Philadelphia, they concluded that the "risk scoring system failed to predict preterm delivery in our population with a high preterm delivery rate" (Main, Richardson, Gabbe, Strong & Weller, 1987:64). They suggest that in a Black indigent population, adverse environmental conditions that are not being screened may be overwhelming the factors that are currently being screened. While it seems valid to criticize the neglect of socioenvironmental factors in the original Creasy screening tool, the Philadelphia study did not apply the original screening system. Therefore, Main's critique of the Creasy screening tool is difficult to substantiate.

Definition of Terms

As prematurity gained medical attention, experts in obstetrics and pediatrics developed the definitions of specialty terms for prematurity. These experts exerted their influence through committees within their professional organizations as well as within state, federal, and international agencies.

The World Health Organization (WHO) established international definitions of prematurity in 1948, 1950, and 1961 based on obstetrical and pediatric recommendations. In 1961, WHO resolved that "the concept of 'prematurity' should give way to that of 'low birth weight'" (Basic Documents of the WHO, 1961). Low birth weight (LBW), a

pediatric referent, is based on the infant's post-delivery weight and includes both intrauterine growth-retarded and preterm infants (the two categories of small infants). Preterm, an obstetrical referent, refers to any birth that occurs before the 37th week of gestation. As preterm infants are LBW infants, the terms are often used interchangeably. Preterm refers to anticipated outcome based on knowledge of infant development at each week of pregnancy and LBW refers to known outcome.

In fact, the most reliable indicator of infant health is the birth rating produced by combining these terms. The actual infant weight, the pediatric referent, is intersected with gestational age, the obstetrical referent, to indicate the probability of infant death. However, as birth weight is a highly reliable indicator of infant mortality and morbidity, low birth weight is the term most frequently used (Heckler, 1985).

Health Care Costs

While this study cannot examine all the macrostructures that influence the Black woman's experience of pregnancy, a brief examination of the cost of caring for preterm infants may illustrate some of these issues. The characteristics of women who have no health insurance, as listed by the Allan Guttmacher Institute (1987:43), are the same as the characteristics of women who have the highest incidence of preterm birth. Those characteristics are Black, unmarried, poor, and without a high school diploma. These women tend to range in age from 15 to 24, to be unemployed, and to receive social services. Again, more Black women than White women are without maternity coverage: 37% for Blacks and 23% for Whites (Allan Guttmacher Institute, 1987:44).

These percentages represent 14.6 million women in the U.S. without maternity coverage, which translates into two billion dollars in annual unpaid hospital bills (Allan Guttmacher Institute, 1987:46). A large part of that expense results from the care of preterm infants. The average monthly cost of caring for the preterm infant in intensive care is $100,000, and preterm infants are usually hospitalized for three months (Newsweek, 1988:67). This $300,000 cost is the tip of the iceberg; the Newsweek (1988:67) article

stresses that "even when parents are able to bring their children home, they find that raising a child with disabilities can be emotionally and financially draining". For families without insurance that financial drain is notable in the county, state, and federal coffers.

In assessing this problem, the Guttmacher Institute (1987:49) concluded:

> "An individual's health insurance coverage at any given time depends on such changing factors as employment status, type of work, state of residence, family structure, and income and assets, age, disability and even the existence of a particular medical condition. Under such a patchwork system, it is not surprising that certain individuals and groups are disproportionately without health insurance."

Ethnicity

Being Black in the United States often poses particular circumstances in relation to preterm birth. As mentioned before, perhaps the most important of these factors is the occurrence of preterm birth at twice the rate of Whites (Institute of Medicine, 1985:1). This is not just an issue of access and utilization for minority groups, as Blacks have almost double the incidence of any other minority group. It is not just an issue of poverty, as all socioeconomic groups of Black women experience an increased incidence of this pregnancy complication. These facts raise questions concerning the biological and social experience of pregnancy for Black women.

Differences Between Black and White Infant Mortality

The incidence of infant mortality and morbidity provided the basis for the medical investigation of preterm birth prevention. While these data have been used repeatedly to support medical research into reducing mortality and morbidity, the figures have actually improved little in the past decade (Neeson and May, 1986:10).

In 1960, the United States ranked 15th in neonatal mortality in comparison with other developed nations, with an overall rate of 18.7 per 1,000 births.[10] In 1970, the national neonatal death rate was 15.1 per 1,000. By 1980, the United States dropped to the 16th position in relation to other developed nations, with an overall rate of 8.5. By 1985, the United States ranked 18th among developed nations. This increase is largely due to a steady 6.8% incidence of low birth weight (LBW) infants since 1976 (Neeson and May, 1986:10). Despite the decrease in neonatal mortality indicated in Table 3, the incidence of prematurely born infants has changed little. However, with improved technology in intensive care nurseries, more preterm infants of very low birth weights (below 1,500 g) are surviving.

Table 3. Neonatal Mortality

YEARS	BLACKS	WHITES
1960	27.8	17.2
1970	22.8	13.8
1980	14.1	7.5

Table 3. The decrease in neonatal deaths is largely due to improved treatment of newborn infections and blood incompatibility problems. (Vital Statistics of the U. S., 1982).

The effects of poverty and minority status on infant birth weight have also been reflected in the statistics recorded over the decades. For example, the overall LBW rate in the U.S. is 6.8%, while the rate for Whites is 5.6% and the rate for Blacks is 12.4 % (Heckler, 1985:55). Further, "when many of the social risk factors are controlled, Black women still have twice the risk of bearing LBW babies as do comparable Whites" (Heckler, 1985:174). Factors "accentuating the ethnic differences" for Blacks include age (teens) , martical status (unmarried), poverty, and pregnancies which are repeated and

[10] Neonatal mortality refers to the number of deaths per 1,000 births prior to 28 days old and excluding fetal deaths. Fetal mortality refers to the number of deaths per 1,000 births occurring after 20 weeks' gestation to birth. Infant mortality refers to the number of deaths per 1,000 births from birth to 1 year of age.

unplanned (Heckler, 1985:174). Poverty increases the risk of poor birth outcomes.

> "Slightly more than one-fourth of all births in the United States occur among poor women. Four-fifths of unmarried women, two-thirds of Blacks, three-fifths of teenagers, and two-fifths of Hispanics who give birth are living in poverty. Birthrates are about twice as high among poor as among non-poor women, and are 30% higher among Black women than among whites."
>
> (The Allan Guttmacher Institute, 1987:5)

Steven Gortmaker's 1979 study examined the relationship between income and differences in infant mortality. The study concluded that poverty can present a variety of hazards to the newborn and impose constraints on parenting activities. Factors related to poverty include inferior housing, poor sanitary facilities, inadequate food and clothing, and inadequate health care, all of which are compounded by a lack of transportation. But the impact of these social conditions is not restricted to infant mortality; they also leave a large number of infants who survive with lifetime handicaps.

The Impact of Low Birth Weight on Infant Morbidity

The extent of infant morbidity due to LBW is more difficult to measure than mortality because the degree to which the infant is affected varies considerably. Preterm births primarily impact the central nervous system (Chase & Byrnes, 1972); manifestations of injury can range from spastic cerebral palsy to learning disabilities noted in the early school years.

One of the earliest studies that associated neurological morbidity with preterm births and disadvantaged socioeconomic status was done by Stewart Clifford (1964). In a study of 120,000 mentally retarded infants in the city of Boston, Clifford documented a 50% higher rate of morbidity and mortality for the third of the city living in low socioeconomic census tracts. Recently, the neurological morbidity of LBW infants has

been demonstrated by longitudinal studies of cognitive development (Wallace, Escalona, McCarton-Daum, & Vaughan, 1982, Smith, 1982, Drillen, 1980). The newborn neurobehavioral performance of low birth weight infants was highly correlated with hearing and language deficits. These findings may impact on later learning because of the relationship between hearing ability and the acquisition of speech (Wallace, et al, 1982:331).

Subtle neurological damage has a more profound impact when development is correlated with socioeconomic status. A study in Oslo that followed the development of LBW infants over three years (Smith, Sumner, & vonTetzcher, 1982) concluded that the social environment may modulate the influences of reproductive and perinatal risk, as children with the same level of risk but higher socioeconomic status received higher scores on standard intelligence tests (Smith et al, 1982:303). Putting aside the debate on the validity of intelligence testing, these findings suggest that Black low birth weight infants have an increased chance of disadvantaged development.

In the U.S., Escalona's 1982 study followed a population of 50% Black, 25% Puerto Rican, and 25% White LBW infants from the intensive care nursery to age 3-1/2. The study concluded that "an unexpectedly large number of infants exhibited significant emotional and behavioral disturbances" (Escalona, 1982:673). This rating of maladjustment was based on family reports that the children were unable to function within the families' standards. Among the children rated as generally adjusted, many were seen as "anxious, labile, troubled, or socially immature by prevailing standards" (Escalona, 1982:673). As in the Oslo study, these differences in cognitive development persisted when families in low, middle, and high socioeconomic groups were compared. Low income families seem unable to access or focus on programs or resources that could stimulate the cognitive development of their children. The factors that inhibit this level of participation in child development are some of the same factors that initially put the

pregnant woman at risk for preterm birth, i.e., unstable living situation, inadequate food and clothing, inadequate health care, lack of transportation, and lack of social support.

Women's Identity and the Social Construction of Preterm Birth

Pregnancy is a reproductive event which may be considered as a social or developmental turning point critical to a formulation of the identity of the woman in this study.[11] It is a life marker triggered by the biophysical capacity to reproduce, just as the beginning of menses, first intercourse, and menopause each mark developmental milestones in the adult life of a woman. This research opens discussion of the conditions which influence how social encounters concerned with pregnancy and risk proceed, are received, and interpreted by pregnant woman. In particular, there is an examination of received and interpreted knowledge as it blends with other life events to formulate the woman's identity as pregnant or as mother-to-be.

The study asks how the events of the pregnancy experience might influence the women's identification of self as adult, as woman, and as parent. Accompanying a first pregnancy is the social recognition of adulthood. Part of the social ritual surrounding birth is the expectation for her to assume the responsibility for "developing and training her offspring" (Hughes, 1984:125). Further, society confers legal recognition of adulthood on all women in preparation for their adult role, even teenagers when pregnant are considered "emancipated minors".

The social rites which accompany the cycles of nature, such as birth, mark significant turning points in people's lives (Hughes, 1984:125). The social rites and rituals associated with birth are for the purpose of acknowledging the new parents and their child

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[11] Hughes (1984: 125) first used the term "turning points" to explicate the connection between social conventions and cycles of nature. Society creates and sustains rites, festivals, and other celebrations of nature such as entering a trade, marrying, beginning a family, growing old and dying. Strauss (1959:93) later used the term "turning points" to note a developmental event that, when reflected back upon, signals a transformation in identity. Both sociological applications of the term are appropriate to this study.

as members of a family and a community (Hughes, 1984:125). Each pregnancy holds the hope and promise that such a union will occur. As such, the pregnancy may be said to serve as one of the social means for securing the woman place within the family and community. Given these circumstances, the question arises as to what occurs when the woman faces actual or potential problems during the course of pregnancy.

The ability of conceive carries the fertile and sexual connotation of womanhood. The involuntary loss of a pregnancy calls into question the woman's ability to fulfill her social role of mother, progenitor of the next generation. The experience of a pregnancy at risk may have personal and social impact on the woman's perception and the family's and communities' perception of her ability to fulfill her social roles. Can or does such an experience cause disjuncture in one's conception of herself?

The women under study are experiencing a uniquely female activity, biologically and socially. Does not pregnancy provide a very particular lens through which these women come to view their lifeworld? Does this effect their conception of themselves, and in turn, effect their interactions with everyone related to the pregnancy experience? Of the interactions reported by the interviewed women, which are identified as important to the definition of the pregnancy as normal versus problematic?

Summary

While experts claim that preterm labor prevention strategies have been successful, a systematic review of research reveals only 37 properly controlled studies between 1930 and 1977 (Hemminki & Starfield, 1978:339). None of these 37 studies reported clinical interventions that beneficially affected birth weight without adverse effects for either mother or infant. Yet efforts to prevent low birth weight infants continue to be directed toward suppressing premature labor with the use of drugs.

At the same time, researchers using quantitative methodologies in the 1980's are still investigating the causes of preterm birth identified in the 1940's and

still using the same tone of condemnation when discussing the results. Socioeconomic status and ethnicity remain pivotal to the collection and analysis of data. Escalona's (1982:671) study serves as an example of research intended to demonstrate a relationship between the infant's cognitive development and its physical and social environment. However, when ethnicity and the socioeconomic index are the only measures used to indicate this environment, the study begins to repeat the social biases seen in the early prematurity studies.

Three problems are particularly apparent in this type of study. First, one cannot extrapolate the impact of environmental stress and deprivation from data on the variables of ethnicity and income. Second, the assumption that data on race and economic status will reveal the social complexity of the environment is questionable. Third, the sometimes erroneous beliefs of health providers concerning the ability of socially disadvantaged parents to nurture their children are, in part, socially constructed and are reinforced through professional publications. These publications print articles that present conclusions based on unsubstantiated studies, and then publish articles that attempt to support these conclusions, producing a growing literature of largely unsupported impressions and assumptions. These impressions and assumptions continue to support a social bias as surely as the overt comments made in the 1940's.

Therefore, while the provider has constructed a view of pregnancy as problematic, the pregnant woman entering the health system has variably constructed (depending on her sociocultural experience) a view of pregnancy as natural. Each perspective leads to health care activities that may be at cross-purposes with the other and to expectations that may hinder communication between patient and provider.

This fundamental disagreement about the nature of pregnancy assumes that at least two realities exist concerning pregnancy. The medical profession has determined the dominant and scientific definition of pregnancy as problematic (Schneider &

Conrad, 1981). This medical view is based on the high rate of infant mortality and morbidity caused by premature births. The medical view is also based on the clinical experience of providers who care for the infants suffering the consequences of preterm birth.

However, the lay person takes for granted the expectation of a normal pregnancy. This view is based on the common belief that, all things being equal, the infant is growing in a protected environment, and the common experience of newborns as robust, active, and healthy. This expectation is reinforced by the available statistics which show that 80% of infants are born healthy, while only 6% are born premature. The remaining 14% of infants have genetic or development abnormalities, of which many are correctable (The Allan Guttmacher Institute, 1987:12).

Despite its dominance, the medical construction of pregnancy therefore provides only one way to discuss the experience of pregnancy. Rather, many different experiences fall between the extremes of normal and problematic events. The experience of individual providers and patients will vary along this continuum. Each person will assign meaning to socially normative actions regarding pregnancy according to his or her particular view of pregnancy. Each act has potentially serious consequences, but this statement does not necessarily support the medical view of pregnancy as problematic. This investigator does not intend to support or refute a view, but rather to examine differing views and offer a theoretical account of why they exist. Therefore, in its most narrow application, this study focuses on whether Black women who are determined by providers to be at risk actually regard themselves as being at risk. More broadly, the study explores how Black women socially construct or take meaning from the pregnancy experience and how their concept of risk relates to this construction.

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CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

While the physiologic experience of pregnancy is highly predictable, the individual woman's subjective interpretation of her experience of pregnancy may vary considerably. For example, the patient may have a limited array of previous knowledge of social recipes from which to formulate actions when her pregnancy is deemed at risk.[12] Therefore, her interactions particular to pregnancy are limited by her foundation of knowledge of everyday life, and particularly, about pregnancy. The composition of that knowledge arises from the cultural environment of her everyday world, from her intimate and distant social relations, and her acceptance or rejection of the relevance of those encounters.

The Cultural Experience

In general, few investigations have focused on women's experiences of pregnancy, particularly the experiences of socially disadvantaged Black women. However, one important qualitative study analyzed the social and cultural impact of preterm births on minority women (Boone, 1982, 1985). Boone (1985) interviewed socially disadvantaged Black women with recent preterm births to determine the attitudes and beliefs that they thought affected their experiences of pregnancy.

Three areas emerged as culturally significant to these women's pregnancy experiences (Boone, 1985:1004). First, the women expressed resentment for the lack of financial and emotional support they received during their pregnancies. Second, the course

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[12] Recipes are social rules and skills arising out of one's vocational life or practical experiences. They provide many systemized solutions for acting in non-problematic situations (Schutz, 1964:78).

of each pregnancy was disrupted by anxiety, depression, and poor interpersonal relationships. Boone (1985:1006) reported that the psychological distress and disappointment associated with this pregnancy was part of a larger pattern of overall failure in their reproductive histories. Reproductive failure ranged from difficulty in conceiving to previous abortions, spontaneous miscarriages, or the loss of prematurely born infants. The cultural belief that there should be "a birth for every death that happens" provides some explanation for repeated pregnancies in spite of previous failures (Boone, 1985:1008) Third, Boone (1985:1008) found that the role of being pregnant was valued and conceptually different from the roles of being married, forming a family, and being a mother. Because Boone's study examines the patient's construction of the pregnancy experience, the findings of lack of social support, reproductive risk, and the meaning of being pregnant are analyzed in terms of the patient's subjective knowing.

Ethnic Studies

Studies have examined the differences in ethnic group and socioeconomic status that affect infant outcomes (Bullough, 1972, Gortmaker, 1979, Bertoli et al, 1984). While the limitations of using ethnicity and income are acknowledged, the ease of working with these quantitative variables and the collection and representation of national statistics continues to encourage this research direction. Working within these limitations, several investigators have discussed the social dilemmas represented by the data. For example, Bullough (1972) found that 68% of the Blacks, 50% of the Mexican-Americans, and 31% of the Whites residing in the same poor Los Angeles neighborhoods lived below the poverty line. This phenomenon of Blacks as the poorest of the poor is reaffirmed by every study that examines differences in socioeconomic status among ethnic groups (Gortmaker, 1979, Bertoli et al, 1984, Heckler, 1985).

In examining the effects of poverty, Bullough (1972:352) suggests that children are socialized in a way that promotes a "culture of poverty", that is an intergenerational cycle of "powerlessness, meaninglessness, normlessness, isolation, and self-estrangement".

Boone (1985:1007) also examined these attitudes and concluded that her study sample did not support a "culture of poverty." She did not find evidence that low economic status was intergenerational, nor did she find weak ego development or feelings of dependency. However, she did note expressions of extreme social isolation and powerlessness. Powerlessness may be related to fatalistic attitudes, lack of knowledge, or lack of control in social interactions. Bullough (1972) suggests that people in such situations can begin to obtain some control by acquiring needed knowledge about preventive care. "This [lack of knowledge] could be a mechanism that relates [to] feelings of powerlessness" (Bullough, 1972:352). Boone (1985:1008) relates powerlessness to the finding that "fear of doctors and nurses represented the single most important factor in their perception of health providers as inaccessible" (Boone, 1985:1008). Further she (Boone,1985) noted that the Black women in her study did not believe health was simply "a matter of luck." However, she did note some fatalistic tendencies in their discussion about rarely making plans and "letting tomorrow take care of itself" as another indication of powerlessness (Boone, 1985:1007).

Patricia Scott (1982) stressed that Black women have not been studied in the diversity of roles they fill in society: as leaders in their communities, as workers, or as women at play. This severely limits the way Black women are viewed by others. When the diversity of the social responsibilities of Black women is not represented, the depth and breadth of their lives is not known (Scott, 1982:88). For example, Dill (1979) notes that Black women have historically represented a large segment in the labor force, yet Scott (1982) notes that most studies on work and achievement motivation have addressed only White men.

Black Women as Mothers

Scott (1982) stresses that too much emphasis has been placed on the Black woman as matriarch. Scott (1982) contends that sociological studies done in the 1960's established the structure of the Black family as matriarchal. Since then, Black women have been

viewed as independent and as placing little value on marriage, monogamy, or the male dominance seen as necessary to the patriarchal nuclear family structure. Matriarchal family structure is, therefore, invariably viewed and studied as a problem (Scott, 1982:87). This established view of matriarchy has been used over the years to explain racial differences in health data (Conrad and Kern, 1986, Spurlock, 1983, Dodson, 1983, Gottleib & Green, 1984). Further, the medical literature tends to present single parent Black families as a cause of health problems rather than viewing Black health problems and single parent families as outcomes of social inequities (Reed, 1986, Watkins & Johnson, 1986).

Census data showing the percent of Black single parent families continue to support this concept of matriarchy. In 1965, when attention was focused on matriarchy, 15% of all Black families were Black single parent families (Malson & Woody, 1985:1). By 1970, this figure had increased to 30%, and by 1981, it reached 47.5% (Malson & Woody, 1985:1). This trend was also found in Boone's (1985) study. She noted that none of the women interviewed came from "matricentric households without a father," yet the majority of them lived in this type of household (Boone, 1985:1004). Matriarchy came under social scrutiny in the 1960's when it represented only a small portion of the Black population, but the subsequent rise in single parent families has reinforced the view that Black men and women do not value the nuclear family structure. This comparison between single parent and nuclear families does not acknowledge that there may be social constraints, such as high unemployment for Black men and employed Black women still at the poverty level, that influence the configuration of the family. Forty-two percent of single Black women with two children receive an income which meets the criteria of poverty. For Black women with three children, 57% live at the poverty level (Malson & Woody, 1985:5).

Census data frequently provide the primary information used to identify social problems and direct health and social programs. Infant mortality statistics are the most common type of data used in health studies because they are considered the most sensitive index of the health status of the group being studied. "The sensitivity of this index is that it

provides *clues* (my emphasis) to the nutritional status of the mother and the family, the housing condition, the health care situation, the income level and the overall socioeconomic condition" (Darity & Pitt, 1979:128). In looking for *clues*, the investigator often makes overt or covert assumptions about the relationship between these statistics and nutritional, housing, or health conditions.

For example, Adamchak (1979) who examined statistics on infant outcomes, assumed that the mother is individually responsible for the outcome of her pregnancy. In concluding, Adamchak (1979) analyzes the relationship between infant mortality and socioeconomic status in the following convoluted way:

> "The only variable that deviated from the predicted direction was female labor force participation. Thus, contrary to expectations, it appears that this variable has emerged as a negative index of status; the lower the status, the higher the percentage of females who are in the labor force which coincides with the matriarchal family structure of lower status families, especially black families." (Adamchak, 1979:22)

Adamchak offers no further discussion to illuminate the relationship between low status jobs, matriarchy, and infant mortality. In fact, the relationship that Adamchak alludes to can be more clearly stated by noting that infant "mortality rates are known to be sensitive to economic instability" (Reed, 1986:273). While 79% of Blacks in the U.S. are high school graduates and 13% are college graduates, the Black median income is $10,000 less per year than that of Whites (Heckler, 1985:51). Instead of addressing economic discrepancies, factors related to poor infant health are associated with social class. Consequently, the common explanation for high Black infant mortality is the greater proportion of Blacks who are poor (Reed, 1986:273).

Statistics are sometimes used to support the premise that no problem exists in regard to Black infant mortality. For example, David (1986) analyzed census data to determine if the incidence of low birth weight babies among U.S. Blacks has really increased. He reported that the increase in low birth weight births resulted from an early "under-reporting artifact" when Blacks were delivering at home. Therefore, according to David, the rise in low birth weight infants is probably due to improvements in recording births and deaths, as most births now occur in the hospital (David, 1986:382). However, David does acknowledge that underreporting probably also concealed a significant number of Black infant deaths which makes any point previous made in the analysis questionable.

Health improvements in Blacks are often measured by comparison with Whites. In all categories, Blacks have approximately double the incidence of illness and death as do Whites (Heckler, 1985). Wornie Reed (1986:272) states that this difference is due to institutional racism, i.e., racism that is "inherent in and manifested in the outcomes of institutional operations". If we acknowledge that institutional racism exists, then we must realize that disadvantaged Black women do not have access to the same quality or quantity of information about the prevention of preterm labor as do White women.

The Social Experience

In this study, social experience is used in the broadest sense to include all social relations and institutions that are available to the pregnant woman. This includes intimate relationships with family and friends, but also distant relationships with health providers and other service and resource persons. If utilized, both intimate and distant relationships may be sources of social support.

Social Support

The importance of social support during pregnancy was raised by Oakley (1985:1260) when she argued for the benefits of the "soft approach", utilizing social

interventions for improving infant birthweight. She correlated social support with reduced stress and noted that a lack of social support can contribute to poor pregnancy outcomes when maternal stress remains high. Berkman and Breslow (1983:119) found in their study of general health behaviors that social networks played an important role in pregnancy outcomes. They reported that even with many life changes, women who "had rich psychosocial resources" had one- third the complication rate as did a comparable group of women without resources. They also found that the absence of supportive family and friends predisposed women to postpartum depression (Berkman & Breslow, 1983:119). Nuckolls, Cassel and Kaplan (1972:431) reported that women with high stress and few resources experienced an overall pregnancy complication rate of 91%. In comparison, a group of women with high stress but strong resources experienced a 33% complication rate. Similar findings have been reported by Norbeck and Tilden (1983) and others who measured the role of psychosocial assets in pregnancy stress reduction.

In examining the theoretical basis for the importance of social support, Levy (1983) cites that family-patient interactions are necessary to form norms and meet dependency needs. In Schutzian terms, the formation of norms may be expressed as knowledge of recipes for giving and receiving help. The implications are that lack of support may be experienced as the loss of a shared intergenerational experience, or those shared experiences may yield a negative pregnancy experience.

Boone (1982:232) found that sources of social support were "predominantly from women". Within the family structure, the mother was the primary source of support. However, responses from the interviews indicate "a greater true reliance on 'girlfriends'" as a source of support (Boone, 1982, 1985). Levy (1983:1329) also discusses the crucial role that peer support from other [pregnant women] plays in problem resolution. Baranowski et al (1983:1609) also found that the decision of married Black Americans to breastfeed was most influenced by their "best friends."

Perhaps a more significant factor is the lack of support from male partners experienced by disadvantaged Black women in Boone's (1985) study. The women expressed bitterness and resentment toward their partners because of this lack. In most cases, these pregnancies resulted from long-term relationships. However, the relationships were unstable, and were ended just as often by the woman as by the man before the birth of the baby (Boone, 1985:1005). Further, the women did not indicate that the relationship carried the expectation for care of the infant. When talking of their partners, the women made no reference to the infant, a shared household, or shared childrearing.

These women often did not receive support from the Black community at-large because they did not participate in social organizations. Boone (1985:1004) describes the women as "not gregarious" and as "having few friends" whom they often stopped seeing while pregnant. In general, the women reported long bouts of depression and anxiety. The extent of the isolation can be summarized by one woman who reported that "she slept a great deal and stayed in the refrigerator" during her pregnancy (Boone, 1985:1005).

However, Baranowski et al (1983) caution researchers to be careful when defining social support. In a study of the impact of ethnicity on the social support to breastfeed, they conclude that the implicit meaning of "support" differs among mothers in various ethnic groups (Baranowski et al,1983:1609). While this study of women at risk for preterm birth does not measure the degree of social support, it is concerned with the woman's identification of both positive and negative support experiences. As knowledge is socially transmitted, utilization of their support systems indicates their opportunity for and way of knowing the experience of pregnancy.

Patient and Provider Interactions

Interactions between patients and providers are frequently examined in terms of the obstacles that bar the woman's understanding and participation in care (Dodson, 1983,

Shapiro et al., 1983, Dutton, 1986).[13] Social class, race, and gender are generally identified as barriers to communication between patients and providers (Kolder, Gallagher & Parsons, 1987). This discussion acknowledges these differences as they may effect the communication of knowledge between a Black woman and her provider. However, the focus of the discussion is placed on the situations and individuals that Black women encounter in obtaining information to further her understanding of pregnancy and risk. Prenatal care and the provider are situations and individuals which remain central to the pregnancy, therefore impact the woman's common sense knowledge of pregnancy in some manner.

In general, women obtain knowledge concerning pregnancy and its risks from lay and medical sources and from the daily experiences of their pregnancies. Information about obstetrical risk from medical sources is abundant but highly variable. Opinions about the risks and benefits of obstetrical options are based on complex and frequently incombatible methods of assessment often resulting in a lack of professional consensus (McClain, 1983:1860) Despite the abundance of studies on pregnancy risk, little information concerning risk is made available to women (McClain, 1983, Shapiro, Chang, Keeping, Morrison, & Western, 1983) In the Shapiro et al. (1983) study on patient information, private patients reported receiving more information about topics of their concern than clinic patients. They concluded that the inability to pay for medical services, either directly or through health insurance, diminishes the patient's power over the process of interaction during the obstetrical encounter.

However, the Shapiro study is somewhat limited in assessing only physicians as a source of patient information. Nurses, in particular, are often responsible for teaching clinic patients information relevant to each particular visit. However, what the nurse

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[13] Throughout this text, the cohort of this study have been referred to simply as Black women in order to avoid identifying them with a particular role. However, their status as "patients" is acknowledged when discussing a direct relationship with the provider.

teaches is not necessarily what the patient wants to know. This caveat applies to whomever is imparting information to the pregnant woman.

Obtaining Objective Medical Information

Starting from the basic premise that knowledge is imparted through interaction, the patient-provider interaction is relevant to the extent that it represents a specific source and type of information. The method of presenting medical information poses both incentives and obstacles to patient acceptance. On the one hand, provider reinforcement of medical directives is necessary for the formulation of the patient's actions (Tullio et al,1986:56). Not surprisingly, Tullio et al (1986) found that patients scored higher on satisfaction with objective knowledge when printed instructions were discussed by the provider. On the other hand, providers have been found repeatedly to control the patient-provider interaction to such an extent that the concerns of the patient rarely get addressed (Shapiro et al, 1983).

The provider control over communications invariably surfaces when the relationship between providers and patients is examined. Health teaching often depends on the providers' "expressed interest in imparting expertise to the patient... " (Danziger, 1986:310). Considerable evidence suggests that the physician's interest is influenced by the patient's social class, race, and gender (Dutton, 1986, Anderson, 1979, Anderson, 1983, Shapiro et al., 1983, Zola, 1986). Anderson (1983:153) notes that frequently providers "have a tendency to blame the low income patient by assuming that the patient is totally responsible for his or her condition." Low income Black patients, in particular, are often cited for their delay in seeking care (Anderson, 1983). However, other studies suggest that this is often due to a lack of access to care (Berkanovic & Telesky, 1985, Snow, 1977, Shadish & Reis, 1984). Their health conditions are often complicated by their social conditions. To provide adequate and meaningful health services, providers must attend to the patient's and community's needs and lifestyles (Anderson, 1983).

Constructing Subjective Knowledge

Studies suggest that provider information is not a major influence in the patient's construction of health attitudes (Shapiro et al., 1983, Snow, 1978, Baranowski et al., 1983). Further, Danziger (1986:310) suggests that the information provided is partly dependent on the "compatibility between the interest of the doctor and that of the patient in receiving the information." Rather, health behavior and beliefs are more strongly affected by ethnic membership and income (Berkanovic & Telesky, 1985). The effect of race and income on beliefs and attitudes revealed three interesting dynamics of pregnancy behavior (Snow et al.,1978). First, although pregnant women knew certain prenatal behaviors were desirable, only 25% of them acted on that knowledge in the first trimester of pregnancy. Second, in some cases, medical providers identified risk factors not seen as such by the patient. Third, women identified some factors as presenting a risk to their pregnancy that were not identified by the providers.

The risk factors identified by Black women depended on their evaluation of past experiences and the roles appropriate to the racial and economic groups to which they belonged (Anderson, 1983). Chrisman and Kleinman (1983:583) identify three factors which influence the evaluation process. First, there is some cultural construction of the clinical reality of the pregnancy risk. Second, the patient assesses the events that occur to determine the degree of trust she will invest in the patient-provider interaction. Third, based on the first two considerations, she determines the degree to which she will carry out the medical directives. In order for patients to comply with medical directives, their sociocultural construction of reality must agree with the clinical reality implied by labeling and treatment. To create such a situation, Chrisman and Kleinman (1983:585) call for joint participation and negotiation in patient-provider interactions:

> "Joint participation in symptom definition and treatment
> is crucial to joint construction of clinical reality.
> Practitioner-patient collaboration in this process is not

> only indicative of success in the management of the case, it is also the opportunity for health-promoting patient education. Instead of hiding behind medical jargon that protects the physician from involvement in the patient's life, medical knowledge can be shared and negotiated".

Reproductive Risk and Uncertainty

Studies often merge uncertainty and risk when discussing normative decision-making behavior (Hirshleifer & Shapiro, 1977, Roumasset, 1977). However, Cancian (1979) makes a useful distinction between the two. She describes risk as occurring when the probabilities of various outcomes are known or can be calculated, and uncertainty as occurring when the probabilities cannot be specified. Cancian (1979:5) differentiates uncertainty and risk by the amount of knowledge one has about the possible outcomes of the situation. Therefore, risk can be calculated, often mathematically, if the objective information is available. This distinction between risk and uncertainty is applied to this study, as uncertainty is considered a phenomenon arising from not knowing the experience of preterm birth risk.

When defining risk, the medical literature focuses on the relationship between the statistical occurrence of preterm births and the probability of recurrence as measured by the presence of specified health characteristics (Creasy et al., 1980, Gaziano et al., 1981, Main et al., 1987).[14] However, the Black women in Boone's (1985) study based their certainty on the reality of everyday life and their uncertainty on their histories of unsuccessful pregnancies. Based on Boone's (1985) findings, this study might expect that women with past reproductive loss would be classified as at risk by medical standards and as

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[14] As the cause of repeated reproductive failure is not well understood, there is little medical chance of avoiding recurrences. However, recurrent pregnancy failure is a reliable predictor of risk for future preterm birth (Creasy, et al., 1980).

experiencing uncertainty based their own history. While women who are pregnant for the first time might experience the general uncertainty of the unknown outcome of the pregnancy, they are not likely to consider specific risk of early birth as relevant to themselves.

Conditions That Produce Uncertainty

Uncertainty was previously defined as a phenomenon arising from "not knowing" the experience of the situation. "Not knowing" means that the situation is problematic for the individual because they have no previous recipe for acting which has been tested and proven applicable to the situation.[15] Atkinson (1984:954) speaks of the relationship between one's stock of knowledge and uncertainty when he proposes that "... knowledge and its reproduction actually rest on an unreflexive attitude toward the acquisition and application of stocks of knowledge." Following Schutz's theory of knowledge, Atkinson (1984) stresses that objective knowledge must be interpreted in a manner that permits everyday practical reasoning and practical activity. In that context, "certainty and uncertainty reflect two modes or attitudes toward knowledge and action" (Atkinson, 1984:954). Certainty reflects a pragmatic empiricism and uncertainty reflects an existential doubt. The two conditions may be operating simultaneously. Perhaps this notion is a little more sophisticated than this investigation reveals, however, the point worth noting is that certainty and uncertainty may equally be seen as features of the social construction of the pregnancy experience.

The next step is to explore the possible conditions that place the individual in flux between certainty to uncertainty. Examining social dimensions studied by Jessop and Stein (1985) may be useful. In their study of uncertainty in chronic illness, Jessop and Stein

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15 "If I formerly had direct experience of [this situation] confronting me, I may, of course, fall back upon the highly specialized information sedimented in these experiences." (Schutz, 1964:30) Therefore, "not knowing" does not imply a total ignorance of the situation but merely no previous direct experience which would allow an unreflexive response based on our "stock of knowledge".

(1985) identified four significant social conditions which contribute to uncertainty: the degree of interference with daily habits, a normal or abnormal appearance, the presence or absence of surgical procedures, and the degree of the family's need to expect changes in the condition. Making these conditions relevant to pregnancy, they may be restated as: the degree of interference with daily habits, the patient's perception of normal versus problematic, the degree of intervention, and the amount of family support. Jessop and Stein (1985) concluded from their study that if the condition was not visible or changeable, the patient tended not to follow medical directives in an attempt to normalize her situation. The more visible or changeable her situation, the more the individual experienced marginality and uncertainty.

Schatzman's (unpublished:9) work on the structure and management of risk found social disclosure to be relevant in assessing risk. Schatzman uses the term risk to refer to the probability that the woman will face some sort of social exposure as a result of her abortion. He suggests that probability, controllability, gravity, proximity, and visibility are considerations in the management of reducing that risk. Schatzman concluded that "if disclosure [which is at risk] can be controlled, then perhaps the [individual's] tenuously held self-composure [which is at risk] and moral identity [which is at risk] can be controlled." As in Jessop and Stein's study, Schatzman seems to suggest that uncertainty increases as visibility increases and control decreases.

Johnson, Snow, and Mayhew (1978) examined whether misinformation of lack of information contributed to the incidence of pregnancy among high-risk pregnant woman. They concluded that misinformation and lack of information about basic physiological facts contributed to unwanted pregnancies. Further they recommended the need for education and help with apathetic and fatalistic feelings to break the pattern of unwanted pregnancy. In this case, "knowing" the pragmatic experience of repeated pregnancies as an accepted part of their relationships, coupled with the "not knowing" how their bodies functioned, created conditions which both contributed to risk.

Methods of Dealing With Uncertainty

Normalizing

Jessop and Stein (1985) reported that patient's addressed uncertainty by attempting to remain within a socially normative situation. The more visible and changeable the condition, the more likely the person will reveal their "problem" socially and be viewed by others as "not normal." To avoid such social disclosure, Jessop and Stein (1985:997) found that individuals rejected the negative or "abnormal" aspects of their condition and emphasized the normal aspects. In emphasizing the normal, they often rejected the medical prescriptions for self care that would interfere with their daily lives. The problem was not with the prescription, but in the self care activities that would reveal to others that they were not normal.

There is a probability that this feature may be operable in this study population since pregnancy is culturally valued and previous pregnancy loss is high. There may be a tendency to emphasize the normal aspects of the pregnancy and conceal the problematic by refusing to follow the self care activity of bedrest. As the pregnancy progresses, refusal to maintain bedrest increases the risk of preterm birth.

Bolstering

McClain (1983) used the term "bolstering" to describe the phenomenon of rejecting the negative and emphasizing the positive in a situation or experience. In studying how patients choose between home and hospital birth, she found that women spread the risks they associated with each option in opposing directions: they discounted the risks and exaggerated the benefits of the chosen option, and they exaggerated the risks and discounted the benefits of the rejected option (McClain, 1983:1863).

It may be that as a result of bolstering, the individual is able to justify to herself and others that her construction of the reality of the pregnancy is "right". This may be a preliminary construction necessary for the normalization of the pregnancy, and a justification for the refusal to follow self care directives.

Projecting Scenarios

Lippman-Hand and Fraser (1979) studied the perceptions of uncertainty in parents receiving prenatal genetic counseling. They observed a bipolar approach to uncertainty. "Regardless of the probability numbers assigned by the counselor, and despite their knowledge of the rates, in the parent's view, it was an either-or-event": the infant would be either normal or abnormal (Lippman-Hand & Fraser, 1979:57).

The authors found that parents dealt with the possible consequences and uncertainties by employing simplifying strategies that they called "scenarios." A scenario is a sequence of outcomes that the parents imagined could result from their choice and around which they organized their decision-making. Parents decided whether to abort or not based on their projection of an imagined outcome (Lippman-Hand & Fraser, 1979:57). Once parents regarded a birth defect as possible, they began to consider the potential impact of what might or might not occur.

The risk of having an affected child was a notion which is imposed on the parents by the medical recommendation to undergo prenatal diagnostic studies. However, the parents interpreted that objective information as it fit the context of their intrinsic relevancies; that is, they translated objective facts into situations which were relevant to their everyday life. The parent's relevancies focused on the desire for the child to have a relatively normal life and on the parent's imagined reactions and adjustment to the child's disability.

The findings from this study suggest the possibility that preterm labor risk as discussed by the health provider will hold little meaning for the pregnant woman. Rather, it will be necessary for her to translate and construct meaning from her total experience of the pregnancy within the context of her everyday life. Under these circumstances, those relevancies which have priority in her life may hinder her view of the pregnancy as at risk.

Summary

Ultimately, how an individual woman experiences pregnancy and how she meshes all of the situations that arise during its course vary considerably. In addition to cultural and social factors, individual factors present their own contextual situations. For example, pregnancy loss frequently recurs in women at risk for preterm birth. Providers attempt to reduce risk to a mathematical probability, but women at risk cannot hold their uncertainty so conveniently remote.

By definition, there is an inverse relationship between uncertainty and knowledge: the more knowledge they have, the less uncertainty they feel (Johnson et al., 1978). However, other investigators report that people generally attempt to reduce uncertainty by gathering information that is relevant to their lives (Lippman-Hand & Fraser, 1979, Jessop & Stein, 1985, Atkinson, 1984). People do not generally pursue technical-medical information on which to base their decisions. Lippman-Hand and Fraser (1979) describe people's tendency to project all possible outcomes and to anticipate their adjustment to those outcomes. Jessop and Stein (1985) identify people's attempts to normalize the situation by emphasizing its positive aspects. Cancian (1979) and Atkinson (1984) suggest the possibility that people may view risk as irrelevant to their particular situation, thereby never acknowledging the problem.

CHAPTER 3

THEORETICAL FRAMEWORK: THE SOCIOLOGY OF KNOWLEDGE

Introduction

The two essential elements in the social construction of knowledge are social interaction (Blumer, 1969, Miller, 1970) and the subjective interpretation of social phenomena (Schutz, 1934, Berger & Luckmann, 1967). These elements provide a framework for understanding how meaning is constructed from the social situation. To define how meaning is taken from a situation, three assumptions must be understood and accepted.

First, this discussion assumes that knowledge must be developed over time to construct meaningful experiences (Schutz, 1970:62).[16] Knowledge is not used here to mean intelligence, formal education, or recallable facts. While it may include these forms, knowledge in this context refers more basically to what we have come to understand about the world around us and where we place ourselves in relation to that world. That knowledge includes the implicit and explicit learning that occurs in the socialization process, the events or actions that we encounter in our daily living, and all that we learn about past events--our histories, both personal and national.

Second, this discussion is based on the premise that all knowledge is socially constructed (Miller, 1973:66).[17] The social context, the interaction that occurs in that

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[16] Schutz applies the concept of time at two levels. The experiencing is always in the present as a "continuous coming-to-be and passing-away". However, we structure our experience by reflecting on events that we organize within a spatiotemporal framework (Schutz, 1970:60-62). Both the experiencing and the experienced form the basis for a way of knowing our world. The verb form, experiencing, is used to connote a process that is occurring NOW, which immediately becomes part of the experienced which provides meaning for the acting which is occurring NOW, and so forth.

[17] Any theorist contributing to the interactionist perspective might be cited here for their concurrence with this concept. However, it was Mead's early work on the function and meaning of language which laid the basic understanding of the social dimensions to

context, and the individuals who interact are the essential components in the construction of meaning. Interactionist theory postulates that selves and social structures are constructed through a process of continuous interaction over time (Charmaz, 1983). This perspective assumes that everyday reality is "socially created" through interaction (Strauss, 1964). Therefore, we construct what we know, how we define a situation, and how we define ourselves in that situation through the process of social interaction. Knowledge only emerges from the meaningful interpretation of a social encounter; therefore, knowledge depends upon an interactive process for the construction of meaning.

Third, this discussion assumes that self is necessary for the construction of meaning. Self does not refer to the psychological construction of id, ego, and superego but to the sociological concept of "I am what I know, and I am known by what I am." That is, the self is socially constructed; we are thinking individuals who communicate with ourselves and others through symbols and gestures about past, present, and future events (Miller, 1970:70). Because these symbols are universally recognized by others in our social world, all of us who share this social view hold a particular "stock of knowledge" (Schutz, 1964:120). That is, a common sense knowledge is shared with others in our social group and provides a basis for interpreting the actions and gestures of the other. Each variation that occurs during such an interaction provides one more bit of information about the possible meaning of the situation. To interpret the situation, we filter the event or interaction and extract what is applicable or relevant to our lives (Schutz, 1964:322). This interaction and interpretation creates a continuous interplay between learning who we are in the world and expressing who we are in each social interaction. Ultimately, this process provides us with "a way of knowing" our social world and ourselves.

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the transmission of knowledge. Miller captures this social nature when he says, "the life of a word is in its use, language is a social affair" (Miller, 1973:67).

Overview of Theorists

Theorists concerned with the social construction of knowledge were reviewed for this study. These theorists included the philosophers, interactionists and phenomenologists, John Dewey (1929), George Herbert Mead (1932), Alfred Schutz (1932), and Florian Znaniecki (1940) and the contemporary contributions of Berger and Luckmann (1967), Charmaz (1980a), and Schneider and Conrad (1983). Ultimately, the combination of George Mead's work on the social production of knowledge and Alfred Schutz's work on the social interpretation of knowledge provided this researcher with a comprehensive and complementary approach to the construction of knowledge.

George Herbert Mead is described as a pragmatist, philosopher, and social psychologist who examined "how culture and norms were 'internalized' in the person through the generalized other" (Mead, 1965: xii). The sociological application of this concept has been to advance the notion of the socialized self and the socialization of group members. Critical to this advancement is Mead's work on the function and meaning of language.

Alfred Schutz was a philosopher and sociologist who worked towards an understanding of how meaning is interpreted from social interaction. While living in the United States, Schutz's later work showed some influence from the American pragmatists: Mead, Dewey, James, and Pierce. Blending philosophy, pragmatism, and sociology, Schutz's research was directed toward a sociological understanding of the construction of knowledge. With a focus on culturally prescribed and socially transmitted patterns of conduct, Schutz details an interpretative process occurring within a form of self, expressed as Thou, as the "only object of experience that can be understood" (Schutz, 1970:22).

Both Mead and Schutz were influenced by many preceding theorists, and as contemporaries they were familiar with each other's work. Both Mead and Schutz were affected by Henri Bergson's work on time and John Dewey's writings on the indeterminacy of the situation. However, Schutz was most influenced by the

phenomenological philosophy of Edmund Husserl. Mead was influenced by the philosophy of John Dewey, and the pragmatism of William James. While much of Schutz's writings advance Max Weber's work on social action, Mead's writing was directed toward refuting John Watson's biological explanations of behavior.[18,19] By recognizing a mechanism that allowed the objectification of self, both Mead and Schutz contributed to a sociological understanding of how knowledge is meaningfully constructed from everyday experiences.

Despite overlapping influences, each man applied his concept of the construction of knowledge in uniquely different ways. Since both theoretical positions are important to understanding the question under study, Mead's and Schutz's positions will be presented in some detail. To introduce issues that are particularly applicable to the social construction of the pregnancy experience for Black women, this discussion stresses the similarities rather than the differences between, the theorists.

The Social Production of Knowledge

Understanding the construction of meaning from the social situation provides a way to approach the examination of three questions regarding problematic pregnancies. The first question is what typifications regarding pregnancy are held commonly and individually by disadvantaged Black women. The second question is how the meaning of risk is constructed by these women after they have been informed of a potential negative pregnancy outcome. The third question is how the subjective knowledge about pregnancy held by women at risk affects their actions.

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18 Schutz expanded Weber's notion of *Verstehen* and argued for the inclusion of subjective interpretation in the process.

19 Mead rejected the application of stimulus-response behavior to explain man's behavior. He argued that man has the ability to internalize both the stimulus, that is the gesture, and the response, that is the meaning. (Miller, 1973, xxvii).

Schutz's (1964: 96) analysis of subjective knowledge is oriented to the four social dimensions of knowledge. First, social knowledge includes both facts and recipes for face-to-face interactions. These recipes recall and anticipate how typified interactions might proceed; such recipes are passed from one generation to another through childbirth folklore, advice from others, shared experiences, and health teaching, to name a few. A general exploration of the everyday world of Black women will help to identify their sources typified recipes concerning pregnancy. Second, because knowledge is socially distributed, it varies according to social class, race, and gender (Dugger, 1988). The social distribution of knowledge is partly revealed in this study by identifying who these Black women learn from and what they recall being told. To capture the other side of the question, the study also asks what topics they want more information about. Third, knowledge is socially constructed, as when the provider identifies what constitutes a normal or abnormal pregnancy. This study acknowledged the medical construction of preterm birth as problematic, and sought to discover the Black woman's construction of the same issue. Fourth, expert or authoritative knowledge held by the provider serves as a form of social control on the actions of the pregnant woman. Social control is also exerted by influences from their homes and community. Sharing experiences among women in the community will powerfully influence the way in which the women in the study perceive their experiences. It will also establish normative expectations such as when to have a first child, how to care for one's self, and how and when to access the health care system.

Zones of Knowledge

Schutz discusses the relationship between knowledge and certainty when he differentiates zones of knowledge into "various gradations of vagueness, obscurity, and ambiguity" (Schutz, 1970:74). Knowledge of skills is the most basic form of knowledge. This knowledge has a high degree of certainty as it is performed the same way by each individual and it produces a known outcome. Useful knowledge is the formulation of a definite solution to a situation that was once problematic. This knowledge has a fairly high

level of certainty, although social factors greatly influence the formulation of the solution. Finally, the knowledge of recipes is somewhat socially standardized but highly variable and uncertain. Both roles and recipes are typified knowledge. Roles are not objective positions or things but are typified forms of action. Similarly, recipes are typified ways of acting. For example, there are typified ways of acting when going to the theater in so far as there are some expectations for dress and deportment. We apply both roles and recipes in common sense ways to the daily interactions in our taken-for-granted world.

These zones of knowledge are relevant to the study population in several ways. First, they focus inquiry on the discovery of recipes and roles that influence the behavior of disadvantaged Black women. This perspective lifts the study from the level of individual problems to the broader level of sociological inquiry into meaningful action in response to risk. While the individual's understanding of preterm labor risk may vary considerably, some thread of loosely formulated knowledge may emerge that demonstrates a cohesiveness among the group under study. This would help to reconstruct the pieces that form the patient's experience of preterm labor risk.

Second, the provider's useful knowledge and knowledge of recipes must be considered. The way the provider and patient interact during the distribution of knowledge can be examined as one form of interaction that produces different experiences of preterm birth risk for individual women. This may allow a more accurate interpretation of the increased uncertainty caused by the external relevancy of being labeled at risk.

The provider's knowledge of roles and recipes will determine her or his approach to the management of preterm labor, and this approach may affect the patient's response. Further, the provider's useful knowledge about pregnancy and preterm birth may greatly influence the context of the pregnancy. The provider's useful knowledge may be considered to be an imposed relevancy that requires an active response from the patient.

Language as a Vehicle for Knowledge

Language is a basic tool that we use to learn about the world around us. Yet differences in the forms and use of language between White and Black groups, professional and lay groups, and different social class groups can highlight their cultural differences around childbirth. How women speak about their pregnancy experience, what they recall about preterm risk teaching, and how they refer to others provide clues to the analysis of what is relevant to their lives. Additionally, forms of language can reveal degrees of intimacy in social relations, which provide some indications of the relevance of various sources of knowledge about the experience of pregnancy.

Mead explains how interaction with others or self through language differentiates humans from other animals as a thinking species. "The ability to think enables people to act reflectively rather than just behave. People most often construct and guide what they do, rather than just release it" (Ritzer, 1983:307). Several points in this statement are worth highlighting. First, Mead situates this statement in a social context, recognizing that people do not act in social isolation. Furthermore, because language can symbolically represent situations in thought as well as in speech, we often use language to construct how we will present ourselves in a situation and how the action is likely to proceed. Therefore, even when alone, we may construct various imagined scenarios, anticipate our role in that action, and reflect on the social consequences of an act.

Like Mead, Schutz (1964:100) focuses on the "active mastering [of language] as a means for realizing one's own acts and thoughts."
Here the emphasis is placed on the interpretative process where we use the symbolic representation of language to reflect on our actions and construct their presentation. Furthermore, he places language within cultural boundaries to show how the use of language is culturally prescribed and socially transmitted (Schutz, 1964:101). This perspective is particularly relevant when examining the interplay between the culture of medicine and the Black culture.

As this study uses the medical definition of preterm birth risk to reflect some indication of the patient's knowledge, this researcher is cognizant of the fact that the provider and patient are coming to the issue from very different directions. Stelling and Bucher (1973:666) use the expression "the operation was successful, but the patient died" to illustrate the differences between professional and lay views as reflected in the language they use. Analysis of the language used by Black women should offer a tangible measure of those differences in this study.

Social Action as a Vehicle for Process

Schutz (1970:5) critiqued and expanded Max Weber's work on social action by drawing from Husserl's and Bergson's contributions to the theoretical construction of internal and external reality. He explained the implied internalized subjective meaning of social action. What emerged was a sociological analysis of how meaning is constructed through a complex dynamic between objective, subjective, and intersubjective knowing that occurs over time in the process of social action.

Max Weber's definition of social action explicates both social and cultural components. Weber said that behavior "is not action unless an actor... or culture in general, has assigned some meaning to it, and action is not social unless it is oriented toward others" (Jesser, 1975:142). However, Weber did not address the relationship between the self and interaction; this became a critical point for Schutz and Mead. Schutz began to explore that relationship between self and interaction using Weber's definition of social action as meaningful action oriented toward others who share mutual intentions (Jesser, 1975). Schutz extended this definition of social action to include the process of self-indication (Schutz, 1970:129). That is, before acting, the individual has assessed the situation, given it meaning, and has placed herself within the context of the situation based on that meaning.

Building meaningful experiences implies the development of knowledge over time. Past, present, and future are all essential to every meaningful act. The individual recalls a

typified action to help formulate a way of interacting in a present situation that furthers the chosen future outcome. The phenomenon, sense, or unity of the present interaction is retained and becomes part of the individual's stock of knowledge for formulating future actions.

Schutz proposes that the individual formulates actions on the basis of typifications or recipes in non-problematic situations. New knowledge results from interactions in problematic situations, those that have not been addressed before. Given that our stock of knowledge is a subjective representation of the taken-for-granted world, then all of our questions about unknown things arise from the existence of things that we already know (Schutz, 1970). Thus, the known or determinate world frames our approach to indeterminate situations.[20]

Since this study is concerned with problematic pregnancies, the appropriate Schutzian definition of social action here is an action that takes meaning from the individual's stock of knowledge and is applied to a problematic social situation to promote a projected future outcome.

Mead used Weber's definition of social action to argue against Watson's theory of stimulus-response behavior. Mead argues that both the development of language and the conscious awareness of our involvement in the social process distinguish the social relations of humans from animal behavior. In particular, language makes possible the symbolic nature of human interaction.

Mead developed the subjective component of social action by emphasizing that meaningful acts are mediated through the use of symbols (Mead, 1970:7). Mead's analysis

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[20] The term indeterminancy is borrowed from Heisenberg's Principle of Indeterminancy as applied to the probablistic calculations of the movement and speed of atoms due to the variance caused by each interaction with other atoms. Sociologically, the concept of indeterminancy as applied to the theory of knowledge might be expressed as "the problem [of knowing] is not so much that the thing in itself is unknowable in principle, but that it can be known in so many different ways" (Shalin, 1986:11). Indeterminancy embraces two notions- the notion of reality as being in a continuous state of flux and the mutual effect on and between the actor and object in determining the situation.

builds on the foundation that the human being has a self. While seemingly obvious, the significance of this statement rests on the understanding that we can regard ourselves as objects, thereby making ourselves an integral part of the act.[21] To objectify something is to be able to set it apart, examine it, give it meaning, and represent it in a symbolic form such as language. The ability to objectify our self and all other concrete and conceptual elements in our world is the central mechanism by which we interact with the world around us.

Social Interaction as Process

The meaning of social action is derived from the interactional context. Social interaction occurs in two forms, symbolic and non-symbolic (Blumer, 1969:8). Every object or event in our social world is identifiable either by direct interaction or through the symbolic representation of that object. This representation is recognized by all others in our social world. In this sense, knowledge is universal (Mead, 1962). For example, all members of the English-speaking world call a printed bound volume a book and recognize a handshake as a form of greeting.

Non-symbolic interaction means that one responds directly to another person's gestures or actions; it is referred to simply as interaction throughout this discussion (Blumer, 1969). Symbolic interaction refers to the interpretation of the act or gesture to arrive at the meaning of the act. To illustrate the distinction, suppose that Party B leaves the room and the door slams behind her. Party A concludes that Party B is "put out" about something, and might respond by addressing the point when Party B returns. The symbolic act of the slamming door has come to be interpreted in a broad social arena as an act of anger or frustration. If, unknown to Party A, the wind blew the door shut with a slam, Party A's interpretation of the act would still be the same.

Four points are particularly worth emphasizing in this example. First, a gesture can hold the same meaning for a great number of people who participate in the same social

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21 Both Mead and Schutz drew from Henri Bergson's work on the body-mind relationship for the concept of objectification of self.

arena. Therefore, meaning is socially constructed and transmitted. Second, there are specified ways of responding to a gesture or act. That is, established patterns of acting "just do not carry on by themselves but are dependent for their continuity on recurrent affirmative definition" (Blumer, 1969:67). Third, the symbolic interpretation of the act is more significant than the natural phenomenon, because reality is constructed from symbolic interpretation. Fourth, language is necessary to symbolic interpretation. You were able to understand the outcome of the situation in the example because you can interpret the symbolic representation of the words "slamming the door."

The Self and Social Interaction

George Herbert Mead's contribution to the definition of social interaction was to elaborate the concept of self as who we are and how we define the situation. Self is not present at birth but "arises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process" (Mead,1965:199).

The ability to differentiate between self and other, I and you, is important to the process of defining a situation. This does not merely refer to the fact that Party A would recall the slamming door encounter differently than would Party B. It also implies that each of them may give more or less attention to the encounter. The amount of conscious attention we give to the encounter is influenced by our conception of self, what we offer to the interaction, our intellectual understanding of the content of the encounter, our familiarity with the type of encounter, and the degree of relevance we have assigned it in our life.

Mead applies the concept of self to Bergson's concept of duration to capture the interpretative process.[22] Mead refers to the component parts of self as the "I" and the "me." In Mead's construction, as in Schutz's, the concept of time is crucial to the

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22 The "I" is always in the present, experiencing as a steady stream of consciousness. It is the "me" that reflects upon the experience and interprets it within some spatiotemporal framework.

distinction between "I" and "me" and We and Thou (see below). When we take the attitudes of others we experience the "me," but we react to those experiences as "I" (Mead, 1962:174). The phrase "the 'I' of this moment is the 'me' of the next moment" captures the difference between experiencing and knowing the experience (Mead, 1962:174). The "I" is that part of the self that experiences now but is never fully aware of the totality of the self. It is necessary to reflect on what just occurred to add the experience of the "I" to the knowledge of self as "me."

The "me" is an organized set of attitudes of others or the "generalized other", and in Schutzian terms the "me" represents my "stock of knowledge". Yet during an interaction, the "I" responds as a unique individual to a unique situation. However, the "I" does so partly by calling on the knowledge that makes up the "me."

The Social Interpretation of Knowledge

Both Mead and Schutz talk about being conscious, that is, observing, taking in, and reflecting on what occurs in our everyday world. Having an alert attitude allows us to "distinguish between the experience that immediately takes place and our own organization of it into the experience of the self" (Mead, 1970:135). This idea implies that we "see" the interaction through the unique lens of our past experiences, and that we assimilate this present experience into our construction of self. These experiences are not created as verbatim scenarios but as appearances, unities, or meanings. These meanings are assimilated into our experience of self, our knowledge of how we are in the world and how the world is socialized within us.

Mead and Schutz also recognized reflexiveness as essential to the development of self. Mead defines reflexiveness as a "turning-back of the experience of the individual upon himself so that the whole process is thus brought into the experience of the individuals involved in it" (Mead, 1970:134). This reflexive process enables us to take the attitude of the other toward ourselves, to consciously adjust ourselves to the social process, and to modify the outcomes of that process by our adjustment to it. Mead implies that this

process occurs during social interaction, while Schutz describes it as occurring after the interaction and providing ways of acting for future interactions.

Ways of Deriving Meaning--The Mind

The concepts of acting reflexively, regarding oneself as an object, and having foreknowledge all imply that a process occurs inside as well as outside the individual. This process is interpretation and both Mead and Schutz made important contributions to the interpretative dimension of social action and interaction through the notion of self as object. As discussed above, Mead captured this concept of self by differentiating between "I" and "me". Schutz uses a similar mechanism in differentiating We-relations from Thou-relations.

Schutz often discusses processes at a theoretical level and at a pragmatic sociological level. His theoretical constructs represent a "typical" example of that concept, but the concept is never found in the real world in its pure form. This is the distinction made between We-relations and Thou-relations. According to Schutz, We-relations and Thou-relations are two ways in which we come to know what we know. Thou-relations are the pure form of We-relations. Thou-relations represent typified knowledge of social reality and of others in general. In Thou-relations we are interacting with types of people rather than with unique individuals. For example, the Black woman may construct possible scenarios for her first prenatal visit based on her knowledge of doctors or nurse-midwives as types of people. She also brings to that interaction a particular typification of herself as Black pregnant woman. Only in a face-to-face encounter with the provider (when they share "a common sector of time and space") will she experience a We-relation, a direct interaction with a specific individual (Schutz, 1964:23).

The quality and depth of We-relations vary with the directness of the experience. The women in this study will not experience all others with equal intimacy. The more they share personal experiences with others, the greater their intimacy with that person is likely to be. Even interactions with the same person may be enhanced or constrained, depending

on the different roles they both represent at the time. For example, a pregnant woman's mother may act as her teacher, caretaker, babysitter, or nurturer--the intimacy of their interactions will vary accordingly.

And finally, the degree of attentiveness will vary in each interaction depending on its relevancy to the person. If this woman is attentive to the other during the interaction, the "other is more vividly and directly known than she is known to herself" (Schutz, 1964: 29). This position occurs because her knowledge of self is gained through reflection; only upon reflection of this interaction will she know the experience of now.

Schutz joins Bergson's concept of duration to Husserl's theory of the experiencing and the experienced in developing this concept (Schutz, 1970:59). According to Schutz, every act includes the knowledge of past experiences and the "perceiving, retaining, recollecting" of the experiencing (Schutz, 1970:59). To give meaning to an action or symbol that we have not previously experienced, we must be able to translate it from our knowledge of what we have experienced. We are able to translate new experiences by finding similarities between them and previous experiences to which we have already assigned meaning.

To summarize, in face-to-face situations, Black women experience the immediate We-relation (Schutz) or the "I" (Mead). They bring to that interaction knowledge of typified ways of acting conceptualized as Thou-relations (Schutz) or the "me" (Mead). In particular, Thou-relations is part of the "me" (Mead) as her knowledge of expressive and interpretative schemes of objective symbols and the vernacular language she uses (Schutz). Together, these parts form the way she comes to know herself and the world around her--the basis of her knowledge.

The Construction of Meaning

Regardless of the patient's stock of knowledge about pregnancy, preterm labor cannot be known until it has occurred. Schutz (1967) states that objective information is not meaningful until the individual experiences the situation, reflects upon it, and extracts a

subjective way of knowing the experience. Preterm birth risk cannot be subjectively known until after the delivery, when the patient reflects back on the event and constructs some meaning of the experience. According to Schutz, lack of knowledge may be regarded in two ways, as situational indeterminancy or objective indeterminancy (Schutz, 1967:72). Situational indeterminancy refers to a lack of knowledge about ways of acting in an unfamiliar situation. Objective indeterminacy refers to the fact that the reality of an experience cannot be determined before it occurs. Objective indeterminancy is present for everyone in every interaction or situation: we can not know that which has not occurred. Situational indeterminancy, however, may reveal the conditions under which Black women lack the knowledge concerning pregnancy and risk.

Three problematic issues arise in this study when considering the situational indeterminancy of "not knowing." First, many women in the study have had previous pregnancy losses but have never experienced a normal pregnancy, so their previous subjective experience provides either no translatable knowledge or negative knowledge. Second, the social class and culture of socially disadvantaged minority women strongly influence their knowledge concerning pregnancy. Additionally, the women's knowledge will differ considerably from that of the providers. Third, some women know they have an increased risk of having a negative pregnancy outcome--that of delivering before term. As such, they are constructing the meaning of preterm birth risk as an ongoing, day-to-day process. Without knowledge of the outcome for the infant, they are constructing risk in a common sense way based on their everyday experiences.

Interpretation Through Interaction

While "stocks of knowledge" as typifications and objectifications are critical to this discussion of knowledge, it is important to remember Weber's admonition that concepts of the mind are not phenomena. Typifications, objectifications, and conceptualized discrete entities are representations that are not found in the empirical world. They often discriminate distinctive rather than common features, and, as Schutz notes, in the process

of conceptualization some of the living dynamics are often lost (Schutz, 1967). With this *caveat*, further discussion of stocks of knowledge is necessary to understand the patient's construction of preterm birth risk.

According to Schutz (1970:59), experience is the culmination of all our perceptions and reflections. These perceptions are not intentional objects, but appearances, phenomena, unities, or meanings culled from all of our particular experiences in We-relations. Schutz proposes that phenomena in our stream of consciousness have no meaning until after the event, when upon reflection the "experience is 'lifted out' of the stream of [experiencing] and becomes clear and distinct; a discrete entity" (Schutz, 1967: xxiii). This discrete experience is then represented in the mind as a form of a typified action. When this discrete entity is identified, the experience of the action or symbol acquires subjective meaning.[23] The repetition of this process creates the individual's "stock of knowledge" of typified actions.[24]

Therefore, our stock of knowledge is the subjective meaning that we have attached to every object in our everyday world, whether concrete or conceptual. This knowledge allows us to consider the probability of a phenomenon occurring at some time and places us within a framework for action.

Summary

The interactionist and phenomenological relationships between the self, others, and the social context provides a theoretical framework in which to examine the pregnancy

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[23] Schutz discusses this as a purely rational process. In an effort to reveal a replicable process which is differentiated from the emotional responsiveness of the psychological sciences, the emotional and sensual components which contribute to our stream of consciousness have been neglected.

[24] While this discussion emphasizes the intersubjective dynamic of knowledge, the equally important aspect of having a stock of knowledge is the social dynamic. A stock of knowledge is "an intersubjective knowledge that existed long before our birth, is experienced and interpreted by our predecessors, and is now given to our experience and interpretation" through the social act (Schutz, 1970:72).

experience of Black women. The theoretical concepts crucial to an understanding of the Black woman's construction of preterm birth risk are based on the work of George Herbert Mead and Alfred Schutz. Critical concepts from the work of Mead and Schutz include the construction of meaning through social interaction, language as a facilitator or barrier to knowing, and interpretation through reflexive dialogue with self.

Both Mead and Schutz agree that we use stocks of knowledge, or knowledge of socialized normative behavior to formulate ways of acting when we anticipate or engage in a familiar social situation. But a central question of this study is what occurs when the situation is unfamiliar or problematic- when common sense knowledge about the pregnancy experience no longer applies because the probability of a problematic pregnancy is introduced.

To answer this question, the investigator examined the everyday world of Black women to determine whether they actually viewed themselves as being at risk. To determine whether Black women come to know what the provider knows about preterm risk, medical definitions of preterm risk are used as a measure of knowledge. And finally, to determine how Black women come to know what they know, Black womens' definitions of their experience, their interactions, and the context of their pregnancy were examined.

CHAPTER 4
APPROACH TO THE STUDY

Introduction

This investigation is concerned with how Black women come to know what they know about pregnancy and what meaning that knowledge holds for them. To explore these questions effectively, both the design of the study and the method of analysis were kept open, flexible, and receptive to the responses of these women.

Design

An open-ended design was chosen for the interview guide for two reasons. First, because of the lack of available information about Black women's understanding of pregnancy and risk, a structured interview tool would have provided questionable results. Second, open interviewing would best serve the point of view of the women's experiences.

A one-time interview was chosen as a method to assure the participation of the study population. Since the providers observed that women frequently forgot to bring information that was requested at a previous visit, diary recordings were not considered. Diary recordings were also not well suited to providing information that would reveal causes of risk nor explore the widest social circles that contributed information about risk. Serial interview would allow the additional evaluation of the woman's developing conception of risk. However, that approach was not selected because the method was projected to require a considerable increase in daily time spent at the clinic and it would also extend the length of the study.

Open-ended interviewing allowed issues to emerge while the study was in progress. Phrases from the interviews suggested concepts that began to form themes and to describe the relationships between them (Strauss & Corbin, 1989). The grounded

theory method was chosen for the analysis as it allowed conceptualizations to emerge from the data and suggested a theoretical framework to best explain the phenomena under study (Knafl & Webster, 1988:207).

Interview Guide

The interview guide was devised to provide sufficient structure to assure that similar types of information was gathered from each woman. (see Appendix C). The questions, which moved from the general to the specific in three topic areas, were designed to probe the issues of pregnancy risk.

Questions in the first topic area asked for general knowledge about pregnancy: what they know and who taught them what they know. These questions were intended to establish the terms these women used to refer to pregnancy. Was the language medical-technical or colloquial? If the vocabulary was colloquial, were they translated from the health teaching of the provider or did they represent the shared knowledge of Black women from generation to generation?

The second topic area focused on sources of social support. This topic was emphasized because the literature in this area correlates positive social support with improved participation in prenatal care, decreased pregnancy complications, and increased birth weights (Nuckolls, Cassel, Kaplan, 1972, Norbeck & Tilden, 1983, Gottlieb, 1985, Oakley, 1985, Boone, 1985).

The third topic area focused on the concept of risk as expressed in terms of trouble, concern, worry, danger, or similar terms used by the women. This area examined whether women perceived themselves to be at risk. It also focused on how they came to that conclusion, probing both their own construction of pregnancy and influences from their interactions with others. This topic was emphasized because of clinical experience with Black women in preterm birth prevention programs and because of the preterm birth studies that examined these risk factors (Hemminiki & Starfield, 1978, Creasy et al, 1980, Gaziano, Freeman, & Allen, 1981, Main et al, 1987).

After preliminary analysis, the questions that seemed to best promote discussion were emphasized in the interviews. The interview guide prompted women to speak about these issues from their point of reference and in their language. Questions were stated so that women could respond in their own terms without feeling inadequate or intimidated.

The interviews were intended to gather data that would reveal what conditions came to represent pregnancy risk as meaningful for Black women. To include influence from the broadest social context, the interview guide included questions that pursued various sources of knowledge: family, friends, partners, health providers, and other social resources. Questions were directed toward identifying what information seemed most important, relevant, meaningful, and applicable to these women.

Therefore, the chosen design included a one-time interview conducted during the at risk period, with the possibility for follow-up interviews. Three follow-up interviews were conducted. One follow-up was pursued because the woman was early in her pregnancy and had not yet addressed many of the applicable issues. Two other women did not have the time to complete their interviews so time was arranged at a future prenatal visit.

Consent to Participate

The interviews were conducted from June through September, 1988. From the list of all the women who met the criteria for inclusion in the study, the appropriate interview time was calculated for each woman based on her weeks of gestation (using a standard obstetrical calendar). The next prenatal visit for each woman was compared with the at risk period of gestation between 24 and 36 weeks. If the woman was between those weeks of gestation, the date for the interview was coordinated with her regularly scheduled prenatal appointment and with the time convenient for her.

When the patient checked in for her appointment, the researcher, who was at the clinic, was notified by the receptionist. While waiting for her prenatal visit, the pregnant woman was introduced to the researcher. The researcher introduced herself as a nurse and a student at the University of California, San Francisco, and explained that the study being

conducted was part of her research requirements. Personal introduction to the researcher and the study was preferred as some of the providers thought that patients might be resistant to participating. The woman was then given the opportunity to be interviewed on that date or at a following visit. Every attempt was made to assure them that participation was strictly voluntary.

Only three women refused. One women was highly suspicious about "being studied." She asked many questions about what would be done with the information, and ultimately decided not to participate because she would have been recorded on tape. One women said she did not have the time and would not have the time in the future. She felt she already had enough to contend with in her life. The third woman was very young and did not want to be interviewed, but did not know how to say no. She repeatedly made appointments to be interviewed at her next visit and then did not keep her prenatal appointment, coming to the clinic about two days later for a "walk-in" appointment. The researcher stopped pursuing the interview after recognizing this pattern.

If the woman agreed to the interview, she was given the consent form and the UCSF Experimental Subject's Bill of Rights (Appendix C). After she read the forms, each item was elaborated upon by the researcher. They were told that this was a study about what they thought, felt, or knew about pregnancy. They were asked to talk about what was important about the pregnancy from their point of view. They were also told that the study emphasized how all parts of their lives affected or were affected by the pregnancy, so questions about their lives in general would be included. They were not told that two different groups were involved nor was risk or preterm birth mentioned.

The Study Population

This study was restricted to Black women because they have approximately two times as many preterm births as any other ethnic group (Heckler, 1984:174). Because of

this increased risk, they experience a high degree of intervention in the management of their pregnancies from a health system that knows very little about them.

This study included a total of seventeen pregnant Black women (see Appendix D for a demographic and reproductive description of the study population). Thirteen of the women were poor, unemployed, and received Medi-Cal benefits. Four women were employed and carried private health insurance. This mix was representative of the population that received care at the study site.

The ages of these women ranged from 18 to 34 with a mean age of 22 years. Eighty-eight percent of the group had 12 years of education or more, which placed them well above the national average of 22.3 percent for Blacks (Statistical Abstract of the U.S., 1988). The oldest woman was a college graduate, two others had attended some college, 12 were high school graduates, and two had not completed high school.

Eight women had no children, four women had two children, and the remaining five women had one child. Reproductive loss was common in this group; these seventeen women had had a total of 28 elective abortions. Three of the women had each had five previous abortions.

Screening the Population

The women who participated in the study were identified by reviewing 497 records. Out of those records, 227 women were currently receiving prenatal care during the months of May, June, and July, 1988. All prenatal charts were reviewed for the following general criteria for inclusion:

1. Black race.
2. Gestation between 24 and 36 weeks--This criterion was used because elective abortions may be performed through the first 24 weeks and delivery at 37 weeks is no longer considered preterm.
3. At risk for preterm birth--Risk indicated by the provider on the patient's record.

4. No previous experience of preterm birth--The intent of the study was to discover the women's conception of being at risk before knowing the experience of preterm birth.

The women who met these criteria were then assessed for inclusion based on the following preterm risk criteria identified by Creasy, Gummer and Liggins (1980):

1. History of trauma--Trauma due to cone biopsy, two or more second trimester abortions, three or more first trimester abortions, spontaneous abortions, or cerclage (surgical closure of the cervix).
2. Carrying twins or triplets.
3. Evidence of preterm labor with this pregnancy--Preterm labor contractions validated by electronic monitoring or cervical change on bimanual examination.

Women who met the above criteria were excluded if they belonged to any of the three categories below:

1. Age 17 years or younger--This group tends to register late for prenatal care and to report denial, fear, and shame as barriers to care (Brown, 1988:101). These behaviors poses additional risk to the incidence of preterm birth, and yet, are not considered in the provider's risk assessment. Therefore, young teens were eliminated.
2. Substance abuse--The many detractors occurring in these women's lives make it difficult to determine why they acted as they did. Additionally, a high rate of spontaneous preterm birth is caused by cocaine use regardless of medical and self-care measures (Brown, 1988:100).
3. Prenatal care beginning later than the 20th week of gestation--By 20 weeks, the fetus is fully formed and critical events may have occurred without the benefit of medical management that would sharply increase the risk of preterm delivery (Brown, 1988:31).

Twenty-two of the patients reviewed were Black women who were pregnant for the first time and met the other criteria of the study. Another twenty-two were Black women who had had multiple abortions or previous births.

Women at Risk and Not at Risk

One of the questions posed in this study was whether women at risk engaged in different activities than women not at risk. To examine this issue, sample study populations were drawn from provider-identified at risk and not at risk groups. Both groups came from the same setting and both met the same general criteria for inclusion in the study. Seven women, identified by the provider as at risk for preterm birth and ten women not at risk, were interviewed during the at risk period between 24 and 36 weeks of gestation.

The Provider-Identified At Risk Group

The seven women in the at risk group were so labeled by their providers because of presence of significant risk factors (as listed in the criteria for inclusion in the study). All were informed by the provider of their preterm risk and were given instructions for self-care activities before being interviewed.

The women who were at risk for preterm labor were older and had a greater number of pregnancies than the not at risk group. This finding follows the pattern reported by Creasy et al (1980). The mean age of this group was 24. The seven women averaged 4.4 pregnancies each, but four women had only one living child and three had two children. This pregnancy to birth ratio represents the considerable prior pregnancy loss in this group, and a key factor in identifying these women as at risk.

The Provider-Identified Not At Risk Group

The not at risk group consisted of ten women. The mean age for this group was 22; four women were 20 years old or younger. They were younger than the at risk group and had little prior experience of pregnancy. Eight women would become mothers for the

first time, four were pregnant for the first time, and four had one previous abortion. The remaining two had normal term deliveries with the birth of their children.

The Women-Identified At Risk Group

Seven women identified themselves as experiencing significant pregnancy risk. Two women, who were identified by the provider as being at risk for preterm birth, identified themselves as facing preterm birth risk. Five of the youngest women in the study identified multiple social factors, such as interpersonal relationships and living situations, as having a strong negative impact on their pregnancy experience. These women did not experience preterm birth changes but organized their pregnancies around problematic social events. This group will be discussed in Chapter 7 as women with high social risk.

The Women-Identified Not at Risk Group

Ten women described their pregnancies as normal, healthy events. Seven women, who were experiencing their first pregnancies, were identified by the provider as not at risk for preterm birth. The remaining three women were identified by the provider as at risk for preterm birth. However, they defined the pregnancy as normal if they did not experience preterm risk or if the infant was defined by the provider or others as "normal".

Establishing the Study

The Setting

All of the women interviewed attended the private Women's Health Care obstetrical service in Oakland, California. This site was chosen partly because it was one of the few private services that served pregnant women insured by Medi-Cal. It was also selected because it now served many of the patients who transferred from a recently closed city facility. Many pregnant Black women in this community had converted their Medi-Cal benefits to membership in a Health Maintenance Organization (HMO) that contracted with the State of California to accept Medi-Cal reimbursement. Members of that HMO group received their maternity care from this private practice group.

The all-woman practice group is organized into two teams each consisting of obstetricians and nurse-midwives. Although the patients choose who will attend their births, they are seen prenatally by both types of providers. High risk patients are co-managed by physicians and nurse-midwives.[25] Low risk or not at risk women are managed and cared for primarily by nurse-midwives. However, all patients are reviewed and discussed by both types of providers during case conferences.

When a women was identified as at risk for preterm birth, she was counseled by the provider about appropriate self-care measures to take until the next visit. At the same time, the patient was given the preterm labor handout in Appendix B.

To identify the management protocols and philosophy of the providers, the researcher interviewed two physicians and two nurse-midwives. The providers were asked about their views on preterm birth prevention and what specific instructions they normally give the at risk patient. As placing the patient on bedrest is the first intervention for preterm birth prevention, they were asked specifically about their patient teaching, expectations, and follow-up of bedrest compliance. Data from these interviews were examined to determine the degree of variability in provider teaching, but also to seek what information was consistently given by the members of the practice group.

Gaining Access to the Setting

The proposal for this study was reviewed by the research committee of the private practice group. They considered the potential impact of the study on their practice (time and use of facilities and staff) and their patients. This non-interventionist study agreed with their practice philosophy and approach to patients.

The clinic administrator fully supported the study. However, the other staff facilitated the data collection more directly. This included the nurses' aides who checked in

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[25] Co-managed refers to prenatal care that is primarily provided by a nurse-midwife but that includes close consultation with a physician who determines the management direction.

the patients, the receptionists who chronicled their arrival, and the secretary who made their next appointments. In addition, the medical records secretary gave this investiagator free access to the patients' records; the appointment calendar and the computer data system were also accessible. All of these women were Black, except for one Chinese woman. They had no prior acquaintance with me, but knew that I was a professional colleague of the providers in the group.

Over the weeks of data collection, I took every opportunity to informally discuss my study with the support staff, sharing my interview questions with them and talking about my positive experiences with the women I interviewed. This approach seemed to cement an easy relationship with all the staff except one. She regarded my interest in studying Black women with suspicion throughout the study but did not interfere with my work.

Method

This research question was selected because of its relevance to obstetrical practice. In particular, the study was stimulated by the increasing medical construction of pregnancy as problematic and the application of that construction to preterm birth management. However, the methodological approach was determined by sociological constructs of qualitative research using grounded theory methodology.

Grounded Theory

Grounded theory is a analytic approach developed and reported by Glaser and Strauss (1967) to generate and test theory (see also Glaser, 1978, Strauss, 1987, Strauss & Corbin, 1989). Grounded theory is a rigorous process of data collection and analysis involving the use of "induction, deduction, and verification" (Strauss, 1987:11).[26] Using

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[26] Strauss (1987) uses these terms not in a quantitative research sense but is intensely interpretive in a phenomenological sense not characteristic of other approaches. Induction means that the question under study arose from some prior experience of the researcher with this type of phenomenon. Deduction refers to the ability of the researcher to think logically while applying his or her experience to the particular data under study. Verification calls for the researcher to apply his or her

this method, data collection and analysis proceed concurrently. While universal inferences cannot be made from data collected with the grounded theory method, such data do allow generalization by abstraction. That is, if the contribution to sociological theory is valid, then the findings of the study can be generalized to other situations where application of the theory is appropriate.

Generative questions concerning a phenomenon of interest lead the researcher to selective sampling. In selective sampling, the researcher chooses individuals or groups that he or she believes will provide information regarding the phenomenon under study (Schatzman & Strauss, 1974:39).

As the interviews are transcribed, each line of data is analyzed in a process referred to as open coding. Open coding orients the investigator to the full scope of phenomenon under study, suggests further questions to be explored, and provides comparative data. As each new piece of data is coded, categories and subcategories may be noted and labeled, and connections among them suggested (Strauss, 1987:62).

Categories are significant classes or properties related to the topic under study (Schatzman & Strauss, 1973:110). For example, in this study, phrases like "my mother said" or "people tell me" were eventually organized under the category of sources of knowledge. Once sources of knowledge emerged repeatedly, subcategories based on social relationships were organized. Those subcategories included mother, other family members, best friend, boyfriend, teacher, and health provider.

Eventually coding becomes organized around one category at a time, referred to as axial coding (Strauss, 1987:64). This forces the researcher to focus on the conditions under which the category of behavior occurs, including the interactions, the strategies used to manage the situation, and the consequences of those strategies.

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prior knowledge about the sites, events, actions, and actors, as well as the procedures for analyzing the data. (p.11-13).

As coding progresses, relationships may be noted between categories. For example, in this study, a woman might have legitimated her pregnancy as normal or problematic either by noticing and acknowledging some change in her body or by others giving her some objective information, such as the provider noting a lack of weight gain.

As more and more activities, interactions, and strategies emerge, the researcher tries to find an explanation for these activities. Eventually, one category will emerge with great frequency and appear to be central to the other categories. If it accounts for most of the variation in a pattern of behavior, it is referred to as the core category. In this study, the core category was identified as the "critical moment," the point when the woman constructs the events of the pregnancy as problematic, or at risk, based on bodily signs and legitimation of her experience. After the core category is identified, coding becomes selective, focusing on only those categories that relate to the core category (Strauss & Corbin, 1989).

Memoing

Early in the analytic process, the researcher records thoughts, questions, and initial hypotheses concerning the problem under study in memos. The process of memoing monitors and stimulates the researcher's thinking throughout the analysis of data. Memoing provides three levels of information about the analysis: observational, methodological, and theoretical (Schatzman & Strauss, 1973:99). Early on, observational memos provide evidence concerning the property, context, or situation (Schatzman & Strauss, 1973:99). These notes serve as reminders of directions to pursue and clues to linkages between categories. Methodological notes illustrate how the researcher moved both from one concept to another and between concepts (Schatzman & Strauss, 1973:100). They provide a logical map of how the analysis moved from descriptive to theoretical conceptions. Theoretical memos from field notes immediately illustrate ideas and suggest questions that require further analysis after future data collection and coding (Schatzman & Strauss, 1973:101).

Using grounded theory, analysis leads the researcher to the integration of the data, a process that brings together the core concept and related concepts into a coherent theoretical formulation (Charmaz, 1983). The next chapter discusses the analytical integration of the data from this study; while the following section discusses its limitations.

Limitations of the Study

This study has several limitations. The first is the boundaries imposed on the study by those women who were included or excluded by the study criteria. The second is whether or not a researcher can gain open, straightforward information doing field work among people from different social and ethnic group (the insider-outsider controversy).

Regarding the first limitation, this investigator received strongly positive responses when requesting interviews. Only three women excluded themselves from the study. As the study sample was self-selecting, some critical information may have been omitted from the study by missing those women who were most difficult to reach.

Further, two groups of women were excluded by the researcher to minimize this limitation. Pregnant Black women under the age of seventeen were excluded partly because of their increased risk and partly because developmentally they tend to be very concrete thinkers making it difficult to uncover concepts like risk. Women who were substance abusers were excluded because their dependency on drugs or alcohol dominates their social reality to the extent that most of their decisions are made according to their dependency needs. However, in eliminating these groups, the researcher eliminated two groups who are particularly at risk for preterm birth.

And finally, as a White woman studying the Black culture, there was the potential to encounter difficulty establishing trust and cooperation with Black women. There was the potential to get regurgitated information rather than what they truly thought. There was the potential to misinterpret what I heard.

During two of the interviews, I suspected women gave answers they thought I wanted to hear. When ask what they did to take care of themselves during pregnancy, their responses were "to rest, eat right, and exercise". This curt answer seemed to echo the points emphasized in prenatal pamphlets and health classes. Further probing of how they accomplished each of these tasks lead to more revealing information about their daily habits and the resources available to them. I suspect that this rigid recall was prompted more by my identity as a nurse than by ethnic differences.

In general, this investigator was continually struck by the depth of personal information they revealed. My impression was that the women were eager to talk about themselves and how their pregnancies fit into their lives. The interview seemed to provide a refreshing change from the usual orientation of the prenatal visit, which considers the pregnancy first and the individual as the object of the pregnancy.

Regarding the second limitation, let me highlight some of the strengths and weaknesses of this study. First, conducting field research is a methodological approach that sensitizes the investigator to the issues and the context of the minority group (Zinn, 1979). Concern over the subjectivity of the researcher implies that a bias may have been introduced in data gathering or interpretation. This caution applies to both insiders and outsiders and can be guarded against "as long as researchers follow established procedures and logically relate their conclusions to the data" (Zinn, 1979:213). Further, according to Schatzman and Strauss (1973), field research captures meaning through the language of the people being studied. The respondents were not using words from a standard questionnaire: they responded with their language, emphasizing their frames of reference. This study recognized the need to address issues relevant to the individual by interviewing women during their pregnancies. In this period, the pregnancies were central to their lives but the outcomes remained uncertain.

Because this study sampled a small number of women with a specific problem, its applicability must be considered. The intent of the study is not to generalize the findings to

all pregnant Black women in America, but rather to "form working hypotheses that may be transferred from one context to another depending upon the degree of 'fit' between the contexts" (Guba, 1981:81). The possibility of transferability is enhanced by theoretical sampling and the density and specificity of the conceptual linkages.

Chapter 5

Analytic Integration and Findings: The Critical Moment

Introduction

The previous chapter explained the process and terminology of grounded theory analysis, while the first half of this chapter shows how that process was applied to the data gathered for this study. To demonstrate how this investigator moved from the transcribed words of pregnant Black women to the conceptual density necessary to postulate theoretical linkages, examples that represent the stages from initial coding to theoretical integration are provided. These linkages demonstrate that the research was directed and determined by issues that emerged from the interviews with pregnant Black women. The last half of this chapter and the following two chapters present the findings of the study as revealed by the analysis of the data.

Analysis of Risk

This study sought to discover how Black women construct their pregnancy experience in regard to preterm birth risk. Therefore, this investigator began by scanning the interviews for references to risk with the following questions in mind: What were pregnant Black women saying about risk? What words did they use to express it? Who did they talk to about risk and what did they recall? What did the women do when they thought their pregnancies were at risk?

The concept of risk is defined as the "possibility of meeting danger or suffering harm or loss" (Oxford American Dictionary, 1980). In the initial reading of the interviews, this investigator scanned for words that implied risk. These Black women used terms like "worry," "concern," "danger," "problem," and "fear" as direct expressions of risk, and occasionally a women used the term "trouble," as in "I got troubles." Some women referred to pregnancy risk directly, as Caroline did when she said "I started having

problems with the contractions." However, some women focused on other concerns, such as Daphne, who identified financial risk as her major concern with these words:

> "That's been one of my kind of worries. I would
> like to spend at least six months [at home], if I can
> afford to live off of one income..."

At other times, a woman would imply risk by identifying behavior as being outside of the normative boundaries of pregnancy. For example, Audra identified age boundaries when she said "people say I'm too young;" Carla was concerned with weight boundaries when she said "...I'm getting bigger and bigger. It's a lot harder--your blood sugar can go and diabetes can set in."

Women also associated risk with health issues like cholesterol and salt usage. Audra said:

> "My health is a risk and I thought about that a long time since
> I've been pregnant with my high cholesterol level and also I
> have asthma..."

Audra thought these factors were important, but reached no conclusions about their relationship to the pregnancy. Words like worry, concern, and fear were used by these women to connote uncertainty about the current state of the pregnancy or an unknown future.

Risk was also defined partly by how close Black women perceived the risk to be to them. Some dimensions of proximity expressed were immediacy, seriousness, and likelihood. For example, when Jackie was asked whether the swelling she had was a problem, she responded:

> Jackie: Not until I go into labor.
> I: And what's the connection between swelling and labor?
> Jackie: Because it's more of a risk to the baby when
> it's time for the baby to be delivered.

Her comments indicate two important concepts. First, she considers the swelling to be less of a risk because it does not present an immediate danger, and second, she expresses the potential seriousness of the risk in terms of the baby. Although she did mention the relationship of swelling to toxemia later in the interview, she did not indicate that the swelling was a risk to herself.

These women also defined risk through activities such as monitoring, assessing, interpreting, avoiding, minimizing, and normalizing. For example, Deidre, who was at risk for preterm birth, monitored changes in her body contour: "I got up one morning and looked at myself and I said 'my stomach is much lower,' so that kinda scared me." While Caroline monitored and assessed her contractions during her first experience of preterm labor, she attempted to minimize the risk:

> "...so I went inside and put my feet up, rested, had a glass of wine, think 'Well, maybe this will stop it,' but it didn't."

After about four hours of monitoring, Caroline interpreted the situation in this way:

> "I was having, like [contractions] every five to ten minutes, and I got home and I thought 'I'm in labor' and I was only, what, five months at the time?"

However, women who noted body change did not always consider them to be indications of risk. For example, Jackie went on to comment that her "sister had a little girl and she swelled up with her baby." Jackie recalled the immediate past of her sister's experience to verify the normalcy of her own experience. She implied that swelling was a usual discomfort of pregnancy in her family. Michelle also expressed this critical differentiation of risk when she said: "As long as my baby's healthy, I'm not going to worry about it." Joann, who had had an episode of preterm labor and had gained very little weight with this pregnancy, denied all suggestions of risk by the investigator. When asked directly if she thought her previous contractions were a problem, she stated:

> "No. Cause the way they was comin'. They was

comin' like one big one and one little one, then they stop.

When I had my other baby I knew that it wasn't the way it felt."

However, at the close of the interview, the investigator asked Joann if there was anything different about this pregnancy. She immediately responded with concern over the development of the baby:

"They took the sonogram and the baby's head was big.

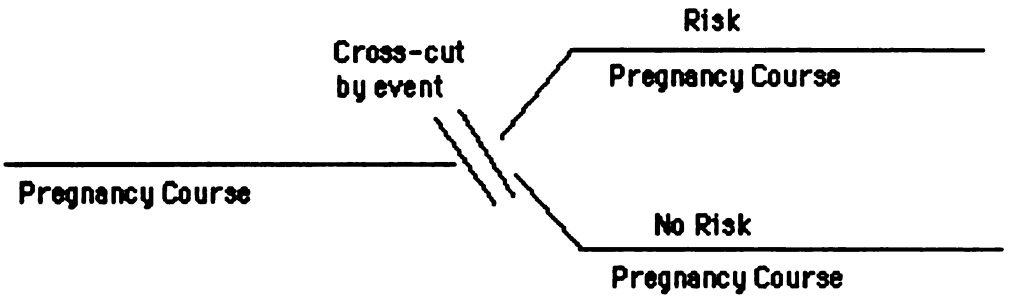
I'm like 'oh, no!'"

Several points can be taken from these discussions. First, these women relied on their own experiences and those of their immediate families to differentiate normal from abnormal or at risk. While they may have been given advice from the provider, none of them consulted a provider for help with any of these issues. Second, they all expressed fear and concern as immediate and grave if they perceived that something threatened the baby's health. These women used monitoring, assessing, interpreting, and normalizing to initially evaluate what was occurring.

At this point, the investigator categorized risk as worry, concern, or fear about something in particular. The particular event was yet to be defined, but an initial diagram, shown in Diagram 1, was drawn to explain the known relationships. This diagram shows how an event cross-cut the course of the pregnancy and resulted in Black women discussing their pregnancies as normal or risky, as problematic or not problematic.

This line of investigation split the subsequent analysis in two directions. The first was to continue to track risk to discover how it was constructed by these pregnant Black women. The other was to investigate what happens when risk cross-cuts the pregnancy course.

Diagram 1. Cross-cutting Event



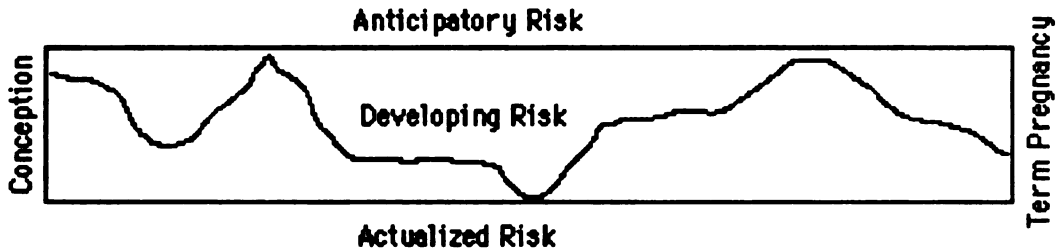
The woman's description of pregnancy became focused around an event that interrupted or altered the course of pregnancy.

The investigator continued the first inquiry by trying to discover what these women were saying about risk. To answer this, I read individual transcribed interviews again and listed each step that followed the identification of a cross-cutting event. After following several high risk interviews, a three-step pattern began to emerge. The first step was the occurrence and acknowledgement of a particular event. The woman monitored this event in an attempt to place the incident into some context based on personal experience. She also made some judgment about the proximity or relevance of the incident. If the woman judged it to be relevant or unfamiliar, she moved to step two, which was to discuss it with someone else. In all cases, the woman consulted someone with whom she had a significant relationship, either another woman in the family or a best friend. If the other woman concurred that the situation was problematic or unfamiliar, the woman proceeded to step three by contacting the provider. The provider then assumed the role of monitoring and assessing with the result that the event was legitimated as problematic or not problematic.

At this point in the analysis, risk was conceptualized as a fluctuating tension that moved throughout the pregnancy course. Risk either was not present, could be present, or was present. The pregnancy experience could be located in one of these states at any given time, but throughout the course of the pregnancy it was variably defined by the provider or

woman in any of these three ways. Analytically, the investigator conceptualized these states as anticipatory risk, developing risk, and actualized risk, as shown in Diagram 2.

Diagram 2. Risk in Pregnancy



The fluctuating tension between risk and no-risk during the course of pregnancy.

The state of anticipatory risk is the cognitive recognition of the potential for an untoward event to occur. For the provider, this state is based on the medical construction of risk as discussed in Chapter 1, which is to assign numerical values to factors in order to calculate a mathematical probability of risk. For the Black woman, anticipatory risk arises when she is aware that a problematic situation has occurred in the past, and could occur again. The state of developing risk arises when an event has occurred and the woman is going through the previously defined steps to evaluate the process. Developing risk may also be identified by the provider noticing some change in the objective measurements of the progress of pregnancy. The state of actualized risk occurs when the provider or the woman identifies the occurrence of an adverse event that immediately impacts the course of the pregnancy.

At this point, the investigator returned to the question of what happens when risk cross-cuts the pregnancy. To consider the timing of the event, this investigator diagrammed the timeline of pregnancy to evaluate risk in relation to the developmental stage of the pregnancy. The timing of the event was found to have an impact on the relevance of risk. The normal course of pregnancy is approximately 40 weeks long, plus or minus 2

weeks. There are medical consequences related to the stage of the baby's development at the time of birth; the ability of the baby to survive in an unprotected environment may be severely compromised. Women and providers both perceived grave risk to the baby if it was born at 28 weeks, whereas they perceived minimal risk if it was born at 36 weeks. Early birth also carries social consequences--the family must adjust to the potential burdens of having a premature infant, and the usual family recognitions and celebrations surrounding birth are disrupted.

The timing for when the event happened was obviously important, but what was the event? The events seemed to be either of a health or social nature. At this stage, this investigator applied the term "health" to any reference to potential or actual problematic situations that were associated with the functioning of the body. This included references to cholesterol as well as contractions. Later this category was subdivided into health risks that were experienced and those that were not, which markedly divided health risk. The majority of the women discussed various types of risk, but few experienced risk. Those women, who discussed risk, had general health concerns about losing weight, exercising, and reducing salt and fat intake, but these health concerns had little, if any, direct impact on their pregnancies. The women, who experienced risk, identified very specific health risks that had direct implications for the pregnancy experience, like having contractions, unexplainable pains, or breaking their "bag of waters."

A few women described particular social events, such as a problematic relationship with the father of the baby, that also had a profound impact on the course of their pregnancy. Those women were identified as at social risk. For example, the investigator asked each woman what she enjoyed the most and the least about being pregnant. Patrina's response to what she liked least was "Oh, a lot." The conversation continued like this:

> I: Give me some examples.
>
> Patrina: The way it changes your whole body, the way it changes you.

I: What are some of the ways?

Patrina: "Your hormones, I got sinus problems, I can't wear my clothes and all. I just feel left out, you know, and a lot of things.

Patrina also talked about being depressed because her partner left her, feeling isolated from her friends, and having suicidal feelings in the past.

The women identified both health and social risk events as having a major impact on their pregnancy experiences. For example, in response to the question "What are some of the things you've learned about being pregnant?" one woman responded: "Well, first of all, I thought it was gonna be easy, but it wasn't. It wasn't easy at all."

Findings: The Critical Moment

Those things that "weren't easy," or that were problematic, are the events that cross-cut the course of pregnancy. These events were identified as critical moments. The critical moments were moments in that women recalled them as pivotal occurrences that changed their experiences of pregnancy. The following discussion with Caroline presents a rather concise example of how pregnancy can be constructed around a primary experience:

I: I just want you to tell me about your pregnancy. How have things been going so far?

Caroline: Up until about, let's see, the first of June, it was a very uneventful pregnancy, it was very easy as a matter of fact.

I: No problems?

Caroline: No, nothing whatsoever, until, like I say, the first part of June I started having problems with the contractions. One day I was at work, and first I thought I was just having false contractions and I

just tried to dismiss it. It was no big deal, but then after about an hour of contractions I thought maybe there's something wrong here.

The critical moment was critical in that it had potentially serious consequences for the survival of the baby. The earlier the threat of birth occurred, the greater the likelihood that the baby would not survive.

Caroline was only five months pregnant when she first experienced these contractions. She was aware of the danger in the situation once she concluded that she was in labor.

Conceptual Analysis of the Critical Moment

At this point, the investigator had discovered that a critical moment was an event that presented a risk because it was identified as problematic by these pregnant Black women. The critical moment was constructed as more relevant if it was identified as a close threat and if it occurred early in the course of pregnancy. Further, these women followed the three-step process to identify the risk around this primary event.

To better understand this process, the investigator moved away from the descriptive mode toward a second level of analysis (Artinian, 1988). After reflecting on the categories that had already emerged, the basic diagram was changed to better represent the interrelationships among the categories, as shown in Diagram 3. This diagram shows the critical moment as being initiated by a precipitating event identified as a health or social risk, and as triggering a process that redefined the pregnancy experience as normal, uncertain, or abnormal.[27]

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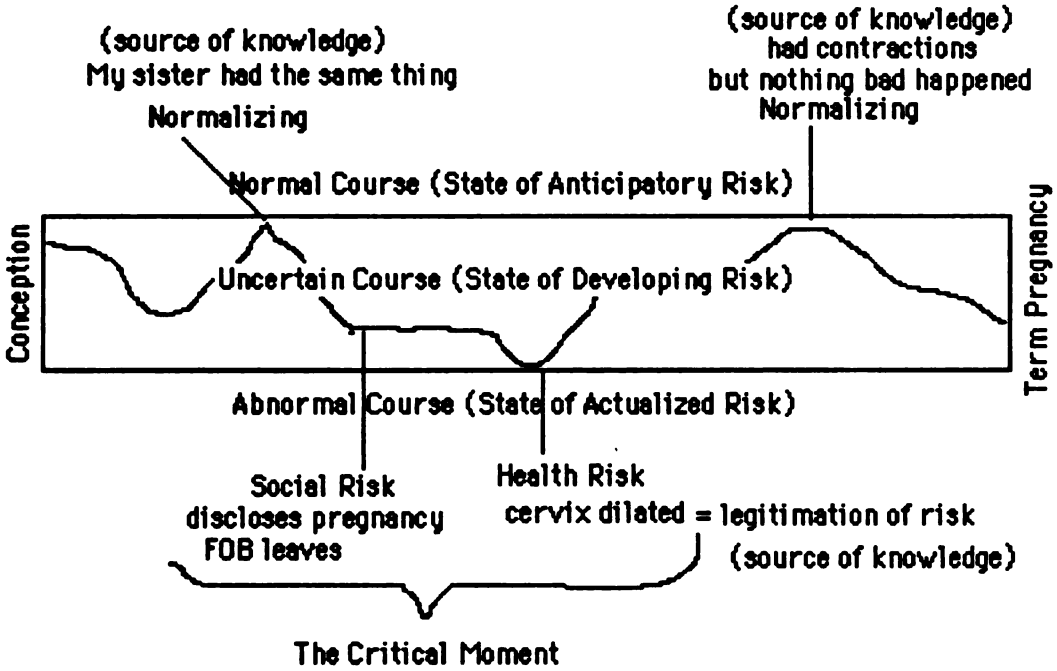
[27] At this stage in the analysis, normal and abnormal were terms that came from the medical perspective of defining the pregnancy as problematic. Later, normal was defined as a pregnancy which met the woman's expectations for a normal healthy experience, and the occurrence of unexpected events resulted in a state of uncertainty.

Diagram 3. Determination of Risk



begins process of monitoring and assessing which is interpreted as either normal, uncertain or abnormal course.

The critical moment was examined more closely as a possible core category. The investigator began axial coding around the critical moment category by returning to the steps (or subcategories) described earlier in the process of defining the situation as normal or problematic.

The initial event, which was most often described by women in terms of some bodily change, was now categorized as a biophysical phenomenon.[28] The woman monitored her bodily signs and interpreted them to have a certain meaning. This process is reflected in Caroline's description of contractions:

> "...they continued, they didn't stop. I was having, like,
>
> [contractions] every five to ten minutes and so I got home

---

[28]Early analysis referred to the description of bodily signs as health related risk which moved into the medical model of interpreting symptoms. Biophysical is a descriptor that stays within the framework of the woman's thinking, using her terms to mark the advent of the critical moment.

and I thought 'I'm in labor' and I was only five months at
the time."

This subcategory was called interpretation of biophysical signs. Other women expressed uncertainty in determining the meaning of biophysical signs. For example, the following conversation occurred after Paulette was told by the provider that her cervix had dilated and therefore she had to stay on bedrest:

Paulette: I hope it helps cause I don't understand it though.
I: Did you talk to anyone about it?
Paulette: Well I talked to my mother. She just told me to
do what the doctor says.

Paulette then attempted to find some meaning in the situation by looking for a biophysical explanation:

"Well, it [the pregnancy] was perfect then. But my. . .
I don't know, maybe I was walking too much or
something. I don't know, because I been on my feets
so much. I don't know why this happened."

Paulette's mother was not able to help her understand the situation. Her mother verified the situation as problematic by supporting the provider, rather than verifying Paulette's experience through sharing her knowledge and experience. This subcategory was called verification through interaction with significant others.

The third component of the process occurred when the woman sought the help of the provider. This is usually the last step in the process rather than the first. For example, Caroline commented that she called the provider after she had already concluded that the pregnancy was problematic:

"They [contractions] just continued so I guess at
about 8:00 I called the hospital, and he just said

'come on in.'"[29]

This subcategory was called legitimation through interaction with the provider.

This series of interactions was essential in order to transform this biophysical event into a critical moment through self-interpretation, verification, and legitimation. In Caroline's case, the provider legitimated her concern: "Your thinking is correct; this is not what should happen at this point in pregnancy. You do need to consult a professional and he or she needs to continue to monitor and assess the process." Caroline consulted a health provider who could provide more knowledge about the event than she could. Other pregnant women consulted a mother or cousin with small children who served as an "expert," providing additional information, assurance, and assistance. At a later point, the provider normalized her pregnancy experience by assessing that no irreversible changes had occurred that would have resulted in immediate delivery. However, she remains in a state of actualized risk in both the provider's assessment and in her own mind.

At the conceptual level, the analysis was still directed towards understanding how elements of experience become reconstituted to form a way of knowing, that is, how events become represented in one's thinking. Caroline had to interpret the biophysical changes she was experiencing in order to construct the experience as meaningful When she said to herself, "I'm in labor," she expressed her interpretation of her biophysical signs. This conversation with self provides a concrete example of a woman calling upon her "stock of knowledge" from her previous experience of labor (Schutz, 1967). It also provides an example of how confusing it can be when applying that experience to circumstances that are not typical or expected (Schutz, 1970). However, at each step in the process, Caroline was interpreting her experience of pregnancy in relation to information received during her interactions with others; this reflective process was then added to what she is experiencing now. When she described the pregnancy as uneventful until the first part of June, she

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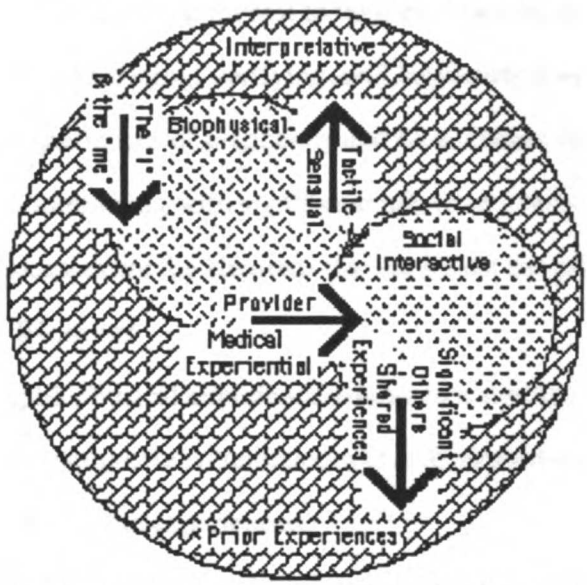
[29] This middle aged, college educated woman was the only woman in the study who did not consult the family before the provider.

expressed her way of knowing the experience of this pregnancy as filtered through critical moment. Therefore, a critical moment is an intersection of biophysical, social interactive, and interpretative events that alters the woman's experience of the pregnancy and that constitutes "a way of knowing" the experience of pregnancy.

At this point, the analysis has moved from conceptualizing the raw data to placing these concepts into a theoretical framework that consistently explains the observed phenomena. This theoretical coupling is shown in Diagram 4.

Diagram 4. The Process of the Critical Moment



Interpretation is a continuous process of defining the experience of pregnancy. The construction of the experience is based on knowledge from prior experiences, from shared experiences, and from medical experiences.

The biophysical events relate to medicine and the phenomenological experience of bodily change, the interactive events relate to social psychology and symbolic interaction, and the interpretative events relate to the phenomenological dimension of derived meaning and social psychological considerations of the emergence of self. The biophysical, interactive, and interpretative events intersect to create a "critical moment." The interactive events provide increasing amounts of input as the biophysical events become more obvious or problematic. And similarly, the interactive and interpretative events are activated

proportionately to the biophysical experience; they are equal to and interactive with each other. The critical moment has now moved analytically from a cross-cut event signaled by bodily changes to a process of defining risk that is experienced, shared and interpreted. Through this process these pregnant Black woman defined the meaning of risk and constructed the experience of their pregnancies.

The Elements of the Critical Moment

The term critical moment arose from a particular event identified by the pregnant Black women in the study as being pivotal to their experiences of pregnancy. The critical moment was a process of defining, verifying, and legitimating to account for a way of understanding their experiences of pregnancy and its attendant risk. Monitoring biophysical changes, interacting with significant others and with the provider, and interpreting these processes are the elements that constitute the critical moment.

The Biophysical Element

The initiating biophysical experience presented a condition that required action. That action was an intersubjective interaction with self, sometimes as experiencing and sometimes as reflecting on the experienced.

LaTonya captured this phenomenon when she discussed her experience of the rupture of her "bag of waters."

> "You know, it was like I went to the bathroom
> and next thing I know I'm using the bathroom
> but I'm there for so long and this water is still
> coming and I know I'd finished a long time ago.
> [I asked myself] now why is that?"

The form of the words reflecting and experiencing emphasizes Schutz's (1970) notion of the "experienced and the experiencing". LaTonya described a taken for granted situation which becomes an unexpected event of passing a large volume of water. She is

experiencing the above while continuously reflecting back in an attempt to interpret the unexpected in relation to that which is familiar.

In monitoring the experience of contractions, women drew on a network of typifications about what constitutes normal health and a normative experience of pregnancy and used expressive and interpretative schemes to think about or discuss their interpretation with others. This was possible because they had some cognition of abdominal pain as gastrointestinal cramps, menstrual cramps, or labor pains. Abdominal pain was their cognition of the experienced. It existed as a certainty, while the origin of the pain existed as a possibility or presumption. Marcella provided an example of this when she said:

> "... the pain started coming and going in waves
> and so I said "something's not right." That's all
> I kept thinking was that something is not right,
> you know, so I called my mom, you know.
> [she said] "oh! I know the thought, I sit a lot, I sit a lot.
> ...so then I thought maybe I was sittin too much..."

The experiencing is a continuous monitoring of physical sensations. Heightened awareness of those sensations leads to a specific description and differentiation based on prior experience. For example, Caroline first experienced contractions as "false contractions," but prior experience told her that false contractions did not last long. Later she states "after about an hour of contractions I thought 'Maybe there's something wrong here'."

By assessing the similarities to and differences from their prior knowledge of the experience, these women differentiated between the experienced and the experiencing. Using all of the knowledge they have assimilated about pregnancies, they labelled this experience problematic because they had not previously experienced it. Assessment consists of asking one's self questions and providing probable answers. Does this feel like

anything I've felt before? What was happening then? How is this similar or different? What did I do then? What should I do now?

Biophysical changes may provide the woman with direct information about the conditions of pregnancy, or may prompt her to seek others with whom to share, assess, and interpret these changes. These women experienced their body in a common sense way based on their prior knowledge and experience of pregnancy. When an unexpected change in their body occurred, they monitored and assessed the tactile and sensual abilities of their bodies in order to interpret the significance of bodily change. In this way the body was conceptualized in this analysis as the center of the "manipulatory zone" that constructs reality by both seeing and handling objects. (Mead, 1962:124).[30] Both Schutz and Mead focused on body movements and attitude as a means of gesturing to others. Schutz emphasized that "all other domains of social reality receive their originary legitimation in the direct experience of fellow-men" (Schutz, 1964:23). However, in addition to being the center of the manipulatory zone, the body is an object that can both emit and receive tactile and sensual signals, thereby providing a source of knowledge for the interpretation of an experience.

The Social Interactive Element

As indicated in Marcella's example, these women consulted significant others to help them interpret their experiences. Their discussions included sharing past experiences and interpreting the pregnant Black woman's bodily attitudes or movements that indicated pain or other problematic signs. This consultation moved the woman's assessment of the experience outside of direct experiencing into realm of Thou-relations (Schutz, 1964). The assessment shifts to the generalized "experience" of the other. The information the

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30 In the Philosophy of the Present, Mead (1932) discussed body as a means of constructing reality through the direct manipulation of objects. Those outside of the "manipulatory area" or beyond the sensual and tactile field become less real or distorted by distance. Schutz (1967:77) applied Mead's notion to the concept of the "world within my reach" which includes imagined and perceptible objects.

pregnant woman receives depends on how much the consulting woman can identify with the event and how well she can perceive, retain, recollect, and share what she has experienced with the pregnant woman. The pregnant woman's common-sense presentation of herself in an unexpected situation gives the other a "chance" (Schutz's emphasis) to understand her actions and her concerns (Schutz, 1967:24). To increase this "chance," each woman must postulate a "subjective interpretation of meaning" that is a way of constructing a "course of action in common-sense experience" (Schutz, 1967:25).

The interaction between the woman and provider was essentially a process of legitimation. The Black woman had already interpreted the situation as problematic. The provider now medically monitors and assesses the woman; looking for objective information that suggests agreement or disagreement with her presentation (Telles & Pollack, 1981). However, essentially this legitimation process was not technological, for as Freidson (1971:127) reminds us: "diagnosis and treatment are not biological acts..., but social acts..." that are negotiated between the patient and provider.

The provider approached the interaction from the perspective of the medical construction of a problematic pregnancy. However, the woman approached it from the perspective of pregnancy as a normal event. She projected or anticipated that her pregnancy would proceed in a taken for granted way. When that projection unraveled because of an unexpected event, she began a negotiating process with herself, significant others, and the provider to construct new meanings to the experience. This negotiating process suggests that there are typical pregnancy experiences that, if present, provide some degree of certainty about the outcome of the pregnancy, while unexpected events produce uncertainty. Since the situation is reconstructed in this social process, the fear and worry

about the uncertainty of the situation is referred to as socially defined or woman-identified risk.[31]

The woman's experience of bodily change either confirmed, denied, or expanded her own, the provider's, and others' previous knowledge base. New knowledge resulted from interactions in problematic situations (Schutz, 1970:75). The experience of the bodily change, the shared experience with the family, and the legitimation of the provider defined the pregnancy as problematic. Since relatively little knowledge about preterm birth risk is certain, this conclusion was reached by negotiation about what is known (Schutz, 1970:74). The interactions ultimately verified or legitimated the experience as normal or problematic. Social interaction provided an arena for interpreting and assigning meaning to the biophysical experience.

The Interpretative Element

Interpretation is an underlying and continuous activity during self-monitoring and assessment, verification by significant others, and legitimation by the provider. To interpret bodily signals, the woman must be attentive to the physical signs of bodily change in the Schutzian sense of being an "alert, awake observer" (Schutz, 1964:7). Women may not be aware of bodily changes or may interpret them to be normal or usual occurrences in pregnancy. This can happen when concurrent life events demand her attention, or when she lacks the knowledge that would inform her that this bodily change is problematic (Schutz, 1970). In her conception of pregnancy as a normal healthy experience, the Black woman expected discomforts to be a part of the experience and had a high tolerance for discomfort in that context. For example, swelling may be a nuisance of pregnancy or it may be an ominous sign of problems. Patrina talked about her swelling as being so uncomfortable that "it hurts to walk, you know, you can't put on no shoes...". When

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[31] The definition of risk is differentiated from the medical definition of risk which is based on the assessment of weighted factors to provide a mathematical probability for pregnancy complications.

asked if she had talked with anyone about it, she responded: "Yea, my mom. She say, you know, it's just a part of being pregnant."

In interpreting problematic situations, these pregnant Black women recognized what was known from previous experience and identified what was unknown as problematic. They interpreted bodily changes through dialogue with self and others. Interpretation then arises from the subjective experience-at-hand and from the internalized reflexiveness of the "me" in examining the situation occurring now (Mead, 1962). For example, Caroline can only know the difference between "false contractions" and true preterm labor by interpreting the present biophysical experience through the filter of her known past experience. The person she consults can only interpret from her or his subjective experience based on knowledge-at-hand about labor and the generalized knowledge of patients reports of labor.

These Black women ultimately interpreted an unexpected risk in pregnancy as relevant and pivotal to their current life situation; this risk event had a profound effect on their overall experiences of pregnancy. The expressed intensity of this experience indicates the relevance of pregnancy to the total experience of a woman's everyday life (Schutz, 1970). What she attends to depends on the situation [pregnancy] she is in and on the system of relevancies that are a function of her life plan (Toombs, 1987). As she begins to reconstitute her view of this pregnancy, she must also reconstitute her view of her role as a pregnant woman. The process of the critical moment creates a true disjuncture in the woman's self identity--a disruption of her everyday world.

Summary

The pregnancy experience emerges from the interplay between biophysical, interactive, and interpretative phenomena. The critical moment is a process of constructing that experience and is essential for defining risk and motivating action in response to risk. The interactive dimensions of the critical moment are similar to Charmaz's (1980) phenomenon of "identifying moments". Both critical moments and identifying moments

result from conditions which arouse uncertainty or a sense of losing control over the events that are occurring. Both have the potential of suddenly altering the individual's experience of a taken for granted situation and which call into question one's self identity. However, while Charmaz also considers problematic events precipitated by changes in health status, she does not discuss the contribution of the biophysical aspects to the process. Further, Charmaz (1980) discusses identifying moments as it relates to significant interactions, whereas the critical moment represents a process of coming to know your position within a situation. Social interaction is only one dimension in that process. The critical moment examines the impact of problematic health situations around the woman's interpretation of risk and uncertainty and considers all the possible responses that result from that interpretation.

The biophysical element has both a physical and phenomenological component. That is, changes occur in the body that are driven by complex hormonal physiology, while the mind continuously monitors those physical changes and recalls, reflects upon, and interprets them. The social interactive element provides an opportunity for gaining new knowledge and an objective position for the definition of the situation. What the pregnant woman shared with others about her pregnancy experience and what they verified or legitimated about her experience produced a new interpretation of her biophysical experience, of her projected pregnancy experience, and of her conception of herself as a pregnant woman. The last part of this process constitutes the interpretative element.

CHAPTER 6
FINDINGS:
SOURCES OF KNOWLEDGE

Introduction

Knowledge of pregnancy varies from person to person, and also changes for each individual woman over the years from "woman talk" overheard at her mother's knee to shared "woman talk" in her own reproductive years. Knowledge therefore includes all the meaning that pregnancy holds for each woman's predecessors and her contemporaries. Lay knowledge of pregnancy is somewhat socially standardized within ethnic, cultural, and social groups so some culturally and socially normative roles and recipes are transmitted to the Black woman as she assumes the "pregnant role." This chapter explores from whom and within what social framework Black women are informed, teach, and experience pregnancy and preterm birth risk. It also touches on who teaches this information and the context in which this teaching occurs. To capture the breadth of these interactions, the contextual framework includes the extended female family networks, significant relationships that form the broader social network, and finally health care providers.

Black Women from the East Bay

All the Black women interviewed for this study were born and raised in the East Bay, and most had not traveled farther than the 20 miles between Oakland and Richmond.[32] Ten of the seventeen women lived in an extended family situation that included

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[32] One women lived for a time with her grandmother in Northern California and another women recently moved with her husband to Stockton but maintained all of her affiliations in Oakland, including her health care. Otherwise all of the women have lived their lives in the towns that are east of and across the bay (East Bay) from San Francisco.

grandmother, mother, aunts and cousins. The remaining seven women who lived in separate households, maintained daily contact with their mother's or other women in the family. Five of the seven women lived with the father of their babies; two of them were married. The prostitute lived in a hotel for transients, and one woman lived alone with her toddler.

Social Resources

In general, the women reported having few social contacts outside of the immediate family and a best friend. Only three women attended church regularly; one woman sent her son every Sunday. None of the women saw the church as a resource, but they maintained friendships through church attendance. When Joann, who sang in the choir, was asked if she would ever go to the church for help, she expressed the general view of the group by responding, "No, you just stick with family." None of the women identified membership in other social organizations. However, the two employed married women had very active social lives. One woman worked in a chemical plant with her husband and had a strong network of friends in that setting. The other woman was active with her husband in Little League and other activities with their two sons.

Neighborhoods

A sense of neighborhood generally brings a positive feeling of belonging; informal networks cement and reinforce one's sense of being "like others." For example, Michelle lived in the neighborhood she grew up in. Her mother lived nearby and her mother-in-law lived a few doors away. She expressed this sense of neighborhood when she discussed the new house that she shared with her boyfriend.

> "...the people that are on that block have been there for years, so it's not someone moving in and moving out where you've got to watch yourself. I could go out and leave the door unlocked and walk to the store and come back and the $20.00 would still be on the dresser."

Grandmothers, Mothers, Aunts, Sisters and Cousins

Since most of the women in the study lived in extended family situations, they interacted daily with many women. These relationships provided knowledge about pregnancy, emotional support for the changes that were occurring, and modeling of how to become and act as a mother. Generally, mothers were the primary source of support, while women who were peers provided knowledge through shared experiences. Deidre expressed her appreciation for her mother's support:

> "My mother, she was a great help with both of my kids 'cause I started off young with my first one. I was 14 or 15 when I had her and my mother, even through she disapproved of it, she just went along with it and she loves her granddaughter."

Most often these Black women relied on shared experiences with other women to help them define what was normal and what was problematic in their pregnancies. Marcella provided a typical example of this when she called her cousin to discuss the "pulling in her navel:"

> "...I ask a cousin of mine, because I got a little strange feeling in my navel, and you know, I didn't know. It was really like a sharp pain. Like something on the other side was pulling my navel, and so, I didn't want to call emergency or anything like that and at first when I would feel it, I thought it was 'cause I was overdoing it. I do work about 12 hours a day. So then I just call on my cousin and asked her 'Do you remember having this pulling in your navel? What is it?' She said, 'it's just the baby growing, you know.' She's had two [babies] and I figure, I'm sure she's felt it at least once or twice."

These relationships had both positive and negative aspects. Some pregnant women had strained relationships with their mothers, so like Carla, they sought support from other women. In general, however, all the women in these networks were teachers; they shared what they heard and what they experienced. Michelle summed it up like this:

> "You know how when women get around, 'well, I had this,'
> 'my labor was this long or that long', so [I learned] mostly
> from family and friends. Everything they told me about
> pretty much came true."

Some women then base their experiences of pregnancy primarily on the actions of or interactions with others. This phenomenon seemed to apply particularly to very young women and to women without prior childbirth experience. Audra, who was nineteen years old and pregnant for the first time, provided the most striking example of defining her experience in other's terms. As she was estranged from her mother, her most reliable source of information was the aunt she lived with in her grandmother's home. Throughout the interview, she presented her responses in terms of "they say."

> I: Why didn't you want to get pregnant now?
> Audra: I don't know... People say I'm too young.
> I: What do you think about that?
> Audra: I am, and then, I ain't. Not really, 'cause I'm
> responsible.
> I: What do you think about raisin' a baby?
> Audra: They say it's hard.
> I: When you had morning sickness, did it scare you?
> A: No, it didn't scare me.
> I: Why not?
> A: Cause, when other people, when my auntie
> was pregnant, they threw up and she just told me

it was normal and that it'd go away.

Audra has not yet formulated her own thinking about her experiences. She accepts others' definitions of what constitutes a normative experience. She did not recall any particular advice from the providers, as her way of knowing is firmly entrenched in her extended family network. Throughout this study, women reported that the women in their families were the most frequent and most valued source of information about pregnancy. Family members in order of importance included mothers, sisters, cousins,[33] aunts, and grandmothers.

Folklore: Intergenerational Beliefs About Birth

Folklore emerged from this study as an important source of knowledge because of the tradition of passing birth knowledge from one generation of Black women to the next. (See Appendix E for pregnancy folklore.) Their folklore about pregnancy was primarily couched in terms of the mother-infant dyad. Almost without exception, these folk tales caution women about actions or conditions that were thought to adversely affect the physical and psychological health of the baby. Perhaps the most common warning to mothers-to-be was retold by Audra:

"My grandmother told me not to lift my arms over my head.
She said the cord will wrap around the baby's neck."

As with all knowledge, pregnancy folklore is kept alive by constant recreation; tales are repeated from generation to generation and are concretely reinforced by shared experiences. When Audra was asked if she believed the above folklore, she replied:

"Uh huh, cause my auntie just had a baby and she lifted up
a lot and they had to hurry up and make her baby come 'cause
the cord was around her neck."

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[33] Cousins are first cousins raised in the same household, usually less than two years apart, who frequently refer to each other as "sisters." Women in the study reported having babies within two years of their peer friends (sister, cousin, or best friend).

Folklore about pregnancy socialized young women into womanhood and taught them ways of acting in their social world. Folklore operates, like myths, in "a symbolic field which is based on the experiences of people in a particular community, at a particular time and place" (Campbell & Moyer, 1988:100). Myths speak metaphorically about birth and rebirth; folklore speaks concretely (Campbell & Moyer, 1988). Regardless of the academic and technological advances of modern society, folklore or folk tales remain as central to ethnic identity as ethnic cuisine.

The folklore revealed by the Black women in this study formed a basis for their understanding of normal and problematic pregnancies. Problems in pregnancy were always focused on the health of the baby and were caused by what the woman did or ate, such as the following:

> "[My grandmother] said the cord will wrap around the baby's neck. ...And she said if you scratch your stomach, you'll make the baby have a birthmark. And if you don't move around every day, the baby will stick to you."

Like ordinary actions, parts of the everyday diet were now taboo because they were too hot or acidy.

> "Oh! They told me about spicy food. You can burn the baby's eyes out if you eat something too hot, you burn the baby's eyes out, you can't be eating hot link, it's not good."

However, the two college-educated women in the study denied knowing or believing in pregnancy folklore. Caroline responded to questions about folklore in this manner:

> I: I've had some women talk about some of the folklore around pregnancy. I'm going to give you an opening line and see if you can finish it. Has anyone ever told you that you have to get up and be active when pregnant or else something will happen?

Caroline: Yea, if you didn't I think you'll get fat and you won't be very healthy.

The remaining fifteen Black women associated their actions with health problems or developmental abnormalities. This kind of common knowledge passed through folklore served to accentuate the gap in belief systems about pregnancy that exist between these Black women and their health providers.

Other Significant Relationships

Most of the time, when women referred to family, they meant biological family. However, they blurred biological relationships when discussing other women with whom they shared significant relationships. Most notably, they referred to foster mothers and stepmothers as grandmothers or mothers, and called first cousins and best friends of the same age sisters. This type of relationship is clarified in the following discussion:

Carla: My grandmother is sort of an adopted grandmother. She means more than anything to me. She was with me with my first two babies. But this one, she lives in Vallejo (a town in the next county) so it's hard for me to get there. I used to commute back and forth. Nowadays I don't make the money to do that.

I: How did you get to know her?

Carla: Actually she was a foster mother to me. I lived with her for a year when I was 15 to 16. Till just after my 16th birthday. After that I moved away from there.

Best Friends

The phrase "best friends" captured a special relationship between women who were peers. The majority of the women in this study identified one other woman with whom they shared their most intimate thoughts and feelings. This woman was usually a sister, cousin, or childhood friend. Michelle's cousin who had a 6 month old baby,

accompanied her to the prenatal visit and the interview. Michelle's comments captured the intimacy and sharing that occurs when cousins are also best friends:

> "[Indicating to cousin] She knows how I am. She can look at me and I get to the point, I think. It's not that I'm mad at her or I dislike her, but she knows when I don't want to be bothered, when I don't want anybody around. She'll say, 'Well, I'm fixing to go now.' I'll say 'O.K., see you later.' When she leaves I feel bad. I didn't want to throw the vibes off that, you know, I don't want her around, but she understands because she was pregnant. She was the same way."

Sharing experiences like this was an important way that these women maintained their connectedness. Especially for younger Black women who were making the transition from child to adult, having babies within two years of their sisters, cousins, or best friends meant that they mirrored the other's reality of the everyday world. Michelle indicated this type of relationship with her cousin when she said, "She was the same way."

Through shared experiences, these intimate relationships bound the women to mutual beliefs and expectations about pregnancy and childrearing. Audra had been with both her cousin and her best friend during their labors. She compared the two experiences and hoped for an easy experience like her cousin's:

> "[My cousin] said she couldn't sit still, she wanted to walk and walk. She was in labor for only an hour. Then her baby came. ...Not like my friend. She was really screaming, and pulling hair and poking people."

Sisters, cousins and girl friends shared two common features: they were raised together and were approximately the same age. Janice indicated this closeness when she spoke of her reliance on her "best friend:"

> I: Who's the person you feel most comfortable talking to about your pregnancy?
>
> Janice: My best friend. ...we're the same age, she's a week older than I am. She moved here when she was four and she's my next door neighbor. My older sister married her brother. ...I don't have any friends, just her. She's the only one I would say is a friend. I'm not a big group type, I just hang with maybe one or maybe two people.

For many young Black women, pregnancy and birth marked their entry into womanhood. Particularly the younger women in this study, becoming pregnant within two years of their best friends secured a continuing relationship as they both shifted their identity from teenagers to women and mothers.

The older women in the study also identified women who were best friends. However, while they may have had daily conversations with them, they seemed to rely less on them to define the experience of pregnancy. For example, Daphne expressed her reliance on a variety of sources of knowledge about pregnancy like this:

> I: Who do you think has taught the the most about pregnancy?
>
> Daphne: I really can't say because I've had a lot of input from all different people and from books and everything. I've been reading a book that I got from here and it was basically letting you know that every pregnancy is different in every aspect, whether it's the labor position, or the way you feel, or you know, something like that, and I've heard the same thing from everybody.

Caroline, the 34-year-old woman, has already been mentioned because she did not discuss her preterm labor with anyone in her family but rather contacted the provider directly. Since Caroline's mother passed away and she described her sister as "Auntie Mame," her main source of support was her husband's family. In discussing her plans for the first few weeks after the baby arrives, Caroline said:

> "My husband is planning on taking two weeks off from work to be there to help me out. ...My sister-in-law said that she'll be available. She can take off work real easy. My mother-in-law is planning on retiring soon, and she's offered to come by and help."

Husbands and Fathers

Five of the women in the study lived with the father of their babies; two of them were married. All of these women described the father as a key factor in their decision to have children. When the father of the baby lived outside of the home, contact was much more sporadic, and he was generally not regarded as a source of financial, emotional and experiential support. Appendix D, which presents profiles of the women interviewed, offers some comment on each woman's relationship with the father of her baby.

Once again, the two older, college-educated married women were atypical in their relationships with men. They both presented their relationships with their husbands as mirroring a more "traditional family" relationship. As indicated above, Caroline's husband was planning to take leave to help around the home. Caroline also was able to rely on assistance from his mother and sister. Daphne reflected on the caring and concern expressed by her husband:

> "My husband suggested that he doesn't want me to work up until my due date...so that I can have a chance to rest. He says he doesn't want me to go into labor tired."

However, the other women who had continuing relationships with the father of their babies, expressed a discrepancy between what they wanted and what they perceived they had gotten from their relationship. These women were often depressed about their life circumstances. This depression was often based on feelings of powerlessness in their relationships and confusion about what their men wanted. For example, Deidre explained that she was depressed and couldn't eat even though she knew it was not good for her pregnancy. She described "disgusting" morning sickness as her pivotal experience in pregnancy. When Deidre was asked if the morning sickness was the cause of her depression, she said:

> "No, my relationship with the father. We went through a lot of things so I guess it's, you know, a man trying to adjust that you are pregnant and you know, as far as sexual intercourse, you're not that active, you know. So its best taking him through the changes."

Deidre's partner had moved out of the house. Although she was depressed and upset, she was resigned to giving him the time and distance he needed to work through this change. However, she remained hopeful that the separation would be temporary. When Deidre was asked who she thought would be with her when she delivered, she responded: "My mother, she lives not that far away and by then me and the kids' father will be together."

Patrina also described her pregnancy around the critical moment when it was rejected by the father of the baby. She lost weight steadily and expressed suicidal feelings that concerned her mother. At the end of the interview, when Patrina was asked what she would tell her daughter was most important about pregnancy, she answered:

> "Well, one is before she gets pregnant, make sure. Well, you never know 'cause I didn't, but you know, to make sure that you and the father, you know, want this before you get pregnant.

> And um, take care of yourself, think positive and be happy. I'm saying this but I'm none of that!"

Only Marcella, who relied on her religious faith to give her strength, held a positive belief about herself in the future without her partner:

> "I just said, well only thing that's important is what I think and what I want, so fine! I would never go on through life doing something because of someone else's opinion anyway. I've only wanted to please me so now I don't live because of someone else's reactions. I don't let him dampen my happiness, so I said fine!"

Regardless of whether the relationship with the father was what these women anticipated, they all expressed the importance of having these men in their lives. No woman said she didn't care. Most women wanted more than the relationship had to offer as Patrina described:

> "I wanted to, um, get pregnant, but I didn't think it would go like, you know, like it did with me and the father and everything. It's like I'm going through it by myself. I think that's why I'm not really, you know, happy."

The absence of their men only increased their social isolation. Jackie gave one example when she talked about living far away from her family and friends while her truck driver partner was on the road:

> "Me and my fiance' stays together and he's gone most of the time. I have to get up and do a lot of things for myself, even if I don't want to, like washing clothes and going grocery shopping and stuff like that."

She was still struggling to assume the roles of wife and housekeeper, she had not yet begun to anticipate the demands that will be placed on her when she is alone with the baby.

Carla, too, found herself pregnant when the situation with her boyfriend was less than ideal. About her boyfriend, she said:

> "We weren't really close and when he found out I was pregnant, he tried to weasel his way out of it and I said 'well, you can't deny it. We've been living together and you wouldn't let me go anywhere. I mean, who else would I be with?' He finally mellowed out and accepted it."

LaTonya's relationship with her live-in partner represented more of a middle position. He was present for the birth of their last child and planned to be present for this one. She considered him a supportive and involved partner.

Health Care Providers

Since these Black woman and their providers conceive of problematic pregnancies differently, their interactions primarily involve negotiating the definition of the problem and the action to be taken (Freidson, 1970). The provider's role in defining the problem is to legitimate the situation as either problematic or not problematic (Telles & Pollack, 1981:247).[34] The provider does this by negotiating the boundaries of pregnancy norms based on medical knowledge, clinical experience, and patient report. The Black woman usually negotiates such boundaries based on her own experience of the situation and on the agreement of those who play a significant role in her life. She had generally interpreted the situation as problematic by the time she sought the care of the provider. Even Caroline who did not seek verification from others before consulting the provider, delayed seeking the provider's attention for four hours while she interpreted the situation as critical (by recalling prior experiences and assessing her self-care attempts to minimize the problem).

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[34] This does not imply that the woman and the provider have equal influence in formulating the definition as the provider has the social authority in this domain and the process itself is socially structured and controlled (Telles & Pollack, 1981). However, the woman does influence the definition through her presentation of the clinical situation. Her situation either confirms, refutes, or expands the provider's medical knowledge base concerning preterm birth risk.

When she did call the provider, he legitimated the urgency of the problem by telling her to "come right in." The provider then entered the interpretive phase of the critical moment when he monitored contractions and interpreted the electronic monitor that reads those contractions. The provider's experience with the woman's subjective description and with subjectively reading monitor tracings provided a meaningful way for her/him to know Caroline's experience. This process legitimated Caroline's interpretation that experiencing labor at five months of pregnancy was a problematic situation.

The Black women in this study sometimes did rely on the provider to define normal versus problematic pregnancy experiences. This was particularly true when the provider identified risk with which the woman had no direct experience. For example, Brenetta had been on bedrest for the past week for high blood pressure. When she was asked why she thought bedrest would help her blood pressure, she defined the experience according to the doctor's criteria, not her own:

> "Because, like, if I lay down like I'm supposed to and everything then when I come to the doctor and they say 'I see you've been laying down, it's good, your blood pressure's normal', or down, low enough, you know, to be normal."

Paulette had the same response to an incident of cervical dilation without feeling any contractions. After one week on bedrest, while waiting for her checkup, she commented:

> "I'm not really thinking about that it's still the same, I'm just thinking that it's better. That's all I want, ...if it's not better than I'm just gonna ask, you know, what does she do...?"

Both of these women were asking for the provider to declare the pregnancy "normal" again. They were not asking for a particular type of care or treatment, for information that would help their understanding about the problem. They did not perceive themselves as active participants in the process. They perceived the pregnancy to be normal and they wanted confirmation from the provider that it could be again. In this

sense, the provider participated in the social definition of pregnancy as normal or problematic. This interpretative process impacted the women's construction of the pregnancy experience. Paulette had already defined the episode of cervical dilation as the critical moment when the pregnancy became problematic. When she was asked how the pregnancy had been this far, she said:

> "Well, it was perfect then. But my, I don't know, maybe I was walking too much or something. ...I don't know why this happened."

These women's definition of risk or problematic situations seemed related to the degree of severity they perceived and the degree of bodily discomfort they experienced. Both Marcella and Caroline's experiences indicated that great degrees of discomfort are sometimes tolerated. Marcella had abdominal pain for two days before she saw the provider; Caroline had contractions for four hours. Their ability to tolerate pain delayed their seeking medical care during the critical early stages when labor could still be inhibited. Although Joann was advised of her preterm birth risk, she never reported her contractions to the provider because of her assessment:

> "... the way they was comin', they was comin' like one big one and one little one then they would stop."

Both Joann and Caroline had episodes of preterm labor. Caroline interpreted the situation as critical, while Joann concluded that it was normal. Both women had been advised by the provider to immediately report any indications of contractions, yet both delayed until they had made their own assessment of the situation.

Marcella articulated her reliance on significant others who shared the same thoughts and experiences. When she was asked who she talked to about her pregnancy, she responded:

> "Well, if I can remember the questions by the time I get in there, I'll ask [the nurse-midwife], but if not, I ask a cousin of mine..."

Given these women's tolerance for discomfort, their definition of what was critical, and their reliance on the experience and the counsel of significant others, it is not surprising that they did not regard the provider as the primary indicator of risk in pregnancy. The women most valued their similarities and intimacies with others (Belenky et al, 1986). Belenky et al (1986) noted that these qualities, which provided women with "experiences of mutuality, equality, and reciprocity," were most helpful in eventually enabling them to define themselves in relation to their everyday world.

Intimacy influenced the actions taken by these Black women in problematic situations. Their everyday world is an intersubjective world inhabited by people with whom they are connected by significant social relationships (Schutz, 1967: 218). The provider did not share in this significant social network. Therefore, the provider entered the Black woman's experience as a secondary relevancy within the broader context of her social encounters.

Summary

Within these Black women's social networks, a system of knowledge existed that was sufficiently clear "to give everyone a reasonable chance of understanding and being understood" (Schutz, 1964: 95). That knowledge correlated with the cultural group and was taken-for-granted in the absence of evidence to the contrary, which permitted minimal effort in daily interactions.[35] Following culturally prescribed "recipes" about pregnancy was possible, then, as long as the woman's social life remained stable, intergenerational knowledge was held as truth, interactions in which she engaged were familiar to others in the group, and similar schemes of interpretation were accepted and applied by all (Schutz, 1964). These conditions did exist for this group of Black women since they built their social networks in a very stable and limited geographic environment. Further, they strongly indicated their preference for their relationships with family and a few intimate

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[35] A perspective on the workings of social networks may be found in Schutz's writings on "in -groups" (see the essay on The Stranger , Schutz, 1964:91).

friends. These conditions account for their reliance on family, then significant others, and lastly the provider in the construction of the pregnancy experience and the social definition of risk.

CHAPTER 7
FINDINGS:
WAYS OF KNOWING

Introduction

The previous chapter examined the social networks surrounding the Black woman in an effort to determine their influence on the social construction of the woman's pregnancy experience. This chapter examines the Black woman's concept of pregnancy based on the meaning of her daily interpretation and anticipation of events. This is accomplished by examining how the self emerges through the cumulative import of her own experiences, the verification of the woman's experiences by others who share a common base of knowledge about pregnancy, and the legitimation of the provider. Each of these interactions is regarded as an experience that establishes, maintains or alters the woman's concept of pregnancy, and that, in turn, alters her concept of self.

Concepts of Normal vs. Problematic Pregnancies

This study sought to understand what defined a pregnancy as at risk and what defined a pregnancy as non-problematic or normal. All seventeen women in the study began their pregnancies with the belief that pregnancy was a normal healthy event.

The Women-Identified At Risk Group

Subsequently, seven women identified an event that caused them to redefine their pregnancies as at risk. Two of these women experienced labor when they knew it was "too early for the baby to come". This confirmed to them that they were at serious risk of preterm birth. Four women reported major breaks in their relationship with the father of the baby resulting in significant depression, weight loss, and minimal fetal

growth.[36] The response of these women to their social situations accentuated the potential for biophysical risk to themselves and the fetus. One woman, who was a prostitute, faced the grave uncertainty of losing custody of her baby to Child Protective Services. This situation posed considerable risk to the psychological well-being of the woman and high social and physical risk to the future of the baby.

The Provider-Identified At Risk Group

Of the seven women in the provider-identified at risk group, two identified themselves as at risk for preterm birth, two identified social risk events while perceiving the biophysical experience to be normal, and three identified the pregnancy experience as normal in all aspects. The women, who percieved the biophysical experience to be normal, frequently categorized the "health" of the pregnancy in terms of the health of the baby.

Of the ten women in the provider-identified not at risk group, seven women concurred with the provider by reporting normal, healthy pregnancy experiences. The remaining three identified social risk events which became problematic to the pregnancy. The differences in the way these women defined risk validated to this investigator that there are multiple ways of constructing the experience of the pregnancy when faced with the potential for risk to occur.

Defining Normal

When a woman said her pregnancy was normal, or she hoped for a normal pregnancy, most often she was, in fact, referring to the health of the baby. Michelle succinctly stated her position in these terms when she said "As long as the baby's healthy, I'm not going to worry about it." Daphne echoed this view when she discussed her unborn baby:

> "Everybody says 'you'll be glad when you have
> the baby.' I say, 'well, there's no hurry while

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[36] One woman reported that her mother feared she would commit suicide.

it's in me I don't have to worry about anything.
I say, 'all I have to do is eat right, you know,
kind of watch what I do, and I say, when the
baby gets here, that's a lot of worry.'"

Some women defined their experiences as normal if they were similar to their own or a significant other's prior experience. LaTonya expressed it like this: "I learned more by me by being pregnant than I would from what they were telling me." LaTonya based her assessment on the lack of any notable biophysical changes:

"I been looking for some type of sign to let me
know, but it hasn't been, you know, I been doing
just fine..."

Bolstering to Maintain Normal

Some at risk women who continued to define their pregnancies as normal did so by "bolstering" their views while negating, in some fashion, the counsel of the provider. For example, during Joann's interview she was somewhat reluctant to discuss her situation in much detail, giving one word or one line answers. Joann had an ongoing problem of low weight gain during pregnancy which exacerbated her risk of having a low birth weight baby. When she was questioned directly about her weight gain, she responded:

"As much as I eat, I don't know why. Well, I didn't gain
that much with my first one neither. I gained about ten,
twelve pounds and he weighed six pounds, six ounces."

She indicated that this experience was similar to her past experience and, in her estimation, the first baby weighed enough. Her measurement of this experience against a past experience provided a powerful basis of knowledge, especially when the baby was normal and healthy.

In an attempt to open up the conversation by letting her choose its direction, I asked if there was still any information that she would like to know. She responded, "No, I

basically think I know it all." This response connoted two messages. First, she trusted her own experience the most, and second, she distanced herself from others like "providers" to hold off the medical reality of preterm birth risk.

Brenetta was interviewed while she was resting in the clinic because her blood pressure was elevated. Since that was a known problem, I pursued the topic, hoping that she would reveal how she manages this type of pregnancy risk. We were talking about premature birth when I asked what she thought would happen if the baby was born too early. She replied:

> "I don't know. Well, my other was fine, I didn't have no problems with him, but this one I have a lot of problems..."

As she continued to talk she asserted that her blood pressure was high because her father had high blood pressure. I returned the focus to the baby by asking if she worried about the baby:

> Brenetta: Not really.
>
> I: Do you know what can happen if your blood pressure goes up to high?
>
> Brenetta: No.
>
> I: Did you ever hear the word "Toxemia?"
>
> Brenetta: Let me see... I think when I had my son they mentioned something about a seizure or something.

Despite the problems she had, she was able to define the first pregnancy as fine because the baby was fine. Brenetta did not connect her high blood pressure from her first pregnancy with her experience of this pregnancy. Whether this meaning resulted from a lack of knowledge or a rejection of these facts as relevant, Brenetta did de-emphasize the negative aspects of both pregnancies in order to construct the first pregnancy as fine and deny concern about this pregnancy.

LaTonya was also at risk for preterm birth because she ruptured her "bag of waters" early in her first pregnancy and spent weeks in the hospital before giving birth. When LaTonya was asked if she noted anything different with this pregnancy, she commented:

> "Sometimes I might not feel great in the afternoon,
> but I'd say that's normal, so I really don't, you know,
> let it get me down. I just rest for a little while and
> come here and do what I gotta do."

Later, LaTonya commented further on her experience of this pregnancy:

> "It's not that I'm not worried, I'm just, like I say,
> I'm just putting it all in God's hands because
> there's nothing really that I can do and it wouldn't
> do me any good or the baby any good to worry, you
> know. So I'm just trying to be the body and just
> make sure that I'll watch the things that I do."

LaTonya measured her pregnancy experience in three ways. First, she monitored herself for unexpected signs. Second, she interpreted the body signs she experienced as normal. Third, she indicated that pregnancy was not within her control; she was merely the carrier of new life.

These three women provide examples of how at risk women can construct the experience of pregnancy as normal when faced with the probability of problems. Their assessment and interpretation of biophysical changes was the primary determinant in defining the situation. Even LaTonya's fatalistic attitude about this pregnancy was supported by her prior experience of the spontaneous, uncontrollable rupturing of her "bag of waters." Although their discussion implied risk, none of the women directly referred to the pregnancy in relation to provider-identified risk.

This phenomenon is similar to the "bolstering" phenomenon observed by McClain (1983) who studied perceived risk in home birth vs. hospital birth. The women avoided constructing the pregnancy as at risk by rejecting the negative and emphasizing the positive (McClain, 1983, Jessop & Stein, 1985). In so doing, they normalized their pregnancies, thereby reducing the uncertainty that something could happen to the baby (Cancian, 1979).

This "bolstering" does not occur, however, when an event precipitated by the pregnancy is so devastating, intense, and immediate that the experience leaves no doubt in the woman's mind that a serious problem has occurred. Whether the problem was biophysical or social, its significance was so great that the woman felt the impact of it in every aspect of her life.

Defining Risk

Women who identified risk spoke of problematic pregnancies as difficult, trouble, worrisome and of concern. For example, when Paulette was asked what was happening with her pregnancy, she said, "Well, it's difficult now because I'm opening up right now when I'm not supposed to." She succinctly identified an unexpected biophysical change that defined the pregnancy as problematic. She based this conclusion on her previous experience of pregnancy:

> "So it's very strange for me because in my first one, didn't nothin' like this happen on me and the pregnancy went better."

The expression "happen on me" connotes an experience that was out of her control. She went on to say that the experience "...makes me feel a little scary 'cause I never had something like this before." Having no prior similar experience, Paulette recalled as best she could the explanation that the provider gave her. In this case, the provider found the cervix opening during a routine examination. Paulette translated that information to what she previously understood about her body and its reproductive functioning. This was difficult because she did not fully understand what was opening and she did not have any physical experience of that opening.

Paulette had to rely on the monitoring and assessment of the provider to inform her about risk. This situation provides an example of the phenomenological interplay between the provider and the patient in the biophysical domain. Here the provider assumed the perspective of one who is experiencing and has experienced by indicating the change that she found and the meaning it had based on her knowledge of these changes. Having no awareness of the cervical opening, Paulette had no basis for knowing the experience of this situation.

Janice, who had been on bedrest because of an episode of preterm labor, presented her interpretation of pregnancy at risk based on both her interactions with the provider and her estimate of the biophysical cause. When she was asked what she thought about being at risk with this pregnancy, she commented:

> Janice: Well, to begin with, when I did come here for the pregnancy I thought that I was due in November. Then I took the sonogram and it showed that I guess my baby wasn't what I thought it would be, as many inches or something. So I thought maybe that was the reason for this but then I started to think of why. But I haven't been having no pains or anything, but I have been getting a lot of headaches and being tired.
>
> I: What do you think could be causing [the headaches and tiredness], do you have any idea?
>
> Janice: Being on my feet too much.

Janice was attempting to sort out bits of information to construct some meaning to the situation. First she addressed the discrepancy between when she thought the baby would arrive against the baby's medically projected birth date. The sonogram indicated that the baby was less developed than Janice anticipated. She attempted to understand the cause

of this problem by examining a number of her bodily signs that might have indicated the problem. She eliminated the obvious, since there were no indications of labor. However, she listed other bodily changes (headaches and tiredness) and concluded that they might have been caused by being on her feet too much. It is unclear why she made a causal connection between being on her feet and headaches and tiredness. Perhaps this relationship reflects the general feeling of fatigue after too much activity, or perhaps it is connected with advice from the health provider that she is to "stay off her feet," a euphemism for maintaining bedrest.

Both of these women and other women at risk in the study, clearly presented the process of defining risk by assessing notable biophysical changes, by reflecting back on past experiences in an attempt to reference this experience, and by locating self-induced causes of risk.[37]

Five women defined the pregnancy as problematic while the provider did not indicate the presence of risk. All of these women defined their pregnancy as at risk because of their relationship with the father of the baby did not proceed as they had anticipated. After spending half of the interview discussing swelling, tiredness, sinus problems, etc., Patrina finally revealed her experience of the pregnancy while talking about tiredness:

> Patrina: I get tired. I think it'd be better, you know, if when
> you get pregnant and everything, you know, you go through
> your pregnancy being really happy. I think that's, and
> so I don't like being pregnant; I wasn't happy at all.
> I: You didn't plan on getting pregnant, is that the problem?
> Patrina: No, I wanted it. I wanted to, um, get pregnant
> but I didn't think, you know, when I got pregnant,
> I didn't think it would go like it did, you know,

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37 The theme of self-induced problems is seen again in the Black folklore that is passed from generation to generation. For a synopsis of folklore see Appendix D.

> me and the father and everything. It hurts me a lot
> to, you know, think about how I'm going through it
> myself and, it's kind of lonely, you know.

Patrina reported that her mother attempted to normalize the situation: "My mom say 'You're not the only one that went through a pregnancy by yourself'," but she anticipated that her experience would be different. This was not a casual relationship for her and she expected that they would continue to share the changes that were occurred as a result of the pregnancy. She projected herself into the roles of "pregnant woman" and also of "wife."

Certainty and uncertainty were both part of these Black women's risk determination process. When each woman discussed an unexpected change that occurred, she framed it around her previously expected course and outcome for the pregnancy.[38] This projection included many of the details that she imagined would occur over the next few months. When an unexpected event occurred she had to alter this projection.

Risk for these Black women centered around uncertainty aroused by an unexpected change in either the biophysical or social aspect of the pregnancy. Each woman's concept of pregnancy arose from her experience of the pregnancy but was determined by her biographical situation and the choices, decisions and projections that made up her life plan (Toombs, 1987:222). Her definition of the circumstances of the pregnancy was determined by her common sense knowledge of what was normal and what was problematic, and her anticipation of what she could and could not do about it.

Pregnancy as a Reflection of Lifeworld[39]

The Black women in this study used descriptive terms that reflected the pregnancy as a microcosm of their lifeworld. Analysis of the terms revealed three predominant

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[38] Anticipation is discussed later in this chapter as a mechanism that facilitates preparation for changing roles and identity.

[39] Lifeworld is a translation of *Lebenswelt* which is Husserl's term for expressing a "universal passive belief that is certain of itself". It is our common sense knowledge of how our world functions. It is a knowledge that unites us with all other people in a taken-for-granted way (Rogers, 1983:49).

lifeworld views: pregnancy as a miracle of life, as a basic life event, and as a major life change.

Miracle of Life

Such phrases as "it's God's will" or "if God wanted me to have this baby, then..." reflect a life view that acknowledges the power of divine intervention. Pregnancy experiences such as conception, fetal movement, and hearing the fetal heart beat were described as mysterious and wondrous events. Daphne expressed it in these terms:

> "It's amazing to see, to know that you have a little something
> living inside of you that's gonna be just like me when it comes out..."

Michelle conveyed the same feeling about pregnancy when she said:

> "It is a wonderful experience because, you know, you bringing
> in another life, you know, not just you. It's like you wouldn't
> believe that something's growing inside of you until it's actually
> here and you feel it moving, then that was the main thing
> that I liked about [being pregnant]."

Women who described their pregnancy as a miracle of life held a fatalistic view of the course of pregnancy. They often failed to take actions that might improve their experiences of pregnancy. Marcella summed up this view when she said, "Things are out of my hands, I don't worry about them."

Basic Life Event

The women who viewed pregnancy as a basic life event referred to it as a normal body function with expected discomforts. Because they expected they would experience a broad range of discomforts, they often delayed seeking medical consultation in the early stages of problematic changes. These women staunchly held the view that pregnancy was a normal event, and they demonstrated the "bolstering" phenomenon when problems did occur. Carla's tolerance of pain provides an example:

> "I think it was Thursday, I hurt all day Thursday

and I hurt all night Thursday and most of the day on
Friday, well most all the day 'cause up until five
o'clock I couldn't figure out what it was, and so,
I don't like to run [to the doctor's] just because of
a little ache, but it's totally different now, you
know, any little ache you get it checked out."

Carla thought she was being overly cautious in seeking care for "any little ache," but immediate intervention is the important factor in preventing preterm labor. Carla delyed seeking care for two days which only increased her risk of preterm birth. Whether identified by the provider as at risk or not, women who held this view tended to reject situations as problematic.

Major Life Change

However, the women who identified pregnancy as a major life change were able to change their view of pregnancy from a natural phenomenon to a problematic one. These women experienced overwhelmingly compelling events that forced them to reconstruct the experience through the process of the critical moment. The women with biophysical changes usually accepted the provider's definition of the pregnancy as problematic. Caroline took the medication after her second episode of preterm labor, but defined her own limits for bedrest:

Caroline: The second time I started having contractions
they were more severe than the first, and I said,
"I'm definitely in labor this time", so I called here.
[The midwife] did an internal exam and told me
that my uterus was definitely long and then I had
to just stay in bed.
I: How much do you actually stay in bed?
Caroline: um.

I: It's just between you and me.

Caroline: Okay, um, some days I'm better than others. Um, this has been a crazy week, so this week I have not been on very much bedrest. But I guess maybe because I've been on the [labor-suppressing] medication, I start feeling more confident and I've been up and on my feet a little bit more.

For the women who experienced significant social changes and constructed the pregnancy as problematic because of them, their interpretation was often not legitimated by the family or the provider. They were encouraged by their family to "get on with" the pregnancy when they felt immobilized by their depression, as did Patrina's mother when she told her she was "not the only one that went through a pregnancy by yourself." Depressed women were encouraged by the providers to gain weight, eat better, and not to worry. However, they emphasized the biophysical parameters of the pregnancy and usually did not acknowledge their patient's emotional experience.[40] Deidre recalled her experience in these terms:

"I was depressed for a while. I couldn't gain weight, I don't know. With this baby I just really don't have an appetite for food 'cause I can go two or three days without eating, but I know that's not good so I have to force food."

Ways of Knowing

"Ways of knowing" is a term used by this investigator to represent the difference between formal measurable knowledge and the changing social definition of the nature of

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[40] Four providers were interviewed after the patients; some were aware of the patient's depression and others were not. None of the women were referred for psychological support.

things. Ways of knowing refers to the stance a woman takes in her lifeworld that gives her both a general and particular reference to all that is occurring around her. In the broadest sense it is the backdrop, the social framework, the situational context that the individual's life is played against, or it may be thought of as a filter through which every social interaction is funnelled.

Carla's concept of how to stay healthy provided an example of how medical information is filtered through one's own understanding of the nature of things. Other people provided Carla's primary source of information about pregnancy.

> "I asked as many questions as I could and I made a lot of friends by being so inquisitive. So I am very prepared for this child."

But the relationship between the information she received and her interpretation of the functioning of her body cannot be supported by current medical knowledge. For example, Carla's explained how to make sure that she had enough blood:

> "I would rather have a lot of blood in my system than less because without a lot, it's painful....[a friend] asked me what to do about it and I said what I do is I'll make a pitcher of tea, ice cold tea and put plenty of sugar into it. I drink maybe four or five glasses of that once a day."

Carla's belief in this was unshakable, but other Black women interviewed did not think that sugar could be used to build blood. Many of the interviews indicateda significant gap between provider information and the woman's understanding of body functions.

Belief in pregnancy folklore also influenced the Black woman's way of knowing the pregnancy. In most instances, belief in this folklore was more influential than medical information that contradicted those beliefs. For example, when interviewing Audra again, I returned to a comment she had made about being on bedrest:

> I: I think the last time you said that people told you if you laid down in bed and didn't get up and move around that the

baby would stick to you. Who told you that?

Audra: My grandmother.

I: And did you believe her?

Audra: No.

I: You don't think it's true at all?

Audra: No, but I don't go laying down in bed. I always go places everyday.

This folk belief is of particular interest because it was so widespread among the women, and because it affects their response to maintaining bedrest.

Concrete vs. Abstract Thinking

When these women were asked what they would still like to know, many of them, especially those pregnant for the first time, wanted to know about pregnancy in concrete visual terms. Michelle wanted to know how the baby grows in the uterus:

"I just wish I had a camera to see exactly what is going on inside. ...I guess I would like to see an actual contraction when it happens."

Other women indicated that the best part of the pregnancy for them was "seeing the baby move"; some women requested sonograms so they could see the baby. The reality of the pregnancy depended on the experience of pregnancy and the visual experience was the most powerful and the most concrete.

Recognizing Similar Experiences

Some of these women interpreted their risk of preterm labor by identifying aspects of it that they had previous knowledge of. For example, Brenetta interpreted her problems with preterm labor around her knowledge of her father's hypertension and her experience with hypertension with this pregnancy.

Brenetta: My father has it real bad. ...Had a couple of strokes. Seem like the older I get, the more

worser, maybe my blood pressure, I don't take

any medication for it. I've stopped eating salts.

I: How old are you now?

Brenetta: Twenty-six.

Brenetta used what she knew from her family to make her current problematic situation more familiar. Her father developed hypertension when he was older and now it seemed the older she got the worse her blood pressure became. She was also familiar with methods of treating blood pressure because this was what her father did.

However, Brenetta also revealed how experiencing and having formal knowledge of something does not always result in the synthesis of new information. During the interview with Brenetta she revealed that she had high blood pressure during labor in a previous pregnancy. Because her first episode occurred during labor and this second episode occurred during her seventh month of pregnancy, she did not associate both episodes of hypertension with pregnancy:

Projecting or Internalizing Social Expectations

Some of the Black women in the study organized defined themselves as pregnant women according to the social expectations that define concrete social roles (Belenky et al, 1986:50). When Joann was asked what being pregnant meant to her, she said, "It means being a mother, a good mother." Joann went on to define the responsibilities of raising a child: "It means taking care of them, and spending time." She did not focus on the pregnancy as an experience within itself, but as the preparation for motherhood. Carla defined herself by the physical and social characteristics that she identified in her mother when she said, "I'm a breeder, just like my mother." Both Carla and Joann took on the roles of mother and propagator as defined by their socialization to those roles. This may have a positive or negative influence on self-identity. For example, although it happened many years ago, Carla still recalled with pain her mother's reaction to her first pregnancy:

"I heard her call me ugly and call me a tramp. I didn't

particularly take to that, but I accepted it."

In contrast, Daphne, who was an older woman pregnant for the first time, expressed a flexible view of herself as a pregnant woman based on the information she gathered from various sources:

> "I've been reading a book that I got from here and it was basically letting you know that every pregnancy is different in every aspect, whether it's the labor portion or the way you may feel, or you know, something like that, and I've heard that same thing from everybody. 'Well, I was this way and that was this way,' so everybody's completely different."

Daphne's life experiences were more varied than most and she had many more life successes than the poor women in this study. She had some college education, worked full-time, was married and had a very active social life. These earlier experiences helped her accept the possibility that her experience could be different from the shared experiences of others.

The Emergence of Self

Pregnancy is a reproductive turning point that is critical to the identity formation of the women in this study.[41] It is a life marker that is triggered by the capacity to reproduce, just as menarche and menopause mark stages in the adult life of a woman. The experience of pregnancy provided a lens through which these women viewed themselves. As discussed in Chapter 6, their experiences were socially defined primarily through interactions with other women during the course of the pregnancy. Audra, the youngest

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41 Turning point is a social acknowledgement of the accomplishment of natural occurrence in the life cycle (Hughes, 1970: 125). a milestone event which when reflected back upon signals some movement or shift in identity (Strauss, 1959:93).

woman in the study, emphasized the importance of these interactions when she commented on who will be at the birth:

> "My mother, I mean, my stepmother [will be with
> me], and my daddy, if he can take it [laughter].

Her comment implied that pregnancy is women's work and women have the stamina and endurance for it. Many Black women commented on this belief as they anticipated their first experience of enduring pain and discomfort. Marcella discussed a typical uncertainty around the pain of birth when she compared herself to what others have said:

> "Everyone else seemed to be much more braver than me.
> My whole thing about the pregnancy was the pain.
> Everyone telling me how they 'acted a fool' in the
> maternity room, and me thinking of an eight pounder
> or nine pounder coming out of me, you know, so I've
> been the one who's been scared."

These interactions between women determined the socially normative experience of childbirth. As Marcella implied, particular ways of acting during labor, brave, scared or foolish, were part of the rites of passage to womanhood. She also revealed her attempts to project herself into that situation by building imaginary scenarios of birth, like having a large baby. Later Marcella talked about becoming a mother and expressed her uncertainty about that new role:

> "My other fear is about how you know to be a mother.
> Everybody says it's just something that as soon as
> it's out it's like an instinct automatically. I'm like,
> 'How do you know how much pressure to put on it?'
> Everybody says it's the instinct. As soon as it pops
> out it's like "snap" you're a mother and you know

exactly what to do. I just say 'I hope so!'"

Marcella had gathered information from a variety of women in her social network, and she added each bit of information to her construction of how a woman becomes a mother. The information from others was not substantive but rather attempted to bolster her confidence by suggesting that the ability to mother was innate. Michelle also expected mothering to be instinctive when she described watching her cousin with a six month old baby:

> "By seeing her, I knew, I said, 'Well, I'm having the same thing and maybe I'd better get myself geared up. ...It's better to see than to read. I've watched her take care of him when he was sick. ...By her motherly instincts she was tuned in, so she knew."

Sometimes pregnancy meant that a woman could not assume other roles but had to continue her primary identification as a mother. Caroline, the oldest woman in the study, was confronting this conflict:

> "You know, I thought, I'm 34 years old, I did not want to have any babies at this age, you know, I thought I was definitely through. So on the one hand I was real happy and on the other hand, I was scared. I was really freaked out about having a baby because this was supposed to have been my time, you know, starting a career and all them other kind of things. But now I'm gonna kinda go backwards and have to start all over again."

She implied that there are stages in a woman's life when particular activities are appropriate. Her lifeplan had followed an expected course until now. She married, finished college, had two children, and now worked as a trainer for a large food chain. Her career was just beginning, and now she had to alter those plans and settle back into the

mothering role, because being home with her children when they were still babies was part of her expectations of mothering.

The interplay between the experience of pregnancy, their expectations of role behavior, and their concept of self was critical for all these women. In emphasizing a social psychological framework, Mead (1970) elaborated on the considerable importance of role-taking through play and games to the on-going emergence of self. For these women role-taking arises partly from watching how other women care for their babies, partly from thinking or imaging the changes they will be making, and partly from taking on the characteristics of stamina and endurance. Their preparation for pregnancy emphasizes Blumer's (1969) point that both the situational nature of pregnancy and the changing nature of individual behavior causes a constant redefining of self. As such, the process of identity development is not age bound, but rather evolves through daily interaction with self and others.

Ways in Which the Self Emerges

A woman's identity in relation to her pregnancy and the meaning of the pregnancy in relation to her everyday life was defined through many interactions with herself, with significant others, and with the provider. Most important was the dialogue with self that, through the interpretative process, imbued meaning to the situation of risk (Blumer, 1969:4). Two simultaneous activities were necessary for that interpretation. First, the Black woman had to determine what was relevant in the situation (Schutz, 1970). That is, she must point out to herself those things that have meaning in her everyday world. Second, her interpretation depended on how she handled that meaning (Blumer, 1969). That is, she reflected upon the situation and selected, checked, suspended, and regrouped the meaning in relation to her position in the situation. While interactions with others added knowledge to this interpretative process, ultimately the meaning of risk was individually constructed.

Experiential knowledge was the most powerful teacher in this process. When one of these Black women reflected upon her pregnancy, she constructed a reality that was a "reality for me" (Toombs, 1987:221). The "me" is an organized set of attitudes about pregnancy that represents all the knowledge that was filtered through the experiencing self as "I" (Mead, 1962). The "I" responded to each situation in pregnancy in a unique fashion but did so by calling on the knowledge that is a "reality for me."

Anticipatory Rehearsal[42]

Because of the concrete way they expressed themselves, these Black women quoted their dialogue with self. These vivid descriptions explicitly indicated their rehearsal for the future. Several examples of this have been given in the quotations cited previously in this chapter. For example, Caroline expressed the conflict of remaining in the mothering role when she said, "I thought, I'm 34 years old." She had anticipated that the demands of motherhood would diminish while her career would advance, but this was now changing. Michelle saw the demands that a six month old baby put on her cousin and said to herself "Maybe I better get geared up." The expression "geared up" connotes a changing momentum or a shift in orientation. She was aware that the way she was now was not appropriate for what she thought she would need in the future. This anticipatory rehearsal included many different expectations, but the references to body changes and discomforts, changes in significant relationships, fantasies about the baby, and changing roles are particularly important to this study.

Anticipatory rehearsal was revealed through dreams, participation in childbirth preparation classes, and watchful practice while other women cared for their babies. For

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[42]Terms such as anticipatory rehearsal, anticipatory socialization, or rehearsal of self all refer to "an activity of memory and imagination in which the self is the principal object." In objectifying the self, one is able to play through various imagined interactions, to reherase how those interactions might proceed, and in so doing, to project the future course of the pregnancy (Mead, 1970:137, see also Sykes, 1980 and Olesen and Whittaker, 1968).

example, Deidre attended childbirth classes not to learn technique, but to prepare her mind to anticipate labor:

> "...it's like a class to prepare you, you know, to get your mind to understand what you're gonna go through..."

Similarly, Daphne's concerns about the health of her baby where diminished when she dreamt that the baby was a healthy girl.

What the woman projected in her mind was certain to occur. However, the woman who experienced an unexpected event found that her projection of the future was interrupted, threatened, or altered in a profound way. She then attempted to reestablish some degree of certainty through the process of the critical moment.

Turning Points

Both the nature of birth and the socialized ways of acting when pregnant are turning points that influenced the everyday experience of these women (Hughes, 1971). These turning points present the conditions for new directions and choices, resulting in changes in the woman's self-identity.[43] These changes may occur slowly over the course of the pregnancy, if the pregnancy is experienced in a taken-for-granted way, or they may occur suddenly and unexpectedly causing a profound impact on the woman's identity.

Based on the perceived certainty or uncertainty of changing conditions, these turning points can be used to define four possible typologies. These four types are the not at risk pregnancy identified by the woman and the provider, the woman-normalized risk of an at risk pregnancy identified by the provider, woman-identified risk of a not at risk pregnancy identified by the provider, and the at risk pregnancy identified by the woman and the provider.

The not at risk pregnancy (anticipated normal experience) allowed the most fluid transition in self-identity to occur. In this situation, the woman, her family and the

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[43] All women in this study, at some level, choose to become a mother. The timing may not have been ideal, but the situation of becoming a mother was acceptable.

provider all agreed that the pregnancy was non-problematic (certainty), and the woman anticipated and celebrated the achievement of motherhood (certainty). She fulfilled her biophysical cycle of pregnancy and birth in a way that was within the Black culture's normative expectations of becoming a mother.

The second type was found in the woman who, despite being cautioned about risk (uncertainty), relied on her own experience and knowledge to "bolster" her interpretation that her pregnancy was normal (certainty). In the interpretive process, the woman must acknowledge, at least to herself, that there is an element of risk present. Ultimately, she choses to interpret the pregnancy as normal by emphasizing the positive aspects of the experience. For her concept of the pregnancy and her role within it to change, negative experiences of either a biophysical or social nature must occur.

The woman who expressed concern and worry about the course of her pregnancy (uncertainty) while others anticipated a healthy outcome for the pregnancy (certainty) experienced a more immediate and profound impact on herself concept. These women defined an unexpected social experience as a transforming incident that altered their imagined course of events and forced them to redefine their pregnancy experience. These women differed from the women with biophysical risk in that they did not receive support and legitimation from others and therefore viewed themselves as isolated from others. They became depressed from facing the pregnancy alone when normally it would have been socially celebrated. Sometimes the woman had been rejected by others; sometimes she turned away from other people:

> "I just don't feel like I ought to enjoy, you know, going out pregnant. Lots of people say 'You pregnant, you should go out and enjoy yourself before the baby comes,' but since I been pregnant I guess I haven't been into going out."

Perhaps the most profound impact on self-identity occurred when the woman experienced an event that directly threatened the progress of the pregnancy (uncertainty)

and the threat was affirmed by family and provider (uncertainty). The situation abruptly changed her relationships with others. The rituals surrounding birth were strained; the celebratory air was replaced with concern for the survival of the infant. Baby showers were postponed and family took on a "helping" role as Janice indicated:

> "...my kinfolks would give me a baby shower at Charley Brown's. Just a lot of things happening now. His godmother comes and gets him [her son] every weekend so he don't, I don't have any, you know, worries on the weekend or anything."

Janice began to anticipate, however, what a preterm birth would mean for the baby. She expressed this risk with a realistic view of what changes might occur:

> Janice: I don't want a early labor.
>
> I: What do you think will happen?
>
> Janice: That my baby's gonna be real small and I don't want to see no kid with no tubes in it.
>
> I: Have you seen babies like that?
>
> Janice: Yea, 'cause I had a niece that only weighed two pounds.
>
> I: And how did she do?
>
> Janice: She was in the hospital for quite some time, for like four months.

Because of her sister's experience with preterm birth, Janice was the only woman in the study who could foresee the impact of an early birth on the baby. This helped Janice to anticipate the conditions that she too could be facing.

Critical Moments

Whether caused by biophysical or social risk, divergence from the anticipated experience caused a disjuncture in Janice's self-identity that forced her to explore new or

alternative concepts of the pregnancy experience. When Janice experienced early labor, she was profoundly affected by the threat of preterm birth. She weighed the alternative concept of risk against her sister's experience and her own experience of miscarriage. Her sister's experience with preterm birth made Janice's experience somewhat normative within the family but also increased Janice's avoidance of risk. Janice's first pregnancy, which ended in miscarriage, was fraught with difficulties. She had blood transfusions following severe bleeding. Her mother disapproved of the pregnancy, so Janice moved in with her sister, who was having marital difficulties. Now Janice described herself as older, and "really ready to deal with the baby period." These social factors provided the context of the situation that made this episode of early labor particularly relevant to her and caused her to construct the event as a critical moment or transforming incident in her experience of this current risk.

Summary

As this chapter suggests, there are as many ways of knowing the experience of pregnancy as there are pregnant women. However, the ways in which the self changes as it emerges from these experiences reflect the impact of the experience for the individual woman. For instance, all the women in this study began with the view of pregnancy as a normal healthy event. Further, they all expressed some image of how they expected the pregnancy to proceed. When an unexpected event occurred, they all based their interpretations primarily on their knowledge of similar experiences. At times those experiences were personal, at other times they were shared experiences with significant others. At no time did a woman in this study base her definition of risk and her resulting experience of the pregnancy solely on the provider's identification of risk. The implications of this construction of the pregnancy experience are pursued in the next chapter.

Chapter 8

Summary and Implications of Findings

Introduction

This researcher's interest in at risk pregnant Black women began while working with the Preterm Labor Prevention Program at a prenatal clinic. The providers in the clinic initiated the program because the Black women they served had a high incidence of preterm births and seemed to have little understanding of the gravity of preterm birth. The program built upon the clinical research of risk assessment and prevention (Creasy et al, 1980).

However, knowledge of how Black women thought about their pregnancies and the attendant risks was missing from this effort. Therefore, this qualitative study was undertaken to establish some understanding of what Black women knew about pregnancy and how risk might affect their experiences of pregnancy. An interview guide was devised to avoid preconceived judgments about the way the women would respond to pregnancy. The interview guide was divided into three broad areas. The first series of questions asked what the woman knew about pregnancy. The second series asked who taught her what she knew. The third series discussed concerns or problematic situations that arose during the pregnancy.

Seventeen women, who were between their 24th and 36th week of pregnancy, were interviewed at a prenatal clinic. Initially, the women were divided into two groups; those identified by the provider as at risk for preterm birth, and a provider-identified no risk group. Seven women were assessed by the provider as at risk for preterm birth, while ten women were not considered to be at risk. Black women not at risk were included in this study to examine possible differences in how the two groups defined their pregnancy experiences. Excluded from the study were very young women under the age of 18 and women who were known substance abusers.

During the analysis of the interview's, it became obvious that the more relevant division of the group was indicated by their self-identification of pregnancy risk. Some cross-over occurred between the two groups. Two women, out of the seven identified by the provider, identified themselves to be at risk for preterm birth. Two other women, out of the seven, had significant social problems that they identified as presenting risk to their pregnancies. The remaining three did not identify themselves to be at risk because they had no experience of preterm labor. Three women, out of the provider-identified no risk group, identified significant pregnancy risk. The remaining seven women viewed their pregnancy as a normal, healthy event and, therefore, were in agreement with the provider's no risk assessment. Because the study was directed toward the discovery of the Black woman's perspective of pregnancy risk, the groups are discussed strictly in relation to how they self-identified.

Summary of Findings

Significant differences were found in the processing of the pregnancy experience between women who self-identified risk, and women who described their pregnancies as normal. All self-identified at risk Black women based their assessment first on their personal experiences of problematic situations in pregnancy, second on the verification from significant women who were family members or friends, and third on provider legitimation of a process they had already identified as problematic. However, no differences were found between the two groups in how they cared for themselves and how much they knew about pregnancy. Therefore, these at risk Black women did not appear to act in ways that would exacerbate their potential for pregnancy risk.

Although many facets of this study contribute to an understanding of how Black women experience their pregnancies, this discussion is limited to three major findings in the assessment of risk. These findings are related to how risk is determined by Black

women, who influences that knowledge, and how the interpretation of risk is internalized by the woman.

Determination of Risk

Since health care providers use the term "risk" to refer to the likelihood that problematic situations such as preterm birth will occur, this investigator has used that term throughout the study. However, risk is applied in two distinct ways: as defined by the provider and as defined by the pregnant Black woman. The provider's definition is based on an assessment of standardized, weighted factors that give a mathematical probability of the occurrence of preterm birth (Creasy et al, 1980, Gaziano et al, 1981, Papiernik, 1984). These factors are based on the patient's reproductive history and on clinical assessment of her current pregnancy status. While the patient's history is screened once early in pregnancy, clinical assessment for problematic changes continues throughout the pregnancy. Therefore, medical risk is defined as the mathematical probability that a problem will occur.

The pregnant Black women in this study defined risk as some degree of shift from certainty to uncertainty, from expected to unexpected, which was then verified by her social network of family and friends. This definition of risk is based on culturally bound knowledge of biophysical and social norms pertaining to pregnancy.

These women defined certainty as the expectation, projection, or anticipation of a pregnancy outcome based on the knowledge of past similar outcomes and on shared experiences of present outcomes. Risk, then, was defined as a situation where they experienced uncertainty, where they were unable to determine the outcome because of an unexpected shift in events (Cancian, 1979, Shalin, 1986). The women used words such as concern, worry, problem, or trouble to express their conception of risk. All of the women began with the idea that pregnancy was a normal process. For some that conception never changed; for others, it did change, and the change was precipitated by the occurrence of an unexpected event.

Three of the women who maintained the concept of pregnancy as a normal, healthy process were identified by the provider as being at risk. During the interviews, these women made no reference to this provider-identified risk, despite the information they had received from the provider. Instead, these women engaged in two activities that tended to normalize their experiences. First, they did not seem to expect past reproductive losses to directly influence this pregnancy. Second, they interpreted indications from the provider that the fetus was growing and responding appropriately to mean that the pregnancy was normal. This phenomenon is similar to the "bolstering" effect in which women reject the negative and emphasize the positive aspects of an experience (McClain, 1983).[44]

The "bolstering" effect could not be used, however, when an unexpected event occurred that was so devastating, yet intense, and immediate, that it changed the woman's definition of her pregnancy from normal to problematic. Seven women described their pregnancy experiences in terms that revealed risk determination through the process of the critical moment.

Knowledge of Risk--The Critical Moment

All seven of the women who described their pregnancies as problematic identified individuals and situations that were most important to their understanding of their pregnancy experiences. While each woman's experience included different ingredients or textures, a pattern emerged that revealed a process that was similar for all seven women. This process is referred to in this study as the critical moment. The critical moment was a moment in that a particular event became pivotal to these women's experiences of pregnancy. The critical moment was critical in that the event occurred at a point when birth would seriously compromise the survival of the baby. At the risk of simplifying a complex

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[44] The "bolstering" phenomenon was reported in a study on the perception of risk by pregnant women who were considering home birth versus hospital birth (McClain, 1983).

and dynamic process, the critical moment may be reconstructed as a process of interactions: with self, with significant family and friends, and with the provider.

The process begins with a woman monitoring and interpreting her bodily changes and continues when the woman consults significant others (and herself) for verification of her interpretation. When the woman judges the situation to be problematic, she involves the provider (and herself) in legitimating the risk. The process is completed when the pregnant woman takes action based on her interpretation of the meaning of the unexpected change constructed in this social process.

If the woman experienced "labor pains," her self-monitoring and interpretation is based on her knowledge of what is normal for pregnancy, on her tolerance for the discomfort, and on her fear of the unknown. The same process applies to problematic social situations. She measures her expectations of a "normal" relationship, i.e., family, the pain and disappointment of losing the relationship, and her fear for her and the baby's future without it. In both cases, the woman anticipates how the experience might proceed, or more specifically she places herself in the situation based on what others expect of her and the generalized or normative role she chooses for herself. However, some uncertainty exists in every new situation because of its potential to produce unexpected outcomes. The self-identified at risk woman experienced situations that were not compatible with their projections of a typical pregnancy experience. Moreover, the experiences were so problematic that the woman had to abruptly shift their identification of themselves in the pregnant role.

The uncertainty aroused by the critical moment compels the woman to seek advice from other women in her family or a "best friend." That other woman becomes part of the process of assessing and monitoring; her role is to verify whether the pregnancy is normal or problematic. The women share experiences and knowledge to interpret the situation. If

they determine it to be problematic, the other woman directs the pregnant woman to the provider.[45]

The provider now monitors and assesses the woman using medical knowledge and technology, looking for objective information that suggests the pregnancy is problematic. However, this process is essentially not a technological one, for as Freidson (1971:79) reminds us, "diagnosis and treatment are not biological acts..., but social acts..." that are negotiated between patient and provider.

While the woman is processing the critical moment, she is also continuously monitoring her bodily signs, taking in new knowledge from others, and projecting alternative courses of action (Schutz, 1970). What she attends to depends on her interpretation of the situation and on the relevance of the situation to her life plan (Toombs, 1987).

Implications of the Critical Moment

Risk and the Critical Moment

The critical moment is a process triggered by a situation that is so problematic to a pregnant Black woman that it causes her to reconstruct her expectations of the pregnancy experience. The problematic situation is an experience unfamiliar to the woman; her lack of knowledge hinders her interpretation and resolution of the problem. Therefore, the problematic event evokes a sense of risk. However, the risk is not immediately apparent but is discovered through interactions with self, significant others, and the provider.

For the purposes of this analysis, this conception of risk is defined throughout the analysis as arising from two phenomena that engage the at risk woman as she defines the meaning of the experience. The first is the experience of pregnancy as a normal, healthy

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[45] Telles and Pollack (1981) found similarly that patients define "illness" based on their experiences, while the provider's role is to legitimate or refute the presence of illness.

process that is anticipated to follow an expected course. The second is the actual experience of risk that is compared to the expected pregnancy experience. Therefore, in the analysis the researcher continuously measured risk in relation to the woman's expectations of pregnancy and the social forces relevant to both pregnancy and risk management.

The problematic situation transforms the experience of pregnancy from a normal process to a problematic one, from an anticipated healthy outcome to an uncertain one. The situation that transforms this experience may be either biophysical or social. The importance of biophysical and social risk to pregnant Black women identifies risk as a key concept for understanding the experience of an unexpected incident in one's life plan.

Turning Points

Following Hughes' (1971) analysis, pregnancy is a turning point because it is a naturally occurring transition in the course of a woman's life.[46] The expected and unexpected events that occur during pregnancy constitute the individual's experience that is, of course, defined through interactions with others. The Black women in this study expected that they would experience transitions from adolescence to adulthood, from carefree times to responsible times, from receiving mothering to providing mothering, and from emotional responses to pain to tolerance and endurance of pain. They expected transitions to occur during the nine months preceding the birth of the baby.

The progress of pregnancy is predictable to some degree which facilitates the anticipation of an expected course. The woman's expectations are organized around her social experiences, but the biophysical course is also somewhat predictable in its progress.

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[46] Turning points represent one's movement through passages or stages of life. These passages may mark natural occurring life stages, like birth, childhood, adulthood, old age, and death or refer more directly to the social rituals that acknowledge a person's advancement to or accomplishment of a life marker. (See Hughes, E.C. 1971. Cycles, Turning Points and Careers in The Sociological Eye, New Brunswick: Transaction Books.) Turning points may also be examined as critical elements in the transformation of one's identity. (See Strauss, A.L. 1959. Transformations of Identity in Mirrors and Masks, Glencoe, Il.: The Free Press. See also Goodman, E. 1979. Turning Points: How People Change through Crisis and Commitment. N.Y.: Doubleday & Co.)

For example, the woman may initially be selective about disclosing her pregnancy, but as the pregnancy progresses, her condition becomes obvious to even the most casual observer.

Like Hughes' (1971) turning points, pregnancy constitutes a rite of transition in which a commitment is made to either one's self or someone else. That commitment to an awareness of the other was always evident in these women's concern for the health of the baby. That awareness was so pervasive that, even when a woman was experiencing pregnancy complications, she would define the pregnancy as normal if all indicators acknowledged the baby as normal.

Like other life cycles, the transitions caused by pregnancy occur gradually through the course of the pregnancy. This is a time to prepare for childbirth and the attendant shifts in one's self-conception.

Transforming Incidents

For some women, however, the pregnancy experience was abruptly altered by a critical moment when they realized that they could no longer project a certain progress and outcome. The critical moment is similar to other transforming incidents in that it results from an unexpected situation, is defined through interactions with others, and ultimately alters one's identity (Strauss, 1959). However, unlike Strauss' (1959) discussion of transforming incidents, the concept of the critical moment includes a biophysical dimension that is not usually considered in the interactionist framework. Biophysical dimensions are often subsumed under the process of interpretation that occurs in a dialogue with self.[47] However, the data suggest that biophysical signals are manifestations of the body that provide tactile and sensual dimensions of knowledge; the body sends and the mind receives and interprets. Further, when transforming incidents are examined within the spectrum of health and illness, the body must be considered as the source of a transforming incident.

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[47] See Blumer (1969:5) for a summary of the process of interpretation within the interactionist's framework.

As with a broken leg or a heart attack, the event may strike with sudden and intense impact. Both events result in a sudden shift in the person's experience of their everyday world. The man/woman with a broken leg makes a short term transition from healthy, mobile individual to approximately 6 weeks of hindered mobility. This event may or may not have a long-term impact on his/her self-concept. On the other hand, the man/woman with a heart attack faces sudden and permanent alterations in his/her social roles and responsibilities with an equally profound effect on his/her self-concept.

The critical moment is a transforming incident because it is an unexpected event that suddenly shifts the woman from her taken-for-granted knowledge of the pregnancy experience to an unknown position. The critical moment alters the woman's experience of conception and birth as a natural cycle. Because the critical moment is socially defined, the woman views risk as an interruption to the usual social relations surrounding birth; for example, it may require suspending the baby shower or shifting household responsibilities from the woman to other family members. This new position of uncertainty causes her to suspend, check, and transform the meaning of her pregnancy experience and to reconstitute her position in relation to it.

The Emergence of Self Through the Critical Moment

All turning points alter one's conception of self. However, within the experience of turning points (the pregnancy), transforming incidents (the experience of risk) can occur which follow Strauss' (1959) description of events that strike "with great impact." Strauss (1959) examined transforming incidents as unexpected events that caused an abrupt shift in one's identity. The women who anticipated and experienced normal, healthy pregnancies became mothers slowly over nine months of gradual change. The women who identified pregnancy risk, however, experienced an abrupt change similar to Strauss' transforming incidents. This investigator speculates that such an impact may strike with varying degrees of intensity as demonstrated by the women who had some awareness of risk but

"bolstered" their concept of a normal pregnancy with no apparent change in their self-conceptions.

The normal course of pregnancy is a turning point consisting of experiences that are normative for the culture, are anticipated and shared, and are celebrated by the larger social network. Through the interactions that inform, condone, and support, the woman makes the transition to motherhood: she assumes the responsibilities of her new status, she extends her family to include her partner's family, and she forms a dyadic relationship with the baby or triadic relationship with the father and baby.

However, when the pregnancy becomes problematic, the woman's conception of when and how she will become a mother shifts abruptly. She must now address conditions that she did not anticipate as part of the experience. The phenomenological construction of this experience is similar to the experience of "identifying moments" (Charmaz, 1980). Charmaz (1980) discussed "identifying moments" as arising from situations where individuals sense a loss of control, or as in pregnancy, face an uncertain future. Critical moments and identifying moments present conditions which cause the woman to alter her relationship to her current circumstances in such a way as to assume a previously unforeseen identity. Through her interactions with others, she begins to redefine, add new knowledge to, and understand the experience as it is now.[48]

To sort through all the potential scenarios, the pregnant Black woman must construct new meanings for her experience by expanding her understanding of the situation. This learning process is the process of the critical moment, which involves interaction with self and others and her intersubjective interpretation.[49]

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[48] This notion emphasizes the phenomenology of experience- while standing in the position of anticipating a normal pregnancy, the woman is constantly reflecting back on past experience to define the meaning of the experience to herself. At any moment, the pregnancy experience can change. There is a lag between what she is experiencing now and her reconstruction of the experience. What is occurring in the interim is a definition of the experience from interaction with self and others. (Schutz, 1970)

[49] This approach combines both Mead's and Schutz's contributions to the interpretation of meaning, or in a broader sense, the construction of reality. (See Schutz, A. 1967.

The Critical Moment Model

The construction of meaning and the definition of self can be traced through the process of the critical moment. Therefore, this concept provides an alternative to the psychoanalytic model for examining issues of becoming and being a mother. To date, psychoanalytic principles have predominated the analysis of mothering issues.[50] However, the psychoanalytic model is narrowly introsubjective in failing to examine the social contributions of interactions with others in defining meaningful pregnancy experiences. Further, the psychoanalytic model has little explanatory power when examining the sequelae of the critical moment as new knowledge about pregnancy becomes integrated in the self.

This study of pregnancy risk contributes to a small but growing literature on the sociological analysis of the pregnancy experience.[51] In particular, the sociological model of the critical moment contributes structural, interactional, and phenomenological understandings of the process of becoming a mother.

Structural contributions

Structurally, the concept of the critical moment includes the somewhat institutionalized social rites associated with birth. The social rites may be celebratory such as the gathering of family and friends at the baby shower or christening, or supportive such as the changes occurring in the family configuration in response to a problematic situation. Structural considerations also include the health care system that imposes its definition of risk on the culturally normative experience of these women.

The Reality of the World of Daily Life in Collected Papers Vol I: the Problem of Social Reality, p. 210. See also Mead, G.H. 1934. Mind, II. Meaning in Mind, Self & Society, p.75.)

[50] For examples of psychoanalytic measures of and responses to stress in pregnancy see Mercer et al. 1988, Norbeck & Tilden, 1983, Nuckolls et al, 1972.

[51] See Oakley, 1985, Boone, 1985, and McBride, 1982.

Interactive contributions

The critical moment provides another form of transforming incident that the interactionist can use to examine the influence of problematic situations on a natural life process. By examining critical moments, the interactionist can begin to identify those conditions that determine the action one takes in a problematic situation. The element of risk can be followed through the processing of the critical moment to identify the social determinants of risk-taking rather than deducing meaning from observed behavior. While the focus remains on the social encounters that help the individual to define and reconstitute the experience and herself in relation to it, the critical moment can also be divided into its component parts to reveal this process. It can be used to answer such questions as: Who is consulted? How does verification and legitimation occur? Does this constitute new knowledge? Does this knowledge facilitate the individual's transition in identity?

Phenomenological contributions

Phenomenologically, the critical moment is a continually changing process that takes meaning from the individual's previous and present knowledge, and is redefined through social interaction. However, both changes in both bodily signs and social relationships can transform the woman's experience from normal to risky. In its application to health and illness, the critical moment combines biophysical changes with the interactive dimensions of self and others to provide the knowledge that is needed to interpret the situation and give it meaning.

Future Studies

Substantive Issues

The cultural influences on the determination of risk suggested in this study were derived from a group of Black women residing in the urban communities east of San Francisco. The processes that they revealed in discussing risk in relation to their pregnancy experiences may be processes that generally occur with at risk pregnant women. However,

significant variations may exist in social support, the role of the provider, and the role of the partner. The influence of culture on the definition of risk should be explored by replicating this study with at risk pregnant women from different cultural groups. Knowledge of other ways of constructing the experience of pregnancy and its attendant risk would contribute to our understanding of those cultures.

Despite the small sample size, the results of this study suggest differences between very young Black women and women over the age of 25, between college-educated working Black women and poor unemployed women, and between Black women pregnant for the first time and those who have children. To substantiate these differences, risk in pregnancy should be examined in comparison groups differing in education, income and birth experience.

Even though this study based its definition of risk on the medical definition of statistical probability, in the real world of patient-provider interactions, the provider also processes his or her definition of preterm birth risk. The pilot interviews conducted with the providers of these Black women suggested some factors that influence this decision. These factors are daily exposure to women experiencing preterm birth, shared experiences with colleagues, peer pressure to adopt common approaches to practice, and liability issues governing practice. A larger study of providers would be useful to examine the role that these and other factors play in the management of the preterm birth patient.

Particularly relevant to this study are the differences found between the medical identification of risk and the Black woman's identification of risk. This finding suggests that further studies explore the "patient's" construction of "medical" problems in order to discover alternative perspective's to health and illness. In order to accomplish this, the researcher must demedicalize health issues by examining them within broader social frameworks, rather than from within the medical framework.

The critical moment provides a method for examining both adverse biophysical and adverse social conditions as they influence the woman's socialization to motherhood. The

concept of the critical moment can be applied to the broader issue of reproductive loss among Black women in seeking to understand how that loss impacts a woman's self-concept in relation to her identity as "fertile woman," "good partner," and "successful mother."

Theoretical Issues

Further examination of situations precipitated by critical moments would substantiate the importance of a dramatic event as a transforming incident in one's life plan. In particular, further research should address the possible variations in the forms of transforming incidents, with some analysis of the differences between and similarities among them. For example, critical moments occur when people are suddenly confronted with unexpected events that they must accommodate in their life plans. This situation occurs for the man or woman who wins the lottery and for the young soldier who goes into combat.

Winning the lottery is a jubilant occasion; nevertheless, the everyday life of the winner is totally disrupted. He/she must shift his/her self-conception from worker to independent entrepreneur. He/she comes to know the magnitude of the transition through the series of interactions that begin when he redeems his/her ticket, including the legal procedures that legitimate his/her new status. He/she receives a flurry of attention both from significant others and from strangers. He/she is besieged by petitions for favors as a person of wealth that he/she is becoming, not the person that he/she was. The transition is abrupt and difficult; he/she is an overnight success.

The young man who is transferred to combat also experiences an abrupt transition triggered by being "shipped out." During his six weeks in training, he is the farmer's son being drilled on the proper attitude for soldiering. This turning point to manhood presents many of the conditions faced in other life cycle transitions; the first move away from home, and the acknowledgement of responsibility and independence. A comradery develops that substitutes new relationships for family and significant others from "back home." Then

with only one week's notice, he is in combat, fighting and seeing death around him. Once again the situation changes abruptly, and the soldier is compelled to respond in order to survive. He will monitor, assess, and interpret the conditions of combat as he experiences them and as he comes to know them through his interactions with others.

The model of the critical moment identifies two types of situations that influence the emergence of identity. One situation, a turning point, occurs in the normal course of everyday life, while the second, a transforming incident, occurs in problematic situations. Therefore, the model of the critical moment could be used as a framework to examine other identity issues that are complicated by unexpected events, for example, the woman who learns she is pregnant in her first semester of college. In this case, college is the turning point and the pregnancy is the transforming incident that calls forth the process of the critical moment.

Pregnancy presents a particular type of critical moment because of the temporal boundaries of the gestational period. The reality of pregnancy is noted with fetal movement at a certain period; abortion must be decided within the initial weeks; birth occurs early, on time, or late. However, war is a timeless event for the soldier in combat, and the winning the lottery is not bounded by time. Further study is required to examine the question of whether the processing of self-conceptions is altered when time constraints are placed on the individual.

Conclusion

> "Prematurity is basically not a medical problem. It's a social problem with medical consequences." Rae K. Grad, Executive Director, National Commission to Prevent Infant Mortality

This study revealed the process of the critical moment--a dynamic interplay between biophysical changes, patterns of social interaction, and intersubjective reflection. When these elements are combined, they provide a model for how Black women construct their

experiences of pregnancy. These woman interpreted risk for themselves, whether or not that risk was legitimated by the provider. These findings stress the significant role of sharing between Black women in perpetuating their culture's normative expectations concerning pregnancy.

The relevance of the information was determined, not by the content or logic of the information, but by the women who provided the information. The experience of change was the strongest factor in the woman's definition of risk, but the shared experiences of other Black women was also a strong determinant. Shared experience implies an intimate and reciprocal relationship. It also emphasizes the importance of the experiential component of knowledge.

Perhaps the most crucial finding in this study was the recognition of the critical moment, which abruptly changes the woman's definition of her pregnancy from a normal event to a problematic one. The critical moment was the turning point in the woman's experience of the pregnancy and in her conception of herself in relation to the problem. The processing of the critical moment resulted in the interpretation of the situation as problematic and placed the woman in a position for action.

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APPENDIX A

Form 1. Creasy Risk Assessment Tool

Form 2. UCSF Modified Risk Assessment Tool

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These consist of pages:

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U·M·I

Form 1. Creasy Risk Assessment Tool

Scoring System to Determine the Risk of Preterm Delivery[a]

Points	Socioeconomic Status	History	Life Style	Current Pregnancy
1	2 children at home Low socioeconomic status[b]	1 first-trimester abortion Less than 1 year since last birth	Work outside home	
2	Younger than 20 years Older than 40 years Single parent Low socioeconomic status[b]	2 first-trimester abortions	More than 10 cigarettes per day	Less than 10 lbs gain by 26 weeks' gestation Albuminuria Hypertension Bacteriuria
3	Low socioeconomic status[b] Shorter than 5 ft Lighter than 100 lbs	3 or more first-trimester abortions	Heavy work Long tiring commute	Fibroids Breech at 32 weeks Weight loss of 5 lbs Febrile illness Head engaged at 32-34 weeks
4	Younger than 18 years	Pyelonephritis		Metrorrhagia after 12 weeks' gestation Effacement > 40% Dilation Uterine irritability
5		Cone biopsy Uterine anomaly 1 second-trimester abortion DES exposure		Placenta previa Hydramnios
10		Preterm delivery 2 or more second-trimester abortions Preterm labor		Twins Abdominal surgery

[a]Score is computed by addition of the number of points given any item. 0-5 = low risk; 6-9 = medium risk; 10 = high risk.
[b]Points of 1, 2, and 3 for socioeconomic status are determined by the following criteria:

	Expectant Father's Occupation	Pregnant Woman's Educational Background
Score 1: Items A or C.	A: semiskilled laborer laborer student	C: grades 10-12
Score 2: Items B or D, or A + C.		
Score 3: Items A + D, or B + C, or B + D.	B: farm laborer unemployed	D: less than 10 years

Note. Adapted from "Prevention of Preterm Birth" by R. Creasy & M. Herron, *Seminars in Perinatalogy,* 1981, *5,* 295-302. Copyright 198 by Grune and Stratton. Reprinted by permission.

Form 2. UCSF Modified Risk Assessment Tool

PTL SCREEN	1ST VISIT	RESCREEN
JOR FACTORS		
vious PTL with or without preterm delivery		
S daughter		
ne biopsy		
d trimester abortions, 2 or more		
erine anomalies		
Current pregnancy		
ltiple gestation		
aced or dilated cervix (⟨ 1cm long or dil.) 1cm int. os)		
dominal surgery after 18 weeks		
clage		
dramnios		
NOR FACTORS		
roids		
Current pregnancy		
itable Uterus		
eding after 12 weeks		
brile Illness		
IY MAJOR AND/OR 2 MINORS: REFER TO PTL CLINIC AT 20 WEEKS OR WHEN DETECTED		

ET: Nutrition Risk Factors

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UCSF Obstetrical Clinic

Modified Creasy Risk Screening

?

timate of Diet Quality (Circle) Excellent Good Fair Poor

umber	PROBLEM LIST	
# 1	Health Maintenance a. Prenatal	Date Resolved

PRENATAL MEDICATIONS

Multivitamins DATE	Iron DATE	Calcium DATE	Other DATE

APPENDIX B

Recognizing Preterm Labor

What Should You Do...

If you think you are having uterine contractions or any of the other signs and symptoms of premature labor:

1. *Lie down* tilted towards your side. Place a pillow at your back for support.
   —Sometimes lying down for an hour may slow down or stop the signs and symptoms
   —Do not lie flat on your back, because lying flat may cause the contractions to occur more often
   —Do not turn completely on your side because you may not be able to feel the contractions

2. *Check for contractions* for one hour.
   —To tell how often contractions are occurring, check the minutes that elapse from the beginning of one contraction to the beginning of the next.

3. *Call* your doctor, clinic or delivery room, or go to the hospital *if*

- you have uterine contractions every ten minutes or more often for one hour (more than five contractions in one hour)

  or

- you have any of the other signs and symptoms for one hour

  or

- you have any spotting or leaking of fluid from your vagina

REMEMBER Uterine contractions that happen every ten minutes or more often for one hour may cause the cervix to open

REMEMBER Do not wait for signs and symptoms to disappear. The symptoms may not go away, and waiting to call for help could result in the birth of a premature baby

REMEMBER Medication is available to help stop premature labor *if it is recognized early!*

Written by Marie Herron, R.N.

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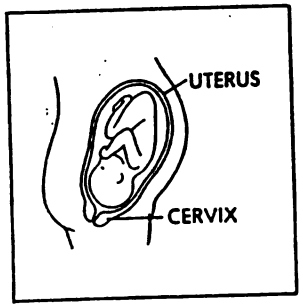
RECOGNIZING PREMATURE LABOR MAY PREVENT A PREMATURE BIRTH

PREMATURE LABOR

A term pregnancy takes about 40 weeks to complete. Babies born before 37 weeks may have problems breathing, eating and keeping warm.

Definition: Premature labor occurs after the 20th week but before the 37th week of pregnancy. It is a condition in which uterine contractions (tightenings of the womb) cause the cervix (mouth of the womb) to open earlier than normal. It could result in the birth of a premature baby.

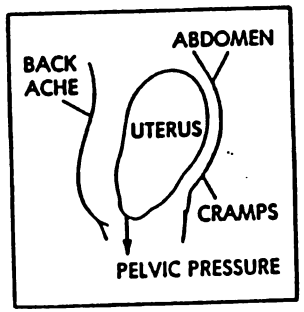


Cause: Although certain factors or reasons may increase a woman's chances of having premature labor, such as carrying twins, the specific cause or causes of premature labor are not known. Sometimes a woman may have premature labor for no apparent reason.

Prevention: It may be possible to prevent a premature birth by knowing the warning signs of premature labor and by seeking care early if these warning signs should occur.

Warning Signs and Symptoms

- *uterine contractions* that happen every ten minutes or more often, with or without any other warning sign
- *menstrual-like cramps* felt in lower abdomen. May come and go or be constant
- *low dull backache* felt below the waistline. May come and go or be constant
- *pelvic pressure* feels like baby is pushing down. Pressure comes and goes
- *abdominal cramping* with or without diarrhea
- *increase or change in vaginal discharge*. More vaginal discharge than usual, or change into a mucousy, watery or light bloody discharge



Uterine Contractions

It is *normal* to have some uterine contractions throughout the day. They usually occur when a woman changes positions, such as from sitting to lying down.

It is *not normal* to have frequent uterine contractions (every ten minutes or more often for one hour.) Frequent uterine contractions or tightenings may cause the cervix to begin to open.

Self-Detection of Uterine Contractions

Since the onset of premature labor is very subtle and often hard to recognize, it is important to know how to feel your abdomen for uterine contractions. You can feel for contractions this way:

1. While lying down, place your fingertips on the top of your uterus like this—

2. A contraction is the periodic "tightening" or "hardening" of your uterus. If your uterus is contracting, you will actually feel your abdomen get tight or hard, and then feel it relax or soften when the contraction is over.

APPENDIX C

Interview Guride

Consent Form

Experimental Patient's Bill of Rights

INTERVIEW GUIDE

INTRODUCTION: I will spend some time in casual talk in order to get to know a little about this woman and give her an opportunity to get a measure of me. Before beginning the interview I will stress the following:

I will ask a series of questions that are meant to help you think about this pregnancy. I would like you to talk as much as you like about each topic. As we discussed before, this information is not shared with anyone who works at this clinic, nor is your name identified with this tape, so please speak freely.

(The topic headings are for academic use only)

ABOUT PREGNANCY KNOWLEDGE

1. WHO HAS TAUGHT YOU THE MOST ABOUT PREGNANCY?
2. WHO ELSE HAVE YOU LEARNED ABOUT PREGNANCY FROM?
3. DO PEOPLE TALK TO YOU ABOUT PREGNANCY IN A NEGATIVE OR POSITIVE, HAPPY OR SAD, SCARY OR BRAVE WAY?
4. DO YOU FEEL YOU KNOW WHAT YOU WANT ABOUT YOUR PREGNANCY?
5. WHAT DO YOU THINK IS THE MOST IMPORTANT THING TO KNOW ABOUT BEING PREGNANT?
6. WHAT IS THE LEAST CONCERN TO YOU ABOUT THIS PREGNANCY?
7. WHAT INFORMATION WOULD YOU LIKE TO KNOW?
8. WHAT DOES BEING PREGNANT MEAN TO YOU?
9. DID YOU PLAN TO GET PREGNANT WHEN YOU DID?
10. WHAT HAVE YOU ENJOYED THE MOST ABOUT THIS PREGNANT?
11. WHAT HAVE YOU EJNOYED THE LEAST?
12. WHAT DOES GIVING BIRTH TO A BABY MEAN TO YOU?
13. HAVE YOU THOUGHT ABOUT WHAT YOUR LABOR AND DELIVERY MIGHT BE LIKE?

14. WHAT DOES RAISING A BABY MEAN TO YOU?

ABOUT SOCIAL SUPPORT

15. WHO WILL HELP YOU WITH THE BABY WHEN YOU COME HOME?

16. WILL YOU BE GOING TO WORK AFTER YOU DELIVER THE BABY?

17. DID YOU DISCUSS YOUR PREGNANCY WITH ANYONE?

18. DID THEY GIVE YOU ANY ADVICE?

19. DID YOU FOLLOW THEIR ADVICE? WHY OR WHY NOT.

20. DID YOU FELL YOU NEEDED MORE THAN ADVICE?

21. DID ANYONE GIVE YOU HELP, RATHER THAN ADVICE?

22. WHERE WOULD YOU GO IF YOU NEEDED HELP WITH FINDING A PLACE TO LIVE (WHO COULD YOU COUNT ON)?

23. WHO COULD YOU COUNT ON TO GIVE YOU MONEY, IF YOU NEEDED IT?

24. DO YOU GO TO CHURCH REGULARLY? IF YES, HOW DO YOU THINK THE CHURCH CAN HELP YOU WITH THIS PREGNANCY?

25. DO YOU BELONG TO ANY GROUPS? DO YOU DISCUSS YOUR PREGNANCY WITH ANYONE IN THIS GROUP?

26 WHO ARE THE PEOPLE THAT YOU SEE DAY IN AND DAY OUT?

27. DESCRIBE AN AVERAGE DAY FROM THE TIME YOU GET UP UNTIL YOU GO TO BED.

ABOUT RISK:

28. WHEN YOU HEAR THE WORD "RISK", WHAT DO YOU THINK OF?

IF THEY MENTION CHANCE, ASK IF THEY THINK ABOUT THE ODDS OF A SOMETHING HAPPENING.

29. GIVE ME AN EXAMPLE OF RISK? (What gives people "trouble"?)

30. ARE THERE CURRENTLY ANY RISKS IN YOUR LIFE? (What are the things that "trouble" you?) PLEASE TELL ME ABOUT THEM.

31. WHAT DID YOU DO OR WILL YOU DO ABOUT (use examples from above list of patient identified risk)?

ABOUT PREGNANCY RISK

32. HOW IS THIS PREGNANCY GOING FOR YOU?

33. DO YOU CONSIDER THIS PREGNANCY TO BE "A NORMAL PREGNANCY"? WHAT DO YOU MEAN BY NORMAL?

34. HAVE YOU BEEN CONCERNED ABOUT ANYTHING IN PARTICULAR WITH THIS PREGNANCY? (Has this pregnancy been trouble for you?) PLEASE EXPLAIN.

35. WHAT HAS GONE WELL FOR YOU DURING THIS PREGNANCY?

36. HAVE YOU HAD ANY PROBLEMS? IF SO, WHAT PROBLEMS?

37. HOW DID YOU KNOW THAT THIS WAS A PROBLEM?

38. HAS THE DOCTOR TALKED ABOUT ANY CHANCES OF HAVING TROUBLE WITH THIS PREGNANCY? TELL ME ABOUT IT.

39. WHAT DID YOU OR CAN YOU DO ABOUT THIS PROBLEM?

40. HAVE YOU HAD TROUBLE WITH PREGNANCIES BEFORE? TELL ME ABOUT IT.

41. WHAT DO YOU THINK CAUSED THOSE PROBLEMS?

CLOSE THE INTERVIEW WITH APPRECIATION FOR HER HELP AND REASSURANCE THAT HER NAME WILL NOT BE ASSOCIATED WITH ANY OF THE STUDY.

University of California, San Francisco
Department of Social and Behavioral Sciences
CONSENT TO BE A RESEARCH SUBJECT

Purpose

KATHRYN PATTERSON, a doctoral student, is conducting a study on the understanding of pregnancy and pregnancy risk. Since I am pregnant and attending this service for prenatal care, I am invited to participate in this study.

Procedure

If I agree to be in this study, I will be interviewed for approximately one hour. The interview will be scheduled to follow my regular prenatal visit at the clinic, or at a place and time of my choice. The interview will be tape recorded for the purpose of recalling the conversation at a later time.

Risks

Confidentiality: The researcher will know who I am. However on the taped interview, only first names will be used. The tape recording will be destroyed as soon as the analysis is completed. No identification of names is necessary for the analysis of the study or report of the findings.

Benefits

There will be no direct benefit to me from my participation in this study. The information may help patients in the future with their pregnancy if the study demonstrates clinical usefulness.

Questions

I have talked with Kathryn Patterson and my questions were answered. If I have other questions, I may call Ms. Patterson or her advisor, Dr. Virginia Olesen at 476-2453.

Consent

I have been given this form and the Experimental Subject's Bill of Rights to keep. I have a right to refuse to participate or to stop at any time without change to my pregnancy care. If I agree to be interviewed, I should sign this form.

_____	_____
Subject's signature	Date
_____	_____
Person Obtaining Consent	Date

5/23/88
H971-03297-01

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to be in a research study. As an experimental subject I have the following rights:

1) **To be told what the study is trying to find out,**

2) **To be told what will happen to me and whether any of the procedures, drugs, or devices is different from what would be used in standard practice,**

3) **To be told about the frequent and/or important risks, side effects or discomforts of the things that will happen to me for research purposes,**

4) **To be told if I can expect any benefit from participating, and, if so, what the benefit might be,**

5) **To be told the other choices I have and how they may be better or worse than being in the study,**

6) **To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study,**

7) **To be told what sort of medical treatment is available if any complications arise,**

8) **To refuse to participate at all or to change my mind about participation after the study is started. This decision will not affect my right to receive the care I would receive if I were not in the study.**

9) **To receive a copy of the signed and dated consent form,**

10) **To be free of pressure when considering whether I wish to agree to be in the study.**

If I have other questions I should ask the researcher or the research assistant. In addition, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the committee office by calling: (415) 476-1814 from 8:00 AM to 5:00 PM, Monday to Friday, or by writing to the Committee on Human Research, University of California, San Francisco, CA 94143.

Call 476-1814 for information on translations.

APPENDIX D

Demographic and Social Profile

Profiles of Pregnant Black Women

The women interviewed are listed alphabetically by first names for easy cross reference with the text.

Althea is a no risk18 year old Black woman who was 25 weeks at the time of the interview. She has had one previous abortion before this pregnancy. She seems very immature in her behavior but listens to her sister who is 10 years older for advise on what to do during this pregnancy. She misses many prenatal appointments and does not relate well with any of the providers.

Audra is a no risk 19 year old Black woman who was 27 weeks at the time of the interview. This is her first pregnancy. She lives with her grandmother, auntie, uncle, brothers and sisters and cousins. Her mother is an addict and is estranged from the family although she lives nearby. Her father has re-married and she speaks to him and her step-mother daily. She was accompanied to her prenatal visit by her 12 year old cousin. She is a shy girl who seems quite childlike in her behavior.

Brenetta is a high risk 26 year old Black woman who was 35 weeks pregnant at the time of the interview. She has had 7 pregnancies with one child living. She is also being treated for pregnancy-induced hypertension and has been on bedrest at home for the last month. She lives alone with her 3 year old son who she says gets on her nerves because he's into everything. Lately her sister has been coming over to spend time with her.

Carla is a low risk 23 year old Black woman who was 29 weeks pregnant at the time of the interview. She has had 7 pregnancies and has two children living. She was removed from her home and placed in a foster home at age 13. She still has an estranged relationship with her mother, but is especially close to her grandmother and foster mother. She has worked at a day care center, but states she can not find a job that pays as well as welfare. She lives alone.

Carolyn is a high risk 34 year old Black woman who was 30 weeks pregnant at the time of the interview. She has two boys and lives with her husband. They are both college graduates and work full-time. C.T. trains managers for a large food chain. She had two episodes of early labor; one at 24 weeks and one at 27 weeks. She has been off work and directed to remain on bedrest for the past 3 weeks. She also takes a tocolytic drug daily to stop contractions. Once she realized that the drug does stop contractions, she resumed household activities and only rests when she feels she needs it.

Daphne is a no risk 25 year old Black woman who was 35 weeks pregnant at the time of the interview. She had one previous abortion before this pregnancy. She lives with her husband and they both work full-time at the same chemical plant. She is an educated (2 years of college), a rather stylish and sophisticated woman who has a very active social life.

Deidre is a high risk 23 year old Black woman who was 28 weeks pregnant at the time of the interview. She has had 5 pregnancies resulting in two children. She lives alone with her children although she has a long-term relationship with her boyfriend. He is the father of the second and this child. She had her first child at age 14, but still managed to finish high school and begin a community college program towards a degree in X-Ray

technology. She is currently unemployed, but plans to finish her remaining 6 months of school after the pregnancy.

Jackie is a low risk 20 year old Black woman who was 30 weeks pregnant at the time of the interview. She had one abortion at age 14 prior to this pregnancy. She got married at the beginning of the pregnancy and moved to Stockton with her husband. He is a truck driver and on the road for 3 to 4 days at a time. She is lonely and depressed about living away from family and friends. She regards this pregnancy as a miserable experience.
Janice is a high risk 24 year old Black woman who was 27 weeks at the time of the interview. She has had 7 pregnancies with one child living who is now 6 years old. She is high risk because of her multiple abortions along with the history of preterm labor with her last pregnancy although she did not deliver preterm. She lives with her mother, her sister and her sister's children. They are all unemployed so she has company and support while she is on bedrest.

Joann is a 20 year old Black woman who was 35 weeks pregnant at the time of the interview. She has two children, ages 5 and 3. She is temporarily seperated from her boyfriend who is the father of the last two children. They are both unemployed. Joann is a high school graduate with no specified future plans.

LaTonya is a high risk 20 year old Black woman who was 27 weeks at the time of the interview. She has had 4 pregnancies with one child living who is 4 years old. She had premature rupture of her "bag of water" which resulted in an extended hospitalization and a slightly early delivery with the baby weighing 4 1/2 lbs. She describes this pregnancy as fun and normal while her previous pregnancy was met with family disapproval and strife. She lives with her boyfriend who is the father of both children. Her mother and

grandmother live nearby. She has resolved her difficulties with her mother, but is especially close to her grandmother.

Loretta is a low risk 30 year old Black woman who was 24 weeks pregnant at the time of the interview. She has had 4 pregnancies with one child living who is 9 years old. She is having this first child in a new relationship. She speaks of the major changes in the last 10 years between the two pregnancies. Maturing over the years, she regards this pregnancy as requiring patience and responsibility. She brings lots of experience to her family as the second oldest daughter in a family of 11 children.

Marcella is a no risk 25 year old Black woman who was interviewed at 20 weks and again at 27 weeks of pregnancy. This is her first pregnancy. She had been infertile and never anticipated that she would be a mother.
Her relationship with her husband ended about the time of the pregnancy. She now lives alone, having moved and resettled during the pregnancy. She works full-time with an additional evening job. She plans to return to work after delivery while her mother's cares for the baby. She has a strong belief in herself and a trust in God to see her through life.

Michelle is a no risk 18 year old Black woman who was 33 weeks pregnant at the time of the interview. She has had one previous abortion prior to this pregnancy. She was accompanied to her prenatal appointment by her cousin and best friend who is 3 months older and has a 6 month old child. Subsequent to the interview she went into preterm labor, was hospitalized, and placed on tocolytic drug therapy.

Patrina is a no risk 23 year old Black woman who was 27 weeks pregnant at the time of the interview. This is her first pregnancy. She works full-time as a secretary at the naval base. She had always planned to be married before she got pregnant, but when she announced

her pregnancy, her boyfriend left her. She has been severely depressed, even contemplated suicide. She has been unable to eat, has not gained weight, and lists multiple physical problems with this pregnancy.

Paulette is a high risk 20 year old Black woman who was 26 weeks pregnant at the time of the interview. This is her second pregnancy; she has one child. She had her first cervical examination at 25 weeks and was found to have cervical dilatation with the fetus presenting low in the pelvis. She has been on bedrest for the week prior to the interview. She lives in an extended family situation where the men in the household are cocaine dealers. She denies use of cocaine and her drug screening was free of any signs of drug use. Paulette has completed high school. Her future plans are centered around raising her children. Shelia is a no risk 21 year old Black woman who was 35 weeks at the time of the interview. This is her first pregnancy and she prayed for the pregnancy as a way to change her life. She has a low I.Q. with minimal formal education. She receives disability benefits, but has mainly supported herself through prostitution. She lives and works out of a transient hotel. Child Protective Services is monitoring her progress. She must find a stable home and gather needed supplies and furnishings for herself and the baby before she can take the baby home from the hospital. She is estranged from her mother, the father of the baby is a "questionable street character" and her best friends are prostitutes. She very much wants this baby.

APPENDIX E

Pregnancy Folklore

Black Pregnancy Folklore

These examples of folklore imply that the pregnant woman is responsible for the adverse effects that may occur to the baby. At times these effects are caused by activities in which women engage in the normal course of the day. Other times, bad effects result from ingestion of foods which are harmful, especially hot and spicy foods. Aside from causal relationships, there is considerable folklore concerning indicators that reveal the sex of the baby.

Caused by activities

1. But in my dream she licked her tongue out at me and that's when I said, "I'd better stop" cause you know they talk about how you can mark a baby.

2. A friend of mine that had a baby, she was large and her uterus came out while she was having a baby, they said alot of that had to do with the weight, so I'm trying to keep it under control.

3. My mother she told me not to reach over my head. She says it's a old wives tale, it wraps the umbilical cord around the baby's neck.
Do you think there's any truth to it?
Yea, cause my girlfriend she used to always reach over her head and the umbilical cord was wrapped around its neck.

4. Yea, they say you can pull the baby's cord or something, if you like, when you get about as many months as I am, it's not good to lift over your head because the baby could get caught on the cord and strangle to death.

5. She [mother] tell me to, you know, quit worrying cause she say when you worry your baby thinking the same thing you thinking.

6. When nothin to do, I read books then my eyes get all watery. Just eat and sleep, that's all I do. But then a baby can grow to you too, cause that what my mother says. And then they have to cut it, cut it out, whatever they do. That's strange, scary. But I doubt if it can, I mean for three months, I don't know. But I'll be moving around going to the bathroom, back and forth.

7. My grandmother told me not to lift my arms over my head. She said the cord will wrap around the baby's neck. (Do you believe that the cord will wrap around the neck?) Uh huh, cause my auntie just had a baby and she lifted up alot and they had to hurry up and make her baby come cause the cord was around her neck.

8. And she said if you scratch your stomach, you'll make the baby have a birthmark.

9. And if you don't move around everyday, the baby will stick to you.

10. If you're not up and active, the baby could stick to you. My neighbor told me that. Yea, I believed her but it wasn't like she was gonna make me get up and go walk either.

<u>Ingesting Foods</u>

1. Oh! They told me about spicy foods. You can burn the baby eyes out if you eat something too hot, you burn the baby eyes out, you can't be eating hot links because it's not good.

2. You shouldn't be eating all them potatoes because it's gonna get stuck and they're gonna split you.

3. Yea, too hot and acids. Don't drink alot of soda water because of the acid, it'd do something to the baby and so I don't drink soda water.

4. But you know, I don't really crave and she said, 'Wow, what kind of baby you havin", 'cause I don't really crave for anything.

Determining the Sex of the Baby

1. If you're carrying up high, it's supposed to be a girl, if you're down low, it's a boy.

2. (Do you think this one is a boy?) Yea. Cause she was lazy. [Didn't move much while in utero.] She didn't move alot. He did, and this one do.

3. With my two girls, my girls seem like I had a bigger rounder stomach, it stuck out, and I'm much smaller so I'm just assuming I'm having a boy because I'm carrying it mostly in my hips and I'm not showing that much in my stomach. But I don't want a boy. Boys are too mischievous.

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