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Engaged Mothering Within a Racist Environment:
The Transition to Motherhood for a Group of African American Women

by

Linda M. Sawyer

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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in the

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of the

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Abstract

ENGAGED MOTHERING WITHIN A RACIST ENVIRONMENT:

THE TRANSITION TO MOTHERHOOD FOR A GROUP OF AFRICAN AMERICAN WOMEN

Linda M. Sawyer, R.N.,C., Ph.D

University of California, San Francisco, 1996

Previous research has documented racial disparities in health status, including more than two-fold infant and maternal mortality rates, but has not illuminated the causes or solutions to these problems. The lifestyles and behaviors of African American women have been blamed for poor infant outcomes. Nursing has studied the process of becoming a mother using Maternal Role Attainment theory, yet this construct has not been studied for its cross cultural relevance. Using grounded theory methodology within a framework of transition theory and an afrocentric feminist epistemology, seventeen first time African American mothers were interviewed to elicit their experiences of pregnancy and motherhood. Women were interviewed both individually and in focus groups from one to three times during the postpartum period. Women also completed a demographic profile and The Perceptions of Racism Scale at the completion of the first interview, and these results were incorporated into the grounded theory analysis. Participants in this study were between 23 to 40 years of age (mean 29.9 years), mostly married, employed and middle income, education ranged from high school graduate to doctorate (59% had an associate degree or higher), and all received adequate prenatal care. "Engaged Mothering" was identified

as the core category, denoting the active, involved and mutual process in which a woman prepares to be a mother, cares for herself and her infant, and dreams about and plans for the future in order to have a "good life" for her child. Strategies which a woman utilized in this process included getting ready, dealing with the reality, settling-in, and dreaming. Two conditions appear to affect how these strategies are utilized, including intentionality of the pregnancy and prior history of miscarriage or health problems of the mother. Although no significant relationships were found between a woman's perceptions of racism score and adequacy of prenatal care or choice of health care provider, women described the effects of racism on their daily lives and on the criteria they used to choose providers. These criteria were employed in an attempt to avoid or decrease a woman's encounters with racism in their care. Nursing interventions are proposed based on these results.

Dedication

I dedicate this dissertation to my beloved husband and partner, Robert A, Good. Without his love, support, critique and patience I would not have been able to either undertake or complete my doctoral studies.

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mentorship of Dr. Meleis, I had the privilege to be a part of a group of scholars who together discussed, critiqued, presented and published on Community-Oriented Primary Health Care. Dr. Meleis provided us with both the role model and the experience of working as Nurse Scholars and developed in me a love of nursing theory and an understanding of the importance of theory in my work.

I particularly appreciate and thank the African American women who opened their doors and lives to me to participate in this research study. I have been very lucky as a researcher to be able to share in the experiences of these articulate and caring women. Their concern for their children and for the African American communities in which they live is inspiring and hopeful for the future. I hope that I have presented their experiences accurately and without bias. I would also like to thank the Home Health nurses -- Sue Gallagher, R.N., Robin Pena, R.N. and Sharon Stockman, R.N. -- as well as Colleen Shipler, R.N., C.S., F.N.P., M.S. and Gwendylon Johnson, R.N., C., M.A. who assisted me with participant recruitment for this study. These nurses are exemplary professionals who have my greatest respect for their knowledge, skills, and caring in working with multi-cultural client populations.

Lastly, I could not have proceeded with this important work without the support and understanding of my family and friends. I particularly wish to express my appreciation to my husband, Robert Good, my son, Nathaniel Good and my mother, Teresa Sawyer who took over some of my responsibilities and allowed me the time to focus on my dissertation.

Table of Contents

Copyright ii

Abstract iii

Dedication v

Acknowledgements vi

List of Tables xiii

List of Figures xiv

Chapter I: The Study Problem 1

Statement of the Problem 3

Purpose 4

Significance 4

Chapter II: The Research Literature 7

Racial Differences in the Health Status of Women 7

Effects of Racism on Health 9

Prenatal Care 13

Stress and Social Support in Pregnancy 19

Description of Motherhood 22

Limitations of Reviewed Studies 24

Sampling 24

Procedures 25

Focus on Experiences of African American Women 26

Methodologic Issues 26

Review Conclusions and Identified Gaps 28

Research Questions 29

Chapter III: Theoretical Framework 31

Transition Theory 32

Definitions 33

Dimensions 33

Conditions for Transitions 34

Maternal Role Attainment Theory 35

Critique of MRA 37

Afrocentric Feminist Epistemology 38

Afrocentrism 39

Race and Racism 41

Racism 43

Everyday Racism 45

Gendered Racism 46

Black Feminist Thought 46

Theoretical Framework 51

Chapter IV: Methodology 55

Design 55

Sample 56

Data Collection Methods 57

Procedures 59

Instruments 60

Research Rigor 62

Data Analysis 64

Human Subjects 66

Chapter V: Results 68

Demographics of the Sample 68

Perceptions of Racism Scale 69

Qualitative Findings 73

The Core Category: Engaged Mothering 73

Context 74

Strategies 75

Getting Ready 76

Anticipation 76

Preparing 77

Attaining Care 82

Readiness 86

Dealing With the Reality 86

Handling Problems 86

Hassles 89

Relationship With Mother 92

Partner Issues 93

Worries 94

Settling-In 95

Sleep 96

Adaptation 97

Role Definition 98

Family Support 99

Trusting Others 100

Dreaming 101

Conditions 106

Consequences 108

Chapter VI: Discussion 110

Meaning of Findings in Relation to Research Questions 110

Significance 114

Motherhood as Transition 114

Comparison With Rubin's Work 117

Comparison With Mercer's MRA Theory 119

Limitations/Alternative Explanations 121

Implications for Nursing 122

Worries 122

Classes 123

Providers 124

Consistent Staff 124

Peer Counselors/Advocates 125

Support Groups for Partners and Grandmothers 126

Future Research 127

Conclusion 128

References 131

Appendix A 145

Consent Form 146

Recruitment Letter 148

Interview Guide 149

Appendix B: Instruments 150

Cover Page 151

Demographic Profile 152

Perceptions of Racism Scale 155

Appendix C: Additional Quotes 157

List of Tables

Table 1. Selected Studies on African American pregnancy, motherhood and health status 175

Table 2. Demographic Description of Participants 71

Table 3. Prenatal Care 72

List of Figures

Figure 1. Dynamic process of becoming a mother 181

Figure 2. Continual processes of becoming a mother 182

Figure 3. Process of engaged mothering, incorporating mothering into the woman's identity 183

Figure 4. The process of engaged mothering 184

CHAPTER 1: THE STUDY PROBLEM

Racial disparities in health status have been documented for many years in the United States, but the causes and solutions to these problems continue to elude us. African Americans as a group have higher mortality and morbidity rates than white Americans for most of the major diseases (Funkhouser & Moser, 1990). The health status of African American women is of particular concern to researchers. Unfortunately, the health of reproductive-age women has been addressed only to the extent that it affects newborns (Wise, 1993). With infant mortality rates at least twice as high for African Americans compared to whites since the first statistics were collected in 1937 (Arnold, Brecht, Hockett, Amspacher & Grad, 1989), it is understandable that many researchers have focused on pregnancy outcomes. Wise (1993) stated that "We must recognize that, in some large measure, problems with infant ill health are a legacy of women's ill health generally" (p. 14).

Most of the research in the area of health status has been epidemiologic in nature. Epidemiologic research focuses on "high risk" groups or factors (Antonovsky, 1984). According to Jones, LaVeist and Lillie-Blanton (1991), science has contributed to the prevalent ideas of deterministic biologic differences between races by simply documenting the existence of race-associated differences or by treating race as a possible confounding variable. Epidemiologic studies assume that the individual behaviors of women are responsible for poor infant outcomes, and this assumption

leads to the development of interventions to transform the lifestyles and beliefs of women until they are "acceptable" (James, S.A., 1993). Sociologic research on this topic has focused on "deviance" (Bennett, 1992; Dickerson, 1995) and research in nursing is limited (Jackson, 1993). Differences in health status by racial/ethnic groups remains poorly analyzed and "untheorized" (Dressler, 1993).

Racial disparities in health status persist and have in some instances worsened during the past decade (Guyer, Strobino, Ventura & Singh, 1995; Kochanek, Maurer & Rosenberg, 1994). Despite the plethora of research, projects and funding, statistics documenting racial disparities remain alarming and there is a persistent inability to explain a myriad of racial/ethnic, black/white differences in health (Krieger, Rowley, Herman, Avery & Phillips, 1993). According to Gates-Williams, Jackson, Jenkins-Monroe and Williams (1992), "Being black is a health hazard" (p. 350). Several assumptions have been made by researchers regarding African Americans as a population group which may constrain progress in identifying causes and effective interventions to address these disparities. These assumptions include: 1) being black is equated with being poor (Rowley et al., 1993), 2) African Americans are a homogeneous group (Krieger et al., 1993; Stanfield, 1993), 3) race is the cause of disease when a group is more susceptible to the disease (Allman, 1992), and 4) the effects of racism on health are due to economics (Krieger et al., 1993). Risk factors identified as affecting the health of middle-class and white people in the United States have been applied to African Americans even when these factors are demonstrated to be inapplicable, i.e. marital status (Bennett, 1992; Centers for Disease Control (CDC),

1990) and education (Rowley et al., 1993; Schoendorf, Hogue, Kleinman & Rowley, 1992).

The documentation of high risk attributes does not explain the complexity of the interaction of person, environment and health inherent in the nursing perspective. Nursing, as a human science, is concerned with understanding human beings as a whole, deals with the lived experience and meanings of persons, and identifies patterns of response within the context of health and illness (Meleis, 1991). As a practice discipline, nursing seeks knowledge to understand a phenomena related to the goals of nursing: providing nursing care, promoting health, teaching self-care, and empowering clients to develop and use resources. The identification of protective factors and health promotive behaviors are important to the provision of nursing care. Nursing research models need to be developed which can uncover the complexity and interaction of factors affecting the health status of African American women in the childbearing years and the health of their children. Nursing interventions need to be grounded in the life experiences of women and should both support the protective behaviors which already exist and create the resources needed to promote health.

Statement of the Problem

The transition to motherhood is the most studied transition in nursing (Schumacher & Meleis, 1994). Nursing has described the process of becoming a mother in terms of maternal role attainment. This construct has been developed almost entirely with white, middle class women and its cross cultural relevance has not been assessed. Nursing research is needed to describe the experiences of African

American mothers within the context of their environment, which includes the cultural, historical, political and economic forces impacting on their health. The effects of racism on the health of African Americans must be documented and may be the key to explaining the currently unexplained differentials in health status.

Purpose

The purpose of this study is to describe the transition to motherhood for African American women and the effect of the women's perceptions of racism on how they care for themselves and on the care they seek during pregnancy.

Significance

Previous research has documented racial disparities in health status, including more than two-fold infant and maternal mortality rates, but has not illuminated the causes or solutions to these problems. The lifestyles and behaviors of African American women have been blamed for poor infant outcomes. Research has shown that prenatal care is sought later and less by African American women as a group, but even with adequate prenatal care the disparities persist (Murray & Bernfield, 1988). Internal barriers were identified as more common than external barriers in a woman's decision not to seek prenatal care (Joyce, Diffenbacher, Greene & Sorokin, 1984). Some research suggests that African American women may recognize their pregnancy later (Pettiti, Coleman, Binsacca & Allen, 1990). External stressors were more frequently experienced by African American pregnant women than the internal stressors identified by white women (Green, 1990). Previous research raises many issues but normal pregnancy, the meaning of pregnancy, or how African American

women care for themselves during the perinatal period has not been described. There is an urgent need to describe the transition to motherhood from the experiences of African American women.

One promising and previously neglected direction for research on differentials in health status involves studying the effects of racism, sexism, and social class on health (Krieger et al., 1993). Rowley et al. (1993) proposed that racial inequality may function as both a psychosocial stressor that alters physiologic response, and as a structural factor which limits access to quality care. Recent research provides support for the hypothesis that exposure to high levels of stressors and other psychosocial factors may put women at increased risk for adverse reproductive outcomes (McLean, Hatfield-Timajchy, Wingo, & Floyd, 1993). Limited research has been conducted in the United States on the effects of racism on health. Research in nursing has been particularly sparse in regards to the health of African Americans (Jackson, 1993).

In Chapter Two, the review of recent literature on the transition to motherhood, the health status of childbearing women, and the effects of racism on health and health care for African American women will underscore the need for a new theoretical framework for nursing research to describe the complexity of issues impacting on the transition to motherhood and health status of African American women. The research questions which guided this study will be stated based on gaps in the literature. Chapter Three will outline this theoretical framework and Chapter Four will describe the methodology utilized in this study. Chapter Five presents the results of the demographic profile, the Perceptions of Racism Scale, and the grounded theory

analysis. Finally, in Chapter Six the meaning and significance of the findings, implications for nursing and suggestions for future research will be discussed.

CHAPTER II: THE RESEARCH LITERATURE

Medline and manual searches for the years 1989-1996 resulted in the location of 25 research studies. Table 1 summarizes these studies in relation to the study sample, design, instruments, analysis, findings, and limitations. This review is organized according to the following topics to provide an overview of recent research related to the health status, experiences of pregnancy, infant outcomes and motherhood for African Americans: 1) racial differences in the health status of women, 2) effects of racism on health, 3) prenatal care, including utilization, barriers and quality, 4) stress and social support in pregnancy, and 5) descriptions of African American motherhood. This review illustrates that despite the plethora of research done on African American pregnancy, the answers to the problems of poor health and infant outcomes have not been found. Research has focused on high risk, low income women who get inadequate prenatal care, but has mostly ignored normal pregnancy.

Racial Differences in the Health Status of Women

Research suggests that racial differences in health status at particular ages may be important factors to explain racial differences in pregnancy outcomes (Geronimous & Bound, 1990). Three studies demonstrated that health deteriorates for many African American women, beginning at age 10 and continuing in the childbearing years (Geronimous, Anderson & Bound, 1991; Geronimus & Bound, 1991; National Heart, Lung and Blood Institute Growth and Health Study Research Group (NGHS), 1992).

Additionally, the way that young African American women define health may have an impact on how women care for themselves and on their health status (Hargrove & Keller, 1993). The reasons for the deterioration in health are unclear.

In a retrospective examination of national mortality data for 1980 to 1985, Geronimous and Bound (1990) analyzed young women's deaths classified by causes known to be risk factors in pregnancy. Over the childbearing years mortality rates for black women exceeded those of whites by at least 25%. Black/white health differences widen as women progress in the childbearing years and this may play a role in the discrepancies in black-white infant mortality. In a second study, Geronimous et al. (1991) examined the prevalence of hypertension in non-pregnant women aged 15-44, using a national data set. No difference in the prevalence of hypertension was found between groups of women in the teen years, but by age 20-24 black women were exhibiting higher rates of hypertension. Black women were far more likely to be hypertensive during pregnancy and twice as likely to begin pregnancy with pre-existing chronic hypertension. Both pregnancy-induced and chronic hypertension are risk factors for poor pregnancy outcomes. The racial difference in infant mortality and low birthweight are 2:1 and this is equivalent to the size of the difference in hypertension prevalence. The authors suggested that infant mortality and hypertension for blacks may be related.

Factors associated with the onset and development of obesity and its effects on major risk factors for the development of cardiovascular disease have been reported from a five year prospective cohort study (NGHS, 1992). By age nine and ten, black

girls were significantly taller, heavier and more physically mature than white girls. Both systolic and diastolic blood pressure were significantly higher for black girls. Although black girls had higher HDL cholesterol levels at age nine and ten, this advantage in HDL decreased with age, possibly due to increasing obesity.

Obesity was found to be perceived as healthy in a descriptive study of twenty-two African American women between the ages of 18 and 40 (Hargrove & Keller, 1993). The participant's definition of health was solicited through interviews. The major component described by the women in their definition was avoiding disease and illness. Factors or behaviors which assisted in the maintenance of health and prevention of illness included being overweight, reducing stress, eating good foods and having enough to eat, having good habits, and exercising. Work stress was identified as a high stressor for this group of women, causing anxiety attacks, stomach problems, hair loss, and "feeling miserable". Active stress-reduction measures were described as important to the maintenance of health. Incongruence between the women's definition of obesity as healthy and the link of obesity to health problems needs to be addressed.

Effects of Racism on Health

Research on racism is reviewed in three areas: access to health care, infant outcomes and hypertension. These studies document women's perceptions of racism in attaining prenatal care, poor infant outcomes based on segregation, relationships among perceptions of racism, stress and self-esteem in pregnant African American women, and increased blood pressure and rates of hypertension related to racism.

A qualitative study was conducted with 14 African American women in the

perinatal period to describe their access to health care and experiences with racism (Murrell, Smith, Gill & Oxley, 1996). Women perceived that pregnant African American women were stereotyped daily in society as young, unmarried, on welfare and having more than one child. Women described other assumptions they experienced, such as the expectation of no father in the household, that they do not take care of themselves or get proper prenatal care, and that they may have a drug problem. They also perceived that prenatal care for African American women is inaccessible, indifferent, and undignified. Participants described experiencing racism in many areas of their daily lives, including in health care. Women often internally processed these incidents with potential adverse effects on their health.

Two studies by Polednak (1991, 1996) suggested that between 1982 to 1986 the most important predictor of black-white difference in infant mortality was an index of black-white residential dissimilarity or "segregation index", rather than a difference in income or poverty prevalence. The segregation index was the only statistically significant independent predictor of the black-white difference in infant mortality rates, despite similar poverty prevalence. This finding was supported in a study by LaVeist (1990). The more highly segregated the city, the higher the infant mortality rate for blacks but lower for whites. However, in the 1996 report for the years 1989 to 1991 the segregation index was not a significant predictor of the infant mortality rate (Polednak, 1996). The rate of unmarried mothers was the only significant predictor in the later study. Regional results were inconsistent and the author questioned whether changes in the environmental-social circumstances of a region caused these

inconsistent results, particularly noting a negative association between the political power of blacks and postneonatal mortality.

Green (1992) investigated the variables of stress, self-esteem and racism with a convenience sample of nulliparous women from a low risk prenatal clinic (n=136). The author hypothesized that these three variables would have a relationship with low birthweight and preterm delivery for African American women. Stress, self-esteem, and racism did not demonstrate a relationship with low birthweight and preterm delivery, but they did demonstrate significant interrelationships. Multiple regression supported a positive relationship of racism with stress ($p<.01$), a negative relationship of self-esteem with stress ($p<.001$), but did not support the hypothesized negative relationship between racism and self-esteem.

Recent research of the effects of racism on hypertension shows promise. The three studies in this review utilized different methods to determine the extent of racism and its effects on blood pressure. In a study by Armstead, Lawler, Gordon, Cross and Gibbons (1989), normotensive black college students were randomly selected and assigned to view one of three film groups and exposed to four study conditions: experimental baseline, neutral stimulus, racist stimulus, and anger-provoking stimulus. Participants were also asked to respond to the question, "How do you cope with racism?" at the end of the intervention. Fifty-nine percent of the participants responded that they ignore racism, 11% reported retaliation and 11% reported informing the racist of their displeasure. Eleven of the 15 women reported holding their anger in, while only 5 of the 12 men reported the same strategy. This study

showed that racist stimuli increased blood pressure to a greater degree than anger-provoking stimuli.

Krieger (1990) conducted a pilot study to determine the feasibility of developing questions pertaining to race and gender discrimination and unfair treatment, and whether there was a relationship between these responses and self-reported hypertension. Results showed that black women were 5.9 times more likely to say they kept quiet and accepted unfair treatment or discrimination. Two-thirds of the black women reported instances of race discrimination. Increased risk of hypertension was related to response to unfair treatment and experience of race or gender discrimination only for black respondents. Women who said they kept quiet or accepted unfair treatment were 4.4 times more likely to have hypertension than those who responded by talking or acting. Women who recalled no instances of gender or racial discrimination were the ones most likely to say they accepted or kept quiet about unfair treatment. No such associations were found for white respondents. The study suggests that gender and race discrimination and response to unfair treatment are risk factors for hypertension, and that persons who least report stressors may be internalizing or not acknowledging stressful events, thereby elevating risk.

James, Keenan, Strogatz, Browning and Garrett (1992) reported on studies associating socioeconomic status and a coping mechanism named "John Henryism". John Henryism is defined as "a strong behavioral disposition to cope in an active, effortful manner with the psychological stressors of everyday life" (James et al., 1992, p. 59). Inconsistent results were found among studies. Studies in a rural community

showed an inverse association between socioeconomic status and blood pressure when stratified by John Henryism status. Differences in mean blood pressure were limited to those African American individuals scoring high in John Henryism. Neither of these findings occurred among white participants. In another study by the same authors, socioeconomic status was inversely related to systolic, not diastolic, blood pressure. Group differences were not statistically significant, but were in the hypothesized direction and achieved "borderline" significance (p=.08). The authors speculated that the weaker support for the hypothesized associations may be due to unexpected psychosocial stress connected with managerial level employment. Perceived stress scores were significantly related to adjusted blood pressures for high socioeconomic/low John Henryism individuals. The posthoc analysis suggested that the association between socioeconomic status and blood pressure, modified by John Henryism, was more apparent when low socioeconomic status implied a greater exposure to stressors which tax an individual's coping resources. The unexpected finding of elevated stress scores for middle level white-collar workers may be due to this population being at the "cutting edge" of social and economic change in this community.

Prenatal Care

In this section, studies document that 1) prenatal care is not the only way that women care for themselves and 2) some women choose to delay the start of prenatal care for various reasons. Women determined when they needed care based on symptoms, problems or because significant persons encouraged them to get care.

Other studies documented that prenatal care, advice and education from health professionals is not provided for everyone with consistent quality. Multiple barriers to attaining prenatal care have been documented in four studies, including financial and insurance status, delayed recognition of the symptoms of pregnancy, lack of motivation, depression, fear of doctors, long clinic waits, no transportation, and lack of child care. Barriers were perceived by low income women as more severe and interrelated.

Patterson, Freese and Goldenberg (1990) conducted a grounded theory study of the utilization of care during pregnancy, labor and delivery for a sample of seventeen black women and ten white women. When a self-diagnosis of pregnancy was made, the woman entered a period of "letting it sink in". Once a decision was reached to continue the pregnancy, a woman sought "safe passage" for herself and the baby. Seeking safe passage did not always include obtaining prenatal care, although most women did search for prenatal care at some time during their pregnancy. The search for care was guided by several criteria: financial and insurance status, and the location, reputation, and preexisting relationships with providers or clinics. Waiting was an active decision to postpone searching for care and was indicated by the woman's assessment of a normal pregnancy, desire to avoid unpleasant aspects of care, or when the woman desired a different option for care and waited in hopes that her insurance status would change. The end of a waiting period occurred with a "push" from mothers, mother-in-laws, husbands or boyfriends or with the appearance of physical symptoms. Contingency planning in case of labor or detection of potential

threats was another active choice women made to ensure safe passage. Prenatal care was not always perceived as essential, but intrapartal care was consistently planned for. Women reported on their efforts to take care of themselves, change their lifestyle and engage in self-monitoring.

Hansell (1991) used data from national data surveys to examine maternal sociodemographic factors in relation to the quality of health services. For many women who had made the effort to obtain prenatal care, the care was not up to the standards of care developed by the American College of Obstetrics and Gynecology. Minority, poor, less educated, and unmarried women received poorer care as defined by the standard. The author proposed that these women may not seek care because they learn early in life that they receive poor care and the costs of making visits outweighs the benefits.

Kogan, Kotelchuck, Alexander and Johnson (1994) stated that previous studies have assumed that all prenatal care is the same. This study examined the percentages of black and non-Hispanic white women who reported receiving advice from health care providers during pregnancy regarding tobacco, alcohol, and drug use and breast-feeding. Overall, one-third or more of the women surveyed reported not receiving advice regarding smoking cessation, alcohol or drug use and approximately 50% of women received no advice regarding breast-feeding. The content of prenatal care is not the same across racial groups. Black women were significantly less likely to receive advice regarding tobacco and alcohol, and the disparity in breast-feeding advice approached significance. Other factors found in this study to contribute to

disparities were sociodemographic factors, with poorer women receiving more advice on tobacco and alcohol and wealthier women more advice on breast-feeding. The site of prenatal care also affected advice given.

Petitti et al. (1990) studied the timing of prenatal care among black and white women in Alameda County who participated in the Alameda County LBW study. Interviews were conducted in a case control study which included a randomly selected control group of women who had delivered healthy infants in the same time period. The authors found that the largest difference between women who received care in the first trimester was related to financial status and insurance coverage for both races. A large percentage of women receiving Medi-Cal did not receive care in the first trimester, which was due in part to long delays in certification of eligibility and few physicians who accepted Medi-Cal patients. Black women were less likely to obtain prenatal care at every level of education, income, and insurance status. Black women as a group tended to discover the pregnancy later than white women, and this was related to the delayed start of care. The authors questioned whether some of the difference in the timing of prenatal care between the groups may be due to a lack of awareness of or a failure to recognize the early signs of pregnancy.

The "Health Belief Model" was the conceptual framework used in a descriptive study by Leatherman, Blackburn and Davidhizar (1990) to determine the reasons mothers did not receive adequate prenatal care. The reasons given for not obtaining care were related to the variables of age, time between knowledge of pregnancy and making an appointment for care, and source of payment. Individual perceptions of

susceptibility, seriousness, threat, benefit, and barriers were included in the survey. The reasons given for not obtaining adequate prenatal care were insufficient money (81%), insufficient motivation (45%), and lack of transportation (19%). There was a significant relationship with the reason given and age, time of first care, and source of payment.

Scupholme, Robertson and Kamons (1991) studied the 7.6% of women at a university medical center in Florida who delivered infants without any prenatal care in 1988. The main barriers were system-related (35.5%), patient-related (35.5%) and financial (29%). The results suggest that being a single parent placed a mother at higher risk for having a low birth weight (LBW) infant and no prenatal care, but educational level and age did not. They found that American Blacks had a higher rate of LBW infants regardless of prenatal care, while black women from the Caribbean had rates similar to American Whites. American women of both races had more difficulty accessing prenatal care because of late registration or perceived problems in the clinic than immigrant women. In this study neither proximity to the clinic nor knowledge of the clinic location were indicative of obtaining care. The authors suggest that more emphasis needs to be placed on identifying which aspects of prenatal care are important to each cultural group and incorporating cultural belief systems into care. There is a lack of knowledge of what constitutes attractive prenatal care to diverse cultures and which attributes of low socioeconomic status inhibit access to care.

A study by Lia-Hoagberg et al. (1990) used a stratified sample of recently delivered white, black and Native American women who received adequate, intermediate and inadequate prenatal care. Women who received inadequate care differed by the number of perceived barriers and the perceived severity of the barriers. Women with inadequate care were more likely to be under age 20, unmarried, less than high school educated, unemployed, and have more children. Financial factors were not identified by these women as a barrier, but child care and transportation problems were identified as barriers. Lack of pregnancy planning and recognition of pregnancy were important issues for most women. Women with adequate or intermediate care recognized their pregnancy at 6 weeks and those with inadequate care at 13.5 weeks. More than 75% of women with inadequate care reported being unhappy that they were pregnant, with black and Native American women significantly more unhappy than white women and more likely to have considered an abortion. More women with inadequate care identified personal and family problems, feelings of depression, and not feeling well as issues during their pregnancy. Although most women acknowledged that prenatal care was important, they still were not motivated to seek care. Women receiving inadequate care also were more likely to seek care only when ill, have negative feelings and fears about seeing a doctor, and dissatisfaction with their treatment. Motivators to obtaining care were the belief that care would ensure a healthy baby, concern for their own health, fear of problems, and encouragement by family and friends. Black women (46%) reported that no one encouraged them to get care and that they received the most advice from their

mothers. These women were more likely to describe inter-related factors which make their daily lives difficult. The results of this study are similar to a study conducted by Joyce et al. (1984) in which internal barriers to prenatal care, including depression, denial of pregnancy, fear of doctors, and unplanned pregnancy were indicated as the reason for 47% of women. Twenty-three percent of women indicated external barriers which included financial problems, no transportation, no child care, inability to obtain clinic appointments, and long waits in the clinic.

Stress and Social Support in Pregnancy

One study in this review found that specific sources and types of support may be most helpful to African American pregnant women and an intervention was developed based on this finding. Social networks provide an important source of information to women during pregnancy, although at times the information can be incorrect or potentially dangerous. Another study documented that African American pregnant women faced more frequent and more severe stressors than white women. These stressors were often external stressors.

Norbeck and Anderson (1989) studied 208 low-income, medically normal pregnant women to determine whether the variables of high stress, low social support, or high anxiety were predictive of pregnancy outcomes in this population, and whether ethnic differences exist. These variables were measured in mid- and late pregnancy for a sample of nearly equal numbers of black (28%), white (35%), and Hispanic (37%) women utilizing several measures. For black women, social support from the woman's partner or mother accounted for 33% of the variance in gestation

complications and 14% of the variance in prolonged labor or C-section complications. High social support for white women accounted for poor pregnancy outcomes and substance use, suggesting that the social network may reinforce negative health practices for this group. None of the predictor values were significant for Hispanic women, who had very low complication rates. The findings support the use of specific sources or types of support for black women, and suggest the use of social support as an intervention for black women lacking partner or mother support.

DeJoseph, Norbeck, Smith and Miller (1996) developed a culturally relevant social support intervention for pregnant African American women considered at high risk to deliver a low birth weight infant. Three advisory groups of African American women were convened to assist in the development of the intervention: a professional advisory group composed of nurse-midwives, a community advisory group composed of women active in the community, and a patient advisory group composed of pregnant women who met the criteria for the intervention study. Major themes identified through both individual and group interviews included the stresses African American women faced when pregnant and how they decreased stress through their personal resources, such as relationships and self-esteem. Women received support from God, their partners, their mothers and other women and defined support as listening to and "being there" for them. Women said that it was often difficult to get the support they needed. Women identified two specific needs which were built into the intervention during the pregnancy, including 1) skill building to enhance self-esteem and to help in accessing support, and 2) acknowledgement of their lives and

experiences.

St. Clair and Anderson (1989) studied the social networks of black and white pregnant women and the pregnancy-related health advice they received. Advice was given most frequently by mothers, sisters and partners, and the advice received from relatives was favored over advice from friends. Advice was given on diet and nutrition (90.8%), hygiene and activity (95.1%), avoidance of harmful substances or practices (85.4%), remedies for the discomforts of pregnancy (51.9%), infant care and nutrition (33%), utilization of medical services (60%), and experiences of pregnancy (41.1%). These recommendations were often in conflict with medical recommendations, and some were potentially dangerous. Recommendations regarding the use of health care services tended to encourage only episodic care when there was a problem. The authors state that the social network is an important source of information for pregnant women, but there was no discussion whether findings were different between the two cultural groups.

Green (1990) conducted a pilot study to replicate the 1987 Arizmendi and Affonso study, which identified the frequency and intensity of stressors related to childbearing for African American women. The typical participant in this study was 23.8 years old, was single (86% compared to 19% of the previous study), had a yearly income of less than $5000 (70%), and had 12.3 years of education. Three additional categories of stressful events emerged, in addition to replicating the categories in the previous study. These categories were: 1) need for housing, 2) waiting time in clinic, and 3) other stressful events not fitting under any category. In both studies the most

frequent stressors were physical symptoms. In this study external events, such as lack of money, mate/spouse and family issues, and job, career, and school issues were more frequent than the internal events found in the previous study. The mean intensity of the stressors was higher in African American women than found in the earlier study with white, middle class women.

Descriptions of Motherhood

Motherhood is usually described in the literature as universal, although most research has been conducted with white, middle class women. Even when samples are multi-cultural, there is no discussion as to whether the experience differs among groups. There is an assumption that all women experience pregnancy and motherhood in the same way. Most previous research on motherhood for African American women was done with low income, single, and often teenage mothers and interpreted as pathological. Two recent studies have focused on the experiences of African American women in depicting aspects of African American motherhood. The findings of one of these studies are consistent with the description of "community othermothers" described by Collins (1991a). Another study demonstrated that nurses' lack of culturally specific knowledge about African American motherhood can potentially lead to misunderstanding and inappropriate care.

Naples (1992) studied the community-work of 42 low-income paid community workers in New York City and Philadelphia. Twenty-six of these women were African American. Through the grounded theory analysis of personal narratives obtained by in-depth interviews, the concept "activist mothering" was coined. Activist

mothering demonstrated that for these women their community work was inseparable from their "mother-work". Paid labor, politics and community were intricately connected to social life, mothering and community. These women desired to improve the lives of their families and neighbors, and this desire was the stimulus for their activism. Racial discrimination was a consistent theme expressed by these women and the struggle against racism was a basis for their work. Many of these women continued the tradition of activist mothering that they experienced as children with their own mothers. Replication of this study with mothers who were not employed in community work would be valuable to determine if this concept of motherhood is shared by other mothers.

In a pilot study of new African American mothers (n=5), Vezeau (1991) investigated the concept of "greedy" which African American mothers often apply to their infants. Nursing staff interpreted this term as derogatory. The mothers were asked to participate in two focus group interviews, the second held after hospital discharge to validate the themes from the analysis. The term greedy was actually used by the mothers as a positive term which implied that the infants were persistent in obtaining what they needed, were survivors, gave clear clues to their needs, were engaging, and would have happy, secure futures. The authors suggest that there may be regional variations in this concept. This study is an example of the need for nurse researchers to conduct qualitative research on the perspectives and meanings of motherhood with African American women.

Limitations of Reviewed Studies

This review included studies from several disciplines, including nursing, public health, psychology, social work and other social sciences, utilizing various quantitative and qualitative research methodologies. Limitations of these studies were noted in relation to sampling, data collection procedures, and focus.

Sampling

Six of these studies are retrospective analyses of data and utilized national data sets (Geronimous et al., 1991; Geronimous & Bound, 1990; Hansell, 1990; Kogan et al., 1994; Polednak, 1991, 1996). Problems with missing or inaccurate data and methods to impute missing data have been identified as important methodologic issues when using large data sets (Alexander, Tompkins, Petersen & Weiss, 1991). Not all states have linked birth and death certificates. Often the data used was old because it was based on the United States census conducted every ten years or on national surveys conducted infrequently (Hansell, 1991; Kogan et al., 1994; Polednak, 1991, 1996). Additionally, some studies used indirect measures of prevalence: mortality data (Geronimous & Bound, 1990), estimates of hypertension prevalence in pregnancy (Geronimus et al., 1991), and Standard Metropolitan Statistical Areas (SMSA) based on 1980 and 1990 census data to estimate socioeconomic status (Polednak, 1991, 1996). These indirect measures may not accurately reflect the actual rates for the group being studied. These studies provide us with information on population groups, but do not address the diversity within groups or give insight into the lives of individuals. The interpretation of aggregate data from large samples has the potential

to stereotype individuals within that population.

In other quantitative studies sample sizes were small or no power analysis was done to determine the sample size needed (Armstead et al., 1989; Krieger, 1990; Norbeck & Anderson, 1989). Although Green (1992) conducted a power analysis, it is not clear how the effect size was determined and on a low risk group of women a larger sample may have been needed. Convenience samples were often used (Green, 1990, 1992; Leatherman et al., 1990), limiting generalizability of the findings. Several pilot studies were included (Green, 1990; Krieger, 1990; Vezeau, 1991) and require replication with larger samples. The demographic makeup of samples was not always described (Leatherman et al., 1990) and methods of determining socioeconomic status were not consistent in these studies. These sampling issues make it difficult to determine if the findings can be appropriately generalized to African American women.

Procedures

In several of the studies, incomplete or no information was provided regarding the procedures and instruments utilized (Hansell, 1991; James et al., 1992; Kogan et al., 1994; Petitti et al., 1990). Validity and reliability of instruments was not always adequately discussed (Leatherman et al., 1990). Self-reports or the use of medical records could possibly have limited some studies due to incomplete, inaccurate records or recall (Hansell, 1991; Kogan et al., 1994). In the study by Scupholme et al. (1991), the use of closed-ended questions based on the Institute of Medicine's monograph on prenatal care may have limited results to the confirmation of preconceived reasons

why women did not receive adequate prenatal care.

Only one prospective study was found (NGHS, 1992), yet prospective studies allow the researcher to observe the development of the disease or problem of interest and have more control over the methods of data collection. Prospective studies provide the most information on the risk of disease development and etiology.

Focus on Experiences of African American Women

Studies using qualitative methods, including grounded theory (Naples, 1992; Patterson, 1990), content analysis (DeJoseph et al., 1996) and other qualitative techniques (Hargrove & Keller, 1993; Murrell et al., 1996; Vezeau, 1991), focused on the experiences and perceptions of African American women. In many of the studies, there was an implied relationship between racism within the society and health status. In some recent studies this relationship has been studied more explicitly (Armstead et al., 1989; Green, 1990, 1992; James et al., 1992; Krieger, 1990). Other studies do not discuss the heterogeneity of African Americans and perpetuate stereotypes of African American pregnant women as young, poor, single and as not receiving adequate prenatal care.

Methodologic Issues

Four problematic representations of people of color in previous research on race and health have been presented in the literature (Allman, 1992). The first problem is "not present", with white, European Americans assumed to be the "norm". The "silences" in research need to be identified, understood, and addressed. The second representation is that race or ethnicity is the source of disease, for example,

being black predisposes a person to be hypertensive: "it's in the genes." The third representation is that of people as objects of research to be exploited, as happened in the Tuskegee syphilis experiments. The fourth problem is the study of culture without context. A sense of history and context of the people being studied, informed by the people, is critical to good research.

Krieger et al. (1993) provided a comprehensive critique of conceptual frameworks, methods utilized, and gaps and limitations of current research in the area of racism and health. The authors differentiated between the traditional public health concern with racial differences and disease, with the emerging investigation of the health consequences of racial subordination. Most of the studies on racism have focused on whether health outcomes are comparable among members of different racial groups at the same socioeconomic status. Questions of race are implicitly or explicitly reduced to questions of class. This redefinition of race to class allows researchers to avoid the issue of racism and its effects on health. Another research approach is to focus on the health consequences of structural racial segregation in the labor force.

Criticisms regarding research on racism and health include the following: 1) the lack of a clear conceptual framework to guide the research and appropriate measures and methodologies to test hypotheses, 2) the analysis of the role of social class in relation to health disparities is flawed, and 3) a lack of study on the non-economic aspects of racism, the diversity among African Americans and the gender-specificity of racism (Krieger et al., 1993).

Review Conclusions and Identified Gaps

The 25 studies reviewed illuminate the complexity of issues affecting the transition to motherhood and the effects of racism on the health status of African American women. As early as age nine, African American girls show significant differences in the development of risk factors and worsening health status into the childbearing years (Geronimous et al., 1991; Geronimous & Bound, 1990; NGHS, 1992). These findings imply that the two-fold differences in infant mortality and increased maternal mortality may have their antecedents in childhood. Most research on the effects of racism and health has been done in the area of hypertension. Several studies associate the internalization of anger, the acceptance of unfair treatment, or the concept of John Henryism -- active, effortful coping with daily stressors -- with the development of hypertension (Armstead et al., 1989; James et al., 1992; Krieger, 1990).

Several studies were reviewed regarding the effect of racism on pregnant women and their infants. Two studies associated residential segregation with poor infant outcomes (Polednak, 1991; LaVeist, 1990), although another study showed an inconsistent relationship (Polednak, 1996). Green (1992) documented relationships between racism, self-esteem and stress for low risk pregnant African American women, although a hypothesized association between racism and low birthweight was not significant. Green (1990) also documented that pregnant African American women were faced with additional stressors compared with a sample of white women in a previous study, and these stressors were more intensive and external. Three studies

suggest that social support from partners and mothers (DeJoseph et al., 1996; Norbeck & Anderson, 1989) and advice from social networks (St. Clair & Anderson, 1989) are important to prenatal care and outcomes for African American women. Two studies demonstrated that African American women received poorer prenatal care (Hansell, 1991; Kogan et al. 1994) and perceived more severe barriers to prenatal care (Lia-Hoagberg et al., 1990). Internal barriers to obtaining prenatal care were found to have equal or more impact on not receiving adequate prenatal care than external or financial barriers (Joyce et al, 1984; Leatherman et al., 1990; Lia-Hoagberg et al., 1990; Scupholme et al., 1991).

The experiences of pregnant African American women and their transition to motherhood has not been described. The research literature is fragmented and silent on issues such as the diversity within the African American community and has ignored the experiences of middle class and well-educated African American women. The focus continues to be on pathology and deficits, with little mention of the resources women utilize or how they care for themselves during the perinatal period. Women continue to be blamed for problems during pregnancy and for poor infant outcomes.

Research Questions

Based on this review of the literature, four research questions were developed to study African American women's transition to motherhood. The following questions guided this research study:

1. How do African American women describe their transition to motherhood?

2. Who/What facilitates and inhibits a successful transition to motherhood for African American women?

3. What protective behaviors/measures do African American women utilize to facilitate a healthy transition?

4. How do women take care of themselves during pregnancy? Does a woman's perception of racism have an effect on how she cares for herself or the care she seeks?

A new theoretical framework is needed for researchers to utilize when investigating these gaps in the literature. Chapter Three will present the framework developed for this study.

CHAPTER III: THEORETICAL FRAMEWORK

Transition theory and an Afrocentric feminist epistemology, including the concepts of afrocentrism, black feminism, and racism, compose the theoretical framework for this study. Transition theory was proposed as the framework to study motherhood in the African American community. I used this framework in the context of afrocentrism and black feminist thought to sensitize myself to the data. I assessed women's perceptions of racism in their lives and the effect of these perceptions on their prenatal care. I elicited protective and health promotive strategies which women utilized during pregnancy, as well as the facilitators and inhibitors to a healthy transition. The review of the literature demonstrated the complexity of issues affecting the transition to motherhood for African American women and effects of racism on their health status. No studies were found that holistically described the transition to motherhood for African American women.

Previous research has ignored the strength and adaptability of African Americans and has focused on pathology. This alleged pathology of the African American community has been described without analyzing American social policy which perpetuates institutional racism. Some scholars have deemed the African American community to be unhealthy, but have failed to see that a community is a force that not only acts upon its members but is acted upon. The "problem", according to Ladner (1972), needs to be redefined. By describing the transition to

motherhood from the perspective of African American women and the effects of their perceptions of racism on their care, nurses can contribute to a new research paradigm which can increase our understanding and improve the effectiveness of nursing therapeutics.

Transition Theory

Transition is a process of changing from one state to another. Meleis and Trangenstein (1994) have proposed that the mission of nursing is to facilitate and deal with people who are undergoing transitions. Nurses work with people who are anticipating, experiencing, or completing transition (Meleis, 1991). Transition can involve a change in health status, role relationships, expectations, or abilities and require a person to utilize new knowledge, change behavior, and alter one's self-definition. Schumacher and Meleis (1994) presented a typology of transitions relevant to nursing: developmental, situational, health/illness and organizational transitions. Transitions are within the domain of nursing when they pertain to health and illness or when responses to transition are manifested in health-related problems (Chick & Meleis, 1986). Viewing transition as an experience and process, rather than as a fixed point in time, allows the nurse to prepare clients for continuity of care, to develop a process within which coping can occur, and to utilize a longer time frame for nursing actions. The use of a transition framework requires the recognition of events, experiences, and responses as processes which are longitudinal and multidimensional and focus on patterns of response over time (Meleis & Trangenstein, 1994). Transition theory will be discussed in terms of selected definitions, dimensions, and

conditions.

Definitions

Transitions are defined as those periods in between fairly stable states, which are associated with some degree of self-redefinition (Chick & Meleis, 1986). Defining characteristics of transition include process, disconnectedness, perception, and patterns of response. Process implies a sense of movement, a flow, and is time-limited or bounded. Disconnectedness is associated with a disruption of linkages and is a pervasive characteristic of transition. Perception of a transition event is affected by the meanings attributed to the event and can influence the individual's reactions and responses to the event. To be in transition a person needs to be aware of the changes (Chick & Meleis, 1986). Patterns of response are not random behaviors, but reflect both intrapsychic structures and processes within the wider sociocultural context. There are three phases of a transition: entry, passage, and exit. The duration of each phase and the degree of disruption experienced vary from client to client.

Dimensions

People experience a transition in different ways, even when the circumstances of the transition seem similar. Commonalities among transitions are described by the dimensions, including duration, scope, magnitude, reversibility, effect, and whether the transition was anticipated, voluntary, and has clear boundaries. The transition event with its dimensions, the meaning to the client, and the associated level of well-being or consequences will provide the data base from which nurses can plan interventions (Chick & Meleis, 1986). Nurses can assist clients to prepare for role change and

prevent negative effects when a transition can be anticipated (Murphy, 1990). According to Chick and Meleis (1986), "A goal for nursing is that the client emerge from any nursing encounter not only more comfortable and better able to deal with the present health problem, but also better equipped to protect and promote health for the future" (p.248). Indicators of successful transition are (1) a subjective sense of well-being, (2) mastery of new behaviors, and (3) the well-being of interpersonal relationships (Schumacher & Meleis, 1994). Additionally, the meaning of the transition to the client is important, but seldom described in the literature.

Conditions for Transition

The context or constellation of personal and environmental factors shape individual transition experiences (Schumacher & Meleis, 1994). Conditions for transition include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being. The inclusion of meaning helps nurses understand the transition from the perspective of the person experiencing it. Expectations may or may not be helpful and can affect the transition experience. The level of knowledge and skill can influence health outcomes and is related to uncertainty. Environment is related to transition in two ways, either by changes in the environment which initiate the transition or by mediating the course of the transition. The environment can influence transition by providing support and by its degree of stability. The level of planning in anticipation of and during a transition influences the success of the transition. Lastly, emotional and physical well-being are affected by the distress inherent in transition.

Four commonalities which characterize a transition period have been identified: (1) disconnectedness from social networks and support systems, (2) temporary loss of familiar reference points or significant objects or persons, (3) needs which may not be met or new needs which may arise, and (4) sets of expectations which are not congruent with changing circumstances (Meleis, 1986). For nursing, transitions can occur either due to an illness or a change in health status or because the transition itself can lead to changes in health, health-seeking behavior, or health care utilization. Transition can increase vulnerability to health hazards and/or provide opportunities for growth or learning. Health-seeking behaviors may be inhibited because the appropriate course of action is not obvious. A person's response to the transition is influenced by her or his perception of the transition process and expectations for the outcome. The utilization of health care services may change in transition for a variety of reasons.

Maternal Role Attainment

Developmental transitions related to pregnancy, birthing and assuming the maternal role are often described in terms of the construct of maternal role attainment (MRA). The pioneering work of Rubin in 1967 described the maternal role as a complex social and cognitive process which is learned, reciprocal and interactive. Four developmental tasks of pregnancy were identified by Rubin (1977). In the first task the mother is seeking safe passage for her child and herself through pregnancy, labor and delivery. The second is insuring the acceptance of her child by her family. The third task is "binding-in" to the unknown child. And the fourth task is learning to

give of herself. Rubin (1967a) outlined several behaviors which mothers use to learn the maternal role: mimicry, role play, fantasy, introjection-projection-rejection, and grief work. New mothers include other mothers, peers, self and generalized "others" as role models or referents in this process (Rubin, 1967b). For Rubin (1984) the formulation of maternal identity marked the successful culmination of the process of MRA. Maternal identity is more than the taking on of a role or a sentimental attachment, but is an inseparable part of the woman's whole personality. It must develop anew with each pregnancy because a woman occupies a different life space and a different self-system at each childbearing experience. The formation of maternal identity binds the woman to this individual child and is a gradual, systematic, and extensive process.

Mercer extended the work of Rubin, and developed her theory and work on MRA beginning in the 1960s. Mercer (1985) defined MRA as a process which is interactional and developmental, and in which the woman becomes comfortable with her identity as a mother by integrating the mothering role into her established role set and by achieving competence in the role. In Mercer's theory, four important concepts are 1) the mother's "self system" made up of the ideal self, the self image, and the body image; 2) the reciprocal interplay between the mother's self system and her "role partner" (infant); 3) role strain; and 4) the mother's perceived quality of role performance (Mercer, 1984). Components of MRA include attachment to the infant, acquiring caretaking skills, and expressing pleasure and gratification in the role. Mercer asserted that the mother's responses are mediated by internal factors, such as

her experiences and self-esteem, and modified by the situational context (Mercer, 1985).

MRA is described as a process with four stages: anticipatory, formal, informal, and personal (Mercer, 1990). The anticipatory stage begins prior to pregnancy with random fantasy of "some day", but becomes focused during pregnancy. The formal stage occurs at birth and mothers follow behaviors which are prescribed by health professionals and society. The informal stage begins when the infant is around two months old as the mother begins to adapt her behaviors to be appropriate for her infant. The personal stage occurs around the sixth to ninth month when the maternal role is integrated into the identity of the mother and she has a sense of harmony, confidence and competence in her role performance. To achieve MRA a mother must adapt on several levels: at the physical or biological level, at the psychological or emotional level, at the cognitive level, and at the social level. In her research Mercer (1986a) reported that 85% of mothers experienced internalization of the role by nine months postpartum. MRA is focused on the mother and infant, and appears to ignore the larger familial context. It appears that MRA may be only one component of the transition to motherhood.

Critique of Maternal Role Attainment Theory

Literature on MRA has been based on research with white, middle class women (Gaffney, 1988; Martell, 1990) and does not discuss the relevance of this construct to women or parents from diverse cultural groups. The maternal attributes usually studied in relation to MRA are parity, age, and education (Pridham, Lytton,

Chang, & Rutledge, 1991). Mercer (1981) asserted that culture and socioeconomic level affect the maternal role, but this assertion is an implicit assumption and not tested in her research. Some studies have included women from several socioeconomic or cultural groups, but have not identified specifically if MRA is experienced the same or differently for these women (Ferketich & Mercer, 1990; Koniak-Griffin & Verzemnieks, 1991; Majewski, 1986, 1987; Mercer, Ferketich, 1995; Mercer, Ferketich, May, DeJoseph & Sollid, 1988). Other studies did not address the race or cultural demographics of the sample (Brouse, 1988) or have acknowledged the influence of culture on childbearing and proceeded to study white women (Martell, 1990; Oakley, 1980). Most of the research on MRA has been quantitative using multiple tools to measure identified components of the construct. Mercer (1986b) stated that most measures have been developed for use with "caucasians" and that further testing and development of instruments is needed to eliminate cultural bias. The construct of MRA needs testing to determine its appropriateness as a framework to describe multicultural mothering. Qualitative research would determine if there is cultural equivalence in the concepts.

Afrocentric Feminist Epistemology

Three concepts were important to understand in describing the use of an Afrocentric feminist epistemology as a foundation for this study. An epistemology answers the questions of who can be a "knower"?, what is legitimate knowledge?, and how and who decides what is legitimate? (Harding, 1987). The concepts of afrocentrism, racism, and black feminism provide the basis for answering these

questions and have profound implications for the methodology utilized in this study.

Afrocentrism

African Americans are a part of the "African Diaspora", the dispersion of African peoples throughout the world through enslavement (Dickerson, 1995; Terborg-Penn, 1991). Afrocentrism is a key concept in the study and understanding of African Americans, one in which African ancestry is consciously acknowledged. Centrism asserts that a group needs to be viewed and understood in terms of its own cultural meanings, attitudes and values (Dickerson, 1995). Afrocentricity, one form of centrism, is an interactive approach which stresses immersion in the history and culture of people of African descent and rejects the social distancing between researchers and subjects. The culture, history and contemporary experiences of African Americans are unique and must be understood in terms of on-going African cultural influences, as well as the history and experiences of African people in the United States (Assante, 1988; Dickerson, 1995). Cunningham (1994) asserted that the concept of afrocentrism is applicable to the health care community and could contribute to nursing theory development and a more humanistic health care delivery system.

Several historical influences on the development of African American communities have been documented (Hacker, 1975; Ladner, 1976; Staples, 1981). African ancestry, enslavement, emancipation, migration to urban centers and the Civil Rights Movement of the 1960s and 1970s have all created a common history and culture. Many African Americans are descended from people who were brought to the

United States as slaves from West Africa. Although these people were from a variety of tribes and traditions, they shared some common cultural attributes. African American families have been labeled as matriarchal, in which all power and authority rested in the hands of strong, domineering women (Moynihan, 1965). The more accurate and preferred term is matrifocal (Dickerson, 1995). A matrifocal system is woman-centered, held together by the extended line of female kin. The most important relationships are those related to blood ties, rather than to marriage ties. "Fictive kinship networks" based on friendship are also key to the extended family (Dickerson, 1995; Elise, 1995; Stack, 1974). Brothers and other adult male kin play an important role in the matrifocal family. Positive values have been handed down from African ancestors, including high esteem for elders, respect for wisdom gained from experience, pragmatic spiritual beliefs, and a collective survival ethic (Dickerson, 1995).

Afrocentric research is an interactive approach which recognizes the connectedness between discerning the "ordinary knowledge" base of the peoples of African descent, calling attention to the social conditions affecting their lives, and taking action to positively affect change to correct injustice. Empowerment is facilitated through the process of inquiry which increases the participants' understanding and provides the information needed to develop a course of action (Dickerson, Hillman & Foster, 1995).

Race and Racism

The concept of race was first used in the biologic literature in 1749, explicitly regarded as an arbitrary classification, a convenient label, and not a definable scientific entity (Cooper & David, 1986). The "invention" of the modern concept of race emerged with three interrelated developments in Europe: the development of nation states which depended on strong ethnic group identity, the colonization of both the Americas and Africa by European nations, and the resultant oppression and subjugation of Native American and African peoples. This oppression led to the development of the African slave trade in the seventeenth and eighteenth centuries. Before 1650, Africans were brought to Virginia as indentured servants and there is speculation that African peoples were present in the Americas before European colonization. The economic development of the English colonies depended on a tractable work force on the plantations and a mechanism to divert class conflict away from the landowners and upper classes.. The identification of slavery exclusively with people of color allowed whites of all classes to unify against "an alien race". The creation of social institutions which separated blacks from whites proceeded rapidly in the late seventeenth century (Cooper & David, 1986) .

On a population basis, the "white" race differs from the "black" race on only six pairs of genes. The diversity between individuals in a population accounts for 85% of the total species variation and only 8.3% is accounted for by race (Cooper & David, 1986). Allman (1992) posed the question of why some genetic differences, like skin pigmentation, are significant in determining race and others are not? Yet, the use

of skin color is also arbitrary in defining race. Cooper and David (1986) stated that many peoples have dark skin, for example the Masai, pygmies of the African rain forest, inhabitants of southern India, Australian aborigines, and natives of the Amazon delta, but they are not considered from the same race. Not all Africans are considered black and others who have light skin color are labeled as black based on their ancestry. The schema of the United States National Center for Health Statistics (cited in Cooper & David, 1986) designates a child as "white" only if both parents are white or one parent is white and the other unknown. If the father is black, no matter what the race of the mother (except Hawaiian), the child is designated as black. If the father is white, the child is designated as the race of the mother. According to Cooper and David (1986), "Entry into 'whiteness' is thereby restricted to those of 'pure' origin" (p. 106). The California Department of Health Services (1986) stated that the "Black race designation" always takes precedence and a child is always classified as black if either parent is black (DHS, 1986).

In public health and medicine, race is virtually never defined. Specific gene frequencies are rarely measured and the criteria for assigning someone to a race are not stated (Cooper & David, 1986). Race can be self-identified or assigned by someone else. The "natural" fact of race is assumed to produce the disease when a group is more susceptible to the disease (Allman, 1992). The search for a cure is confined to the bodies of the individual sufferers, not conducted in the larger social context of living and working conditions. Race is transformed from a social, political, historical, and cultural matter to a problem of nature to be solved by scientists. Social

and natural scientists now admit that racial differences do not reflect different genes, but differences in social environments. The definition of a population subgroup results from historical and economic, not evolutionary developments (Cooper & David, 1986). Race is a social concept with no biologic meaning and races are created as social, cultural and ideological constructions and used as political weapons (Cooper & David, 1986; Krieger et al., 1993; Stanfield, 1993). The important question posed by these authors is how is health influenced by social divisions based on race?

Racism

The principal feature distinguishing oppressor and oppressed groups in the United States, according to Krieger et al. (1993), is skin color. Yet, the previous discussion on race demonstrated that the determination of skin color and race is imprecise and contradictory. Despite its imprecise definition, race functions not merely as a category, but as an organizing principle of everyday life (Stanfield, 1993). Race is involved in decision making about self-concept, concepts of others, residential choice, selection of mates and friends, and in job opportunities and decisions. Racism is rooted in centuries of oppression. Race exploitation and prejudice have continually appeared together and reinforced each other (Essed, 1991). Krieger et al. (1993) defined racism as "an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and others through this domination" (p. 85). According to these authors racism is based on four false assumptions: 1) humans are divided into distinct and different races, 2) genetically determined physical attributes used to identify race are linked to other

characteristics, 3) differences between racial groups reflect genetic differences, and 4) certain races are inferior and others superior. These beliefs both justify and lead to inequalities in living conditions and opportunities.

Racism is expressed and implemented by both institutions and individuals. Most discourse on racism has focused on the macro, societal level (Essed, 1991). Racism has been defined as an inherent part of culture and social order. Focusing on structure and ideology allows racism to be viewed in an abstract manner, something external to the individual, which can be fixed or eliminated, but which is not seen as "my problem". Several authors (Frankenberg, 1993; Russo, 1991) make clear that many whites believe that working on the problem of racism is a matter of working on someone else's problem, and do not see it as a white problem. Yet, racism impacts all of our lives: it shapes our identities, experiences and choices. Allman (1992) proposed that racism is formalized through "routinized micropractices" like checking boxes on forms which indicate racial/ethnic origin. The determination of these preordained categories is part of the re/production of race.

Racism is a complex system of power, and shapes the ways in which social relations and practices are experienced by black people (Essed, 1991). Power belongs to a group which acts in concert. This implies that there is a feeling of belonging to a group and this belonging empowers individual members of the group to act in prescribed ways. Prejudice (attitudes) and discrimination (actions) work to reinforce and reproduce the structures and ideologies of racism. Intentionality on the individual level is not a necessary component of racism, although the structural and cultural

properties of racism intentionally create systems of inequalities (Essed, 1991). Racism often operates through seemingly nonracial practices. Racism is not only a matter of ideology, ideas, stereotypes, images or misguided perceptions, but is about power and control (Russo, 1991). Jewell (1993) asserted that there are individuals in the United States with a monopoly on societal resources who utilize the mass media to perpetuate the belief that those in power have a legitimate right to the resources and institutions which they control. People hold the belief that merit is the basis for privilege and reward.

Everyday Racism

Essed (1991) defined "everday racism" in the following way:

> ...a process in which (a) socialized racist notions are integrated into meanings that make practices immediately definable and manageable, (b) practices with racist implications become in themselves familiar and repetitive, and (c) underlying racial and ethnic relations are actualized and reinforced through these routine or familiar practices in everday situations. (p. 52)

Inherent in this definition is both personal and vicarious experience. Everyday racism involves systematic, repetitive, familiar practices -- behaviors and attitudes -- incorporated into our daily lives through socialization. Racism is transmitted in routine practices that appear normal, which are neither recognized nor acknowledged. Essed's study determined that racial and ethnic conflict are maintained through three major processes: marginalization (a form of oppression), containment (a form of repression), and problematization (legitimizing exclusion and repressing opposition).

bell hooks (1992) said that black people associate whiteness with the terrible, the terrifying and the terrorizing. hooks stated, "All black people in the United States, irrespective of their class status or politics, live with the possibility that they will be terrorized by whiteness" (1992, p. 175). African Americans live in a state of heightened awareness in which all situations are evaluated because of chronic racism. Racism is a continuous stressor (Outlaw, 1993).

Gendered Racism

The struggle for black liberation in the United States historically occurred during the same time periods in which women struggled for equal rights. Racism is a distinct ideology and structure, but also interacts with other types of domination. Black feminists agree that race, rather than gender, has been the primary source of oppression for black women (Essed, 1991). Black women insist that liberation of women depends on the liberation of the black race and the improvement of life in the black community as a whole (Lerner, 1972). Collins (1991b) and King (1986) described race, gender and class interlocking to form multiple structures of domination. The artificial separation of race, class and gender obscures the unequal opportunity structures organized by race and amplified by class (Allman, 1992). Essed (1991) said that it is useful to speak of "gendered racism" as a hybrid phenomenon affecting black women of racism and sexism combined.

Black Feminist Thought

The contemporary information on motherhood in the African American community reflect the writings of Black Feminists who have combined African

American literature and research done in the 1970s. Mother-only families, occurring in 46.7% of African American families (Bureau of the Census, 1994), are assumed to be dysfunctional (Bennett, 1992). Ladner (1972) asserted that blacks have been placed in the context of the deviant perspective in academia. Black women intellectuals have long expressed a unique feminist consciousness about the intersection of race, class, and gender. Ironically, the ideas of these black feminists have been suppressed or ignored within feminist theory (Barbee, 1994). Collins (1991a) criticized white women who omit women of color from their research claiming that they are unqualified to understand the black woman's experience. Five "core themes" are present in the writings of black feminists: (1) a shared struggle against racism and sexism, (2) recognition of the interlocking nature of race, gender, and class oppression, (3) a call to replace denigrating images of black women with self-defined images, (4) belief in black women's activism as mothers, teachers, and community leaders, and (5) sensitivity to sexual politics (Collins, 1991a).

Four themes are expressed in various forms by African American women depending on the degree of oppression experienced and the resources available. Women-centered networks provide community-based child care in the African American community. Providing economic resources for the family is an essential part of mothering. Mothering is linked to community activism for many women, especially for "othermothers", women who function as mothers but are not the biologic mother. Motherhood is seen as a symbol of power. A key role for African American mothers is to socialize their daughters to incorporate a critical posture which allows them to

cope with contradictions. Daughters must be taught to survive in an oppressive society while rejecting and transcending this society (Collins, 1991c).

Analysis of black motherhood historically has been done by both black and white men (Collins, 1991a). Negative stereotypes have portrayed black mothers as "mammies", "matriarchs", "hot mommas", and welfare mothers. Black male scholars have typically glorified black motherhood and have not been able to get past the image of "super strong black mother" to understand the real costs of mothering for black women. In Joyce Ladner's (1972) study of black adolescent girls, the image of the black woman as being strong, independent and self-reliant was pervasive. In African societies motherhood is a symbol of creativity and continuity. In African American communities motherhood is central, reflecting a continuation of West African cultural values and functional adaptations to race and gender oppression (Collins, 1991c). Robert Staples (1985) asserted that the role of the mother is the most important role in the African American community. As mothers, black women can learn the power of self-definition, the importance of respecting and valuing themselves, the necessity of self-reliance, and a belief in empowerment. The views held by black women regarding motherhood range from seeing it as a burdensome condition to seeing it as a base for activism and self-actualization (Collins, 1991a).

S.M. James (1993) stated that "... mothering within the Afro-American community and throughout the Black diaspora can be viewed as a form of cultural work... to nurture itself and future generations" (p. 44). Motherhood is defined within a complex extended family lineage system of obligation and reciprocity, and children

are not the exclusive responsibility of their parents (Elise, 1995). Three categories of mothers form resilient, organized, women-centered networks to care for children in the black communities (Collins, 1991a). Biological mothers or "bloodmothers" are expected to care for their children, but there is a recognition that giving one person the full responsibility for mothering may not be possible or wise. "Othermothers" assist bloodmothers by sharing responsibility. Othermothers may be grandmothers, sisters, aunts, cousins or friends. Women who do not have biological children of their own can receive recognition and status by being othermothers. Collins stated that black women's experiences as othermothers provides a foundation for political activism. Community-centered child care stimulates an ethic of caring and personal accountability to all children in the black community. Thus, the third type of mothering, "community othermother", traditionally allowed black women to treat biologically unrelated children as if they were members of their family. Community othermothers work to bring people along, to "uplift the race", so that vulnerable members of the community can attain self-reliance. Women may assume the role of community othermothers when a problem is recognized as requiring collective action. According to hooks (1984), community-based child care is critical to ensure that children will be raised in the best possible social frameworks. Collective parenting done by women and men of all ages gives children more resources to rely on for their emotional, intellectual, and material needs.

The personal meaning of mothering can be rewarding, but also extract high personal cost (Collins, 1991a). Black women's practical and innovative approaches to

mothering under oppressive conditions often brings power and recognition. African Americans value motherhood, but the ability of mothers to cope with oppression should not be confused with transcending oppression. Although mothering can be seen as a nurturing state for self and others, many African American women have been socialized to take care of others before they take care of themselves (Krieger et al., 1993). Socialization of black women into the caretaker role has been framed in terms of ensuring the survival of entire groups of people, including their own family members, white women, men and children, and the black community. Krieger et al. lamented that "Conspicuously absent is any caring source for black women themselves" (1993, p. 90).

Several dimensions of black motherhood have been identified as "problematic" (Collins, 1991c). For many, becoming a mother is seen as the first step toward womanhood (Ladner, 1972; Stack, 1974). According to Elise (1995), early motherhood is often a mechanism to achieve adult status when other options seem unavailable. However, coping with unwanted pregnancy and being unable to care for one's children is oppressive. Another problematic dimension is the mother's feeling of powerlessness to protect her black children from the many risks they face as they grow up. Black mothers must spend most of their time meeting the survival needs of their children and as a result give up their own dreams of achieving creative ability. Children offer hope and affirmation to their mothers. Alice Walker's 1974 essay "In Search of Our Mother's Gardens", said "...our mothers and grandmothers have, more often than not anonymously, handed on the creative spark, the seed of the flower they

themselves never hoped to see: or like a sealed letter they could not plainly read" (1983, p.240). bell hooks (1984) stated that for poor and non-white women, parenting is one of the few interpersonal relationships where they are affirmed and appreciated. hooks criticized feminists who romanticize motherhood and reinforce sexist stereotypes which imply that a woman's truest vocation is motherhood. Isolated parenting done only by women is problematic; children need to receive care by both parents and hooks calls for the restructuring of society so that women do not solely provide child care.

Theoretical Framework

Transition theory provides a framework which allows motherhood to be studied as a complex, longitudinal and multidimensional process and focus on patterns of response over time. An integrated transition model incorporating developmental, adult socialization and interactionist perspectives appears more comprehensive in describing the transition to motherhood. Common themes in the definition of transitions are disruption, disconnectedness, and emotional upheaval -- certainly themes common to expectant and new mothers. Compared to all transitions which are of interest to nursing, the transition to motherhood has received the most attention in the nursing literature (Schumacher & Meleis, 1994).

Maternal role attainment is the construct used in nursing to describe the transition to motherhood. Chodorow (1978) asserted that motherhood is not simply an acquired role for women, but is a complex process built into the personality. If motherhood is more complex than becoming a mother, if it is an identity as Rubin

(1984) suggests, MRA will not adequately describe the process. Additionally, since the construct of MRA has not been studied cross culturally, this theory cannot be generalized to all mothers. The cultural equivalence of this construct needs testing with multi-cultural populations.

Black feminism, based on Afrocentrism, supports the need for nurses to conduct research with African American women with a sense of their history, experiences and culture. Nurses from group backgrounds other than African American need to be particularly sensitive to the effect of their own experiences and assumptions on the research process. All researchers need to increase their knowledge of the culture, develop cultural sensitivity, and collaborate with cultural "insiders" to conduct culturally competent research (Sawyer et al., 1995). Zambrana (1987) proposed a conceptual model for studying the health of minority women. In this model health status is considered as an interactive relationship among socioeconomic, behavioral, and environmental factors. The complexity of the issues affecting health status require researchers to study health in the context of people's everyday lives, including the environment in which they live and work, the meanings and perceptions of their life experiences, their roles, support systems, protective and health promotive behaviors, resources, culture, and history.

Racism is a continuous stressor in the lives of African Americans and provides the context to study differentials in health status. The definition of a problem can narrow horizons, construct barriers and limit solutions to the problem. The scope of research needs to be broadened and focused on the experiences of African Americans.

Recognizing the centrality of the life experiences of African Americans in research requires collaboration between researchers and participants in the community. Responses to everyday racism can promote health or illness. These responses need to be identified and interventions developed to address the political and social causes of poor health. Protective and health promotive behaviors need to be supported and enhanced with resources. Nursing research needs to bring to bear the discipline's espoused holistic view of persons, environment and health and its ethical mandate to advocate for clients and protect human rights on the complex issues involved. Racism and discrimination practiced by nurses should also be exposed.

Collins (1991a) outlined the dimensions of an Afrocentric feminist epistemology: valuing the concrete, using dialogue to assess knowledge claims, the ethic of caring and the ethic of personal accountability. African American women value experience and find more credible those "experts" who have lived through an experience rather than simply read about or thought about the experience. "Valuing the concrete" is both an Afrocentric and women's tradition of knowing (Collins, 1991a). Connectedness and dialogue are essential components of the knowledge validation process. The ethic of caring is composed of empathy, personal expressiveness, and emotions. People are expected to be accountable for their knowledge claims. Afrocentric scholars need to function as translators to dominant group members to persuade them to become "doubly conscious", to accept and learn from the "ordinary" knowledge of African American women.

Research needs to be conducted from both the population and individual levels. The focus of epidemiologic research on aggregate data makes invisible the experiences of individual members of a population. To understand the differentials in health status, researchers need to explore the social patterning of both exposure and susceptibility, of why some individuals have healthy outcomes with the same exposures. Heterogeneity in the black population in the United States needs to be studied in regard to differences in socioeconomic status, generation, migration and country of birth. There is an urgent need for qualitative research to provide the grounding and understanding of the lives of African American women and the diversity and commonalities in their experiences. Nursing therapeutics are needed to assist and support African American women in the creation and continuance of conditions which enhance a healthy transition to motherhood. Until nurses understand this transition from the perspective of African American women, they will not be able to identify effective therapeutics. The methodology employed in this study addresses some of these critical issues and proceeds from framework of transition theory, informed by the context of afrocentrism, racism, and black feminism.

CHAPTER IV: METHODOLOGY

Four research questions guided the data collection and analysis for this study. Interviews elicited the data to answer the first three questions which were 1) How do African American women describe their transition to motherhood? 2) Who/What facilitates and inhibits a successful transition to motherhood for African American women? and 3) What protective behaviors/measures do African American women utilize to facilitate a healthy transition? The fourth question asked "How do women take care of themselves during pregnancy and does a woman's perception of racism have an effect on how she cares for herself or the care she seeks?" This question was addressed both by interview and through the use of The Perceptions of Racism Scale (Green, 1995) and a demographic profile which each participant was asked to complete at the end of the first interview.

Design

This research is a descriptive study using semi-structured individual interviews and focus group interviews to describe the transition to motherhood for African American women. Grounded theory was utilized to guide data collection and analysis. This method uses a systematic set of procedures to develop an inductive theory about a phenomenon (Strauss & Corbin, 1990). Theory evolves from a continuous interplay between data collection and analysis -- "the constant comparative method." This methodology can be used to generate theory or elaborate on a theory already grounded

(Strauss & Corbin, 1994). Theory generation is explicitly linked to actual research. Researchers are accountable to report not only on observations and give voice to participants, but also to interpret the data. Researchers bring training, experience, knowledge of the literature and extant theories which can sensitize the researcher to the possibilities in the data. Both qualitative and quantitative data can be analyzed using the grounded theory method. Verification of the theory does not wait for follow-up studies, but is done throughout the course of the research project. Underlying this approach to research is an assumption that the concepts pertaining to a phenomenon have not all been identified or that the relationships between the concepts are not well understood. Patterns of action and interaction and the processes and conditions under which a phenomenon occur are of interest to grounded theory researchers (Strauss & Corbin, 1994). The research design and protocol for a grounded theory study are shaped by the collection and analysis of data.

Sample

Seventeen African American women were interviewed from one to three times during the postpartum period. Potential participants were approached using a combination of recruitment techniques. Most participants were identified by Home Health Nurses who visit all first time mothers at least once in the immediate postpartum period at a large health maintenance organization in California. Additional participants were recruited through snowball sampling techniques in the community. Nurse Practitioners were also asked to identify potential participants at prenatal visits in the last trimester of pregnancy, but no participants were recruited from this source.

Theoretical sampling was used, which requires that participants are selected because they can shed light on the concepts being studied. As the study proceeded categories emerged and participants were recruited who could provide data on events or examples of the category, its dimensions, properties, and variations (Strauss & Corbin, 1990). Participants were sought, for example, who represented the diversity of African American women in terms of age, education, socioeconomic status, and geographic origins. The actual number of participants was determined by theoretical saturation. Theoretical saturation of each category is needed for the theory to be conceptually adequate. Sampling continued until 1) no new data emerged, 2) the category was dense, and 3) the relationship between the categories was clear (Strauss & Corbin, 1990).

The focal group sampled were African American women who had delivered their first child. Women who were in the first year postpartum as primiparas were eligible to participate in this study. To meet the criteria for inclusion, a woman was age 20 years or older, able to understand and speak English, identified herself as African American, and agreed to participate in the study.

Data Collection Methods

Both focus group and individual semi-structured interviews were utilized in data collection. Signed consent was obtained prior to the first interview. Interviews were audiotaped and conducted in a convenient and private place, such as the woman's home or in a conference room. Interviews lasted from one to two hours (see Appendix A for the interview guide). At the end of the interview the participant

completed a demographic profile and Green's (1995) Perceptions of Racism Scale (Appendix B).

Focus groups are a tool which allows a larger sample and is time and cost effective (Krueger, 1994; Lankshear, 1993). A focus group is defined as a carefully planned discussion of six to twelve people on a defined area of interest in a permissive and nonthreatening environment (Asbury, 1995; Krueger, 1994). Although the focus group was developed by social scientists in the late 1930s, it has mostly been used in market research over the last thirty years. Focus groups work best when participants are similar to each other on characteristics of interest. Usually for research purposes at least three different focus groups should be utilized to detect patterns and trends across groups. The number of participants recommended for each group varied by author. In a study with disabled elderly, Quine and Cameron (1995) found that five participants in the group were optimal, six manageable and four less dynamic. Halloran and Grimes (1995) found that smaller groups provided consistent findings. According to Krueger, focus groups produce qualitative data on attitudes, perceptions, and opinions of the participants. The researcher's role is one of moderator, facilitator, observer, and listener. Focus groups can be used alone or in conjunction with other methods. Advantages of focus groups include 1) the dynamic nature of group interaction provides rich data, 2) the moderator has the ability to probe responses, 3) the technique is easily understood, relatively low cost, can allow a larger sample, and it can provide speedy results. Limitations of focus groups are that the researcher has less control, data are more difficult to analyze, carefully trained interviewers are

required, groups can vary considerably, groups are difficult to assemble, and there may be possible logistical problems and a need for incentives.

Procedures

Potential participants were identified either by Home Health nurses in the immediate postpartum period or by Nurse Practitioners in the last trimester of pregnancy and given a letter describing the research project. If a woman was interested in participating, I contacted her by telephone to explain the study and answer questions. If the woman agreed to participate she was given the choice of being in a focus group or having an individual interview. Other participants were identified through snowball sampling techniques, but the same procedures were followed. Informed consent was obtained and the interview scheduled at a convenient time and place for the participant. I used good interviewing techniques to establish trust with participants, such as asking factual questions at the beginning of the interview, not stating judgement or disagreement with the participant's statements, and showing interest in and comfort with the participant. I created an environment in which all participants' viewpoints were respected and heard and used good group process techniques. At the close of the first interview participants were asked to complete the Perceptions of Racism Scale and the demographic profile.

In this study, data were collected using two methods. First, individual interviews were conducted with women who were within the first year postpartum. Second, three focus groups were assembled, averaging three to eight participants per group, composed of women who had delivered their infants. All participants were

asked to participate in a second interview two to three months after the first interview to further explore their experiences and perceptions of becoming a mother over time. Participants were given the choice whether to be interviewed individually or in a focus group. All participants were invited to the third focus group and eight of the seventeen mothers attended. A total of thirty contacts were made with seventeen participants, with six women having one interview, seven women having two interviews and four women completing three interviews. Participants were reimbursed $25 in cash after completing each interview and written instruments.

Instruments (Appendix B)

The Perceptions of Racism Scale (Green, 1995) was pilot tested with two samples of women: Study A used a convenience sample of 109 African American women from selected church and community organizations and Study B used a convenience sample of 136 African American nulliparous women in a low birth weight/preterm delivery study (Green, 1992). The scale is composed of twenty statements and the participant is asked to check: strongly agree, agree, disagree, or strongly disagree for each statement. A total score is obtained based on the participant completing at least 16 of the 20 items. If a participant completes fewer than 16 items, the score is discarded from the data analysis. The score is then interpreted as either high, medium or low perception of racism.

The instrument was constructed from a combination of field research, literature review, and content expert review. Alpha reliabilities were .88 for Study A and .91 for Study B. Content validity was strengthened by expert review. Construct validity

was partially supported in Study B by the finding of a positive relationship between racism and stress (p>.01). A lower perception of racism was demonstrated in Study B compared with Study A. Green proposed a possible explanation for why the perception of racism was higher in Study A than in Study B. Study A was conducted anonymously and Study B was conducted on pregnant women in a health care setting where the participants were known. Remaining questions include whether pregnancy is a mediator, if the samples were different in other ways, and the possible effects of class, income, and education on the perceptions and experiences of racism. This instrument is an important step in our ability to measure a person's perception of racism and to determine effects of racism on health status.

I constructed the demographic profile to specifically address criticisms in the scientific literature related to applicability of standard measures of socioeconomic status for African Americans. Partner status is broader than marital status. Education is assessed in terms of credentials obtained as well as years of education. Income is assessed in the context of the number of people the income supports and the total family income. The availability of other assets and resources, such as home ownership, savings accounts and pension funds, ideally need to be assessed to determine the adequacy of income. The number of children, household composition, and occupation of participant and partner were determined. Questions also elicited the initiation of prenatal care, amount of care, whether care was interrupted, who provided the care and whether this provider was the woman's preferred provider.

Research Rigor

Several measures to ensure rigor in this study were integrated into the design. During contact with participants, I sought constant validation and clarification of the data. I discussed my interpretations of the data with a focus group of participants to clarify and expand on my analysis. Utilizing both focus group and individual interviews enhanced comparisons of both group and individual perspectives and added depth to the data. Issues brought up in a focus group interview were explored in more depth in individual interviews. Conversely, an issue raised in an individual interview was examined for its uniqueness or commonality of experience in the group. Grounded theory explicitly examines the variations related to a phenomenon and facilitated exploration of the often ignored diversity within African American communities. Additionally, I documented the decision trail, data collection and analysis techniques for independent audit by the dissertation committee members and utilized other researchers who are skilled in the grounded theory method to advise on design and analysis.

The assumptions and biases of the researcher will affect the research process and results. Since I am Irish American, not African American, it was critical that I examine and acknowledge how my background and assumptions would affect the research and participants. As a nurse clinician of 22 years, I have spent most of my career working in urban communities with many African American families. What I experienced as a clinician did not match the negative view of African American families found in the literature. I do not assume that the experience of African

American mothers is either the same or different than that of women of other cultures. I do believe that it is important for researchers to solicit the meanings and experiences of this cultural group and not assume that they are the same as other groups. The assumptions which I brought to this study include the following: 1) African American women have strengths and resources in their families and communities to assist them in their transition to motherhood, 2) women want to have healthy outcomes and do take actions to ensure the health and safety of their infants, even if they do not receive "adequate" prenatal care, and 3) researchers can better describe this transition by studying "normalcy", by choosing participants who are low risk, middle class and well educated. Developing trust with participants was critical, but even with trust it is possible that I could have been told what participants thought I wanted to hear. This is a problem for all researchers. Information which was told to me in individual interviews was consistent when the same participants were part of a focus group. At times in focus group interviews, women seemed to forget I was there or would preface negative statements about providers with comments such as "No offence, Linda, but...". Validation of the findings was an important step to assure that this research was "for" the women studied, not "on" them (Harding, 1987). I presented eight of the participants with the tentative analysis for their critique in a focus group. Several suggestions were added in the implications section to reflect the feedback from participants. Participants stated that they felt their experiences were reflected in the analysis and the presentation generated a lot of animated discussion amongst the participants.

Data Analysis

Data collection, analysis, verification and the development of theoretical explanations proceeded simultaneously throughout the project. Descriptive statistics were utilized to provide summary profiles of the participants. Adequacy of prenatal care was coded as adequate or inadequate, utilizing onset of care and total number of visits as the determinant. Care was coded as adequate if it began in the first trimester of pregnancy and there were a minimum of nine prenatal visits. The Perceptions of Racism scores were incorporated as a comparison measure to determine whether a woman's perception of racism affected the prenatal care she sought and received.

Data from both instruments was entered into the computer using the statistical program Crunch and appropriate statistical methods were employed to determine relationships. A statistician was consulted to outline the most appropriate procedures. Both the demographic profile and the Perceptions of Racism Scale provided data to verify and clarify the conditions, interactions, and consequences of the emerging grounded theory.

Interview data was analyzed utilizing several layers of coding procedures. I used a word processing program to assist with data management and analysis. Coding of data represents the procedures through which data are broken down, conceptualized and reconstructed (Strauss & Corbin, 1990). The first level of coding is called "open coding" in which the data was broken down into categories and named. Asking questions and making comparisons from the data was key at this level. Coding of the first seven interviews revealed 36 codes in the data. Properties and dimensions of the

each category were identified and theoretical sampling was utilized to develop each category. The codes related to either safely negotiating the pregnancy or becoming a mother. Negotiating the pregnancy included attaining care, preparing, and handling problems. Becoming a mother included anticipation, dealing with hassles, readiness, settling-in, and the meaning of motherhood. Detailed memos, including portions of the interview transcripts to support the analysis, were written to document the processes utilized as the analysis progressed.

The second level of coding is called "axial coding" in which the data are put back together in new ways. As data collection proceeded, the data was reexamined and connections made between categories and sub-categories. Four categories were identified: "getting ready", "dealing with the reality", "settling-in" and "dreaming". The paradigm model (Strauss & Corbin, 1990) was utilized to link categories and sub-categories and illustrate their relationships. In this model, causal conditions lead to the occurrence or development of a phenomenon, or central idea. Each phenomenon has a set of specific properties which locate the phenomenon along a dimensional range, the context or conditions. There can be intervening conditions which constrain or facilitate actions or strategies taken. Actions/interactions are the strategies used to respond to the phenomenon within the context or conditions. The actions/interactions lead to consequences. According to Strauss and Corbin (1990), "In grounded theory we link subcategories to a category in a set of relationships denoting causal conditions, phenomenon, context, intervening conditions, actions/interactional strategies, and consequences." (p. 99) The linking was considered provisional until verified in the

data.

The third level of analysis is called "selective coding". Selective coding is the process of determining the "core category" which is the central phenomenon around which all categories are integrated. In selective coding, I systematically related the core category to other categories, validated relationships, refined and further developed categories. A variety of memos and diagrams assisted me to "gain analytical distance from materials" (Strauss & Corbin, 1990, p. 1990), increased the abstraction, and grounded abstractions in reality. The core category was identified after two focus group interviews and sixteen individual interviews. No new categories were identified after the first twelve interviews and theoretical saturation was reached by the interview of the seventeenth participant. I presented the tentative analysis to a focus group of eight of the participants to validate the findings.

Human Subjects

The University of California, San Francisco Committee on Human Research approved the study before it began (Appendix A). Written explanation of the study was presented to prospective participants in person or by mail. I made a brief contact with each potential participant to ascertain the her interest in participating, to further explain the research, and to clarify any questions.

There were no obvious risks to the participants since the topic is an everyday event. Potentially, some participants could have found it disquieting or uncomfortable to discuss their pregnancy, life experiences, and concerns. However, I used an unobtrusive interview style and sensitivity to a participant's hesitancy to lessen any

potential discomfort. For the focus group interviews, I protected differing views of participants and participants were asked to only use first names and keep all information shared in the group confidential. Participants were assured that although confidentiality could not be guaranteed in focus groups, their confidentiality and privacy would be protected by erasure of tapes after transcription, and by omitting any identifying information on the transcript. Data was stored in a locked cabinet, the location known only to the investigator. Participants were assured that any transcribed segments used for educational or publication purposes would not identify the respondents in any way. If particular elements seemed unique, composite respondents would be constructed for presentation and publication purposes.

While no personal benefit was anticipated or guaranteed, participants seemed to enjoy the interviews and eleven of the participants requested inclusion in a second interview. Participants stated that they enjoyed the interview, all requested a copy of the final report, and ten participants exchanged telephone numbers to continue meeting as a support group. Data from this study provided insight into the range of behaviors engaged in by African American pregnant women, their experiences in the transition to motherhood and with prenatal care, and will assist in the design of appropriate interventions and more effective health services. Chapter Five presents the results and grounded theory analysis.

CHAPTER V: RESULTS

Seventeen African American women were recruited for this study during the postpartum period. Most were recruited by Home Health nurses who visited all first time mothers within 48 hours after the birth of their child. Others were recruited utilizing snowball sampling techniques.

Demographics of Sample

Women ranged in age from 23 to 40 years, with a mean age of 29.9 (sd 4.92). Eleven women were married (64.7%), three were partnered (17.7%), and three were single (17.7%). The number of persons in the household ranged from two to five, with ten households composed of the participant, her partner/spouse and one child (58.8%) and five households of mother and child alone (29.4%). Women or their parents were from a variety of geographic origins, including New York, Jamaica, Panama, Louisiana, Mississippi, Texas, Missouri, and California.

Nine women were employed full time (52.9%), three stopped working during the pregnancy and did not plan to be employed at the present time (17.7%), two were employed part time (11.8%) and one was employed part time and was also a student (5.9%). One woman stated she is a homemaker and one chose the category "other" and specified she was on maternity leave/disability. The occupations of participants and their partners were diverse and included store cashier, secretary, maintenance worker, computer specialist, professor, and contractor. All of the participants had

completed a minimum of a high school education. The highest level of education obtained by participants was high school (11.8%), some college (29.4%), associate degree (11.8%), college graduate (35.3%), masters degree (5.9%), and doctoral degree (5.9%). Family income ranged from $10,000-30,000 (29.4%), 30,001-50,000 (29.4%), 50,001-70,000 (29.4%), to $70,001-100,000 (11.8%), with eleven women (64.7%) stating that their income was adequate to meet their needs and six (35.3%) stating it was not adequate. Work was the source of income for fourteen participants (82.4%), with two also including savings (11.8%) and three women choosing the category "other" (17.7%), with one woman supported by SSI and two supported by "my husband". The number of persons working in the household ranged from zero (5.9%), one (29.4%), two (58.8%) and three (5.9%). Four participants (23.5%) stated that their incomes also supported persons outside the home (Table 2).

Nine women (52.9%) saw a physician for care, twelve (70.6%) saw a Nurse Practitioner, one saw a midwife (5.9%) and four (23.5%) saw other providers including a Physical Therapist, a Counselor and a Doulah (2). Five women saw more than one provider (29.4%). All participants had adequate prenatal care as determined by initiation of care in the first trimester and total number of visits as nine or more. Five women (29.4%) changed providers during the pregnancy, and only one woman did not see the provider she wanted to (Table 3).

Perceptions of Racism Scale

Data was entered into the Crunch statistical program for analysis. Negatively worded questions (#1, #3, #4, #6, #7, #10, #12, #15, #18, #19) were transformed for the analysis. Three questionnaires were scored using the 80% rule of mean substitution because they had missing scores. All questionnaires were either complete or met the 80% rule for mean substitution and were included in the analysis. Higher scores reflect a greater perception of racism, with potential scores ranging from a low of twenty to a high of eighty. Alpha reliability was .9189 (range on individual questions .909 to .927), which is consistent with other studies (Green, 1995). Scores ranged from a low of 36.00 to a high of 69.00, with a mean of 53.98 and a median of 54 (Table 2). All participants received adequate prenatal care as defined by more than 9 prenatal visits which commenced in the first trimester of pregnancy. A Pearson correlation was done to determine if there was an association between the number of prenatal visits and the perception of racism score. The value of -0.3575 was not significant, although it showed a slight trend toward less visits with a higher perception of racism score. A T-test was done to determine if there was an association between changing provider and a woman's perception of racism score, but there was no difference in the means of the two groups.

Table 2. Demographic Description of Participants (n=17).

Characteristic	Number	(%)
Age (mean 29.94)	17	(100)
20-25	3	(17.7)
26-30	9	(52.9)
31-35	2	(11.8)
36-40	3	(17.7)
Partner Status		
Single	3	(17.7)
Partnered	3	(17.7)
Married	11	(64.7)
No. of persons in household		
2	5	(29.4)
3	10	(58.8)
4	1	(5.9)
5	1	(5.9)
Employment		
Work, full time	9	(52.9)
Work. part time	2	(11.8)
Not working	3	(17.7)
Work and student	1	(5.9)
Homemaker	1	(5.9)
Other	1	(5.9)
Education		
High school diploma	2	(11.8)
Some college	5	(29.4)
Associate degree	2	(11.8)
College graduate	6	(35.3)
Master's degree	1	(5.9)
Doctorate	1	(5.9)
Family income ($)		
10,001 - 30,000	5	(29.4)
30,001 - 50,000	5	(29.4)
50,001 - 70,000	5	(29.4)
70,001 - 100,000	2	(11.8)
Support family not living in home		
Yes	4	(23.5)
No	13	(76.5)
Adequate income		
Yes	11	(64.7)
No	6	(35.3)
Perceptions of Racism score (mean 54)		
Moderate (36-54)	10	(58.8)
High (55-69)	7	(41.2)

Table 3. Prenatal Care

Variable	Number	(%)
Start of care		
First 3 months	17	(100)
Number of visits		
< 9	0	(0)
9 - 12	13	(41.2)
13 - 18	4	(58.8)
Changed provider		
Yes	5	(29.4)
No	12	(70.6)
Provider		
Physician	9	(52.9)
Midwife	1	(5.9)
Nurse practitioner	12	(70.6)
Other	4	(23.5)
Several providers	5	(29.4)

Qualitative Findings

The grounded theory analysis is summarized in terms of the core category, context, strategies, intervening conditions, and consequences. The experience of pregnancy and becoming a mother for this group of mostly middle-class, well-educated African American women was one in which the woman was very active and involved in caring for herself and her child and incorporating motherhood into her identity. There was a dynamic interplay between preparing, caring, and dreaming (Figure 1).

The Core Category: "Engaged Mothering"

When an African American woman chose to be pregnant -- either actively tried to get pregnant or became pregnant and decided to continue the pregnancy -- and the diagnosis of pregnancy was confirmed, she began a process of "Engaged Mothering". Engaged Mothering is an active, involved, and mutual process in which a woman is preparing to be a mother, caring for herself and her infant, and dreaming about and planning for the future. Definitions of the word engaged include binding oneself by a promise or being pledged to another; occupied, employed, or busy; involved; attached to or partly set into; interlocked, meshed, or in gear (Webster's Dictionary, 1986). Mothering is engaged on many levels: engaged with baby, partner, parents, family, friends, co-workers, and the general community; engaged with their care during pregnancy; engaged in sorting through information and advice and choosing role models; engaged in dealing with the daily hassles they faced in the society; engaged in handling problems during the pregnancy or after the baby was born; engaged in figuring out the baby and adapting to changes in their lives; and engaged in planning

for and dreaming about a "good life" for their child and family. Motherhood is incorporated into the woman's sense of self and is a synthesis of motherhood into the woman's identity, rather than merely the attainment or addition of a role. Engaged mothering is dynamic and interactive, and embedded within the context of the woman's family, history, life experiences, and dreams.

Engaged mothering was carried out in the context of the woman's readiness to be a mother, her prior history of miscarriage or health problems, her sense of self, her relationship with her mother, and her access to resources and support. Within this context, a woman anticipated what the experience would be like for her based on perceptions, information, and stories from other women and worried about the outcome. Actions and strategies the woman used to make a successful transition included getting ready, dealing with the reality, settling-in and dreaming. If these strategies were effective, the woman developed her meaning of motherhood and dreams and hopes for herself and her child, and increased her desire for connections with family, friends and the community. The ultimate desired outcome of engaged mothering was a "good life" for her child.

Context

The context in which the woman becomes a mother is critical. African American women in this study described many examples of having to deal with negativity, stereotyping, and assumptions about pregnant African American women, and faced discrimination on a daily basis in their lives. Some of the participants labelled these experiences as examples of racism, while others were not comfortable

with that label. One woman described an incident which illustrated these experiences:

> "Like in my Lamaze class ... the teacher didn't mean to put us on the spot, but because we were the only African Americans, they wanted to know, 'Well, what would you do in your culture? What is different?' So you do sometimes feel like ... if I'm in a group of my own race, that they wouldn't ask you these questions, because you would already know that .... and (my husband) wanted to know, why would you point me out of the whole group to ask me about eating habits, other than someone else, because I was African American? And then she said she asked because.... Supposedly more African Americans eat more junk food, and they wanted to know if I was... one who ate a lot of junk food, because of my race..... And when (my husband), asked her that and she explained it, then I really felt offended, because I felt like why would she stereotype me, because all African Americans aren't alike ... I have a problem with people stereotyping me... I was raised that people are people, regardless of what color you are."

Women dealt with these incidents in several ways, depending on their perceptions of the motives of the perpetrator and on the actual or potential power of that person to affect the women's lives. Sometimes women confronted the person and at other times they ignored the incident, especially if the person was perceived as "ignorant" or not intending to be offensive. Other women stated that they chose to interpret the incident in a more positive light, as not racism. Sometimes the woman would not react, but would feel upset. Health care providers were judged as racist based on their body language, how they acted, their tone of voice, and by what they said. "Comfort-with" was a major criteria used in the selection of a provider to decrease the chance of experiencing racist attitudes and treatment during care.

Strategies

Four strategies were identified based on African American women's descriptions of their experiences: "getting ready", "dealing with the reality", "settling-in" and "dreaming". The strategies of getting ready, dealing with the reality and

settling-in are more linear and can be described on a time continuum as overlapping stages. The strategy dreaming is not linear and moves back and forth between past as context, present as experience, and future as vision (Figure 2). These strategies focus on the well-being of the child and not on the mother alone. This does not imply an idealistic, unreal selflessness on the part of these women. These mothers are not self-sacrificing. They are adult, well-adjusted, and career-oriented women. Stages do not capture the dynamic and flowing nature of this process. A woman moved chronologically through time, but there was a sense that her consciousness moved back and forth from the past to the future. There was a reciprocal process in which mother was "figuring out" the baby and vice a versa.

Getting Ready

The strategy of getting ready had four components: anticipation, preparing, attaining care and readiness.

Anticipation.

The first component was the anticipation of what the experience of pregnancy, birth, and being a mother would be like. A woman developed expectations which were formed by hearing "horror stories" usually from other women, observing other mothers, reading or watching videos about the experience, or by fantasy. Regarding the birth experience, most women said:

> "I had actually drummed this experience to be a lot more, a lot harder than what it actually was".

> "But it was nothing like people told us.... I mean, I guess I was expecting the worst of what everybody told me. And none of that happened. I guess every woman is different. Every pregnancy is different."

> "I dealt with the pain. Missed all the horror stories. I thought it was going to be worse! But it wasn't. I just dealt with it."

If a woman planned to breast feed, participants agreed that she needed to develop a strong commitment to be successful during this period. One woman explains:

> "I think it also has to do with ... how you think when you're pregnant. Because I knew, when I got pregnant ... I am definitely going to breast feed. So if you have a positive attitude when you're pregnant, I think it really had a big impact ... once you start to breast-feed.... But if you go in with the attitude that, I want to do this, it's healthier for my baby, I want to take a stab at it, I'm going to try, I'm going to try. To me it's a lot easier than going in there with all of these negative attitudes. It made it a lot easier for me."

Preparing.

Another component of getting ready was preparing. Women actively prepared for motherhood. Many resources were used by pregnant women to prepare, including classes, written materials, role models, receiving advice, asking questions, taking precautions, and writing a "birth plan". Most of the women in this study took multiple classes offered by their health plan, including Lamaze, breast feeding and baby care. The experience of these women is illustrated in the following statement:

> "We took every class we could take. Our Lamaze teacher was wonderful. She was really helpful. She had all the information you could ever want to ask, or she knew how to get it to you. It was great."

Some women who did not attend classes cited barriers, i.e. fees, transportation difficulties, lack of time, too tired after work, or had no coach. These women said that the information was not relevant, they had other resources, or that they would likely forget what they were taught. Two women describe that they had other resources, one was a teacher and the other was a breast-feeding counselor:

> "I went to Lamaze, but I cut class because I had a Doulah. So when it was going to be about what Doulah had already talked about .... And so I knew things sometimes two weeks in advance. And then other times I was just really tired, because I was still at work."

> "I can't speak for every African American. But I know, like personally, ... So I guess I just depend on family members' support and insight on care for the baby more so than going to a class."

Another woman described the influence her mother had on her:

> "I was going to take it, but then it was like, I'm not going to pay to take a class, cause I'll just probably totally forget when I get in there, and everything... And my mom just told me, stop listening to what everybody's has to say ... everybody's pregnancy is different. The more you ask, the worse it's going to be.... you'll be fine. And that's exactly what I did.... I just put in my mind -- the more I ask, the worse it would be."

One mother who had pre-existing health problems cited barriers to attending classes:

> "I didn't take any of that (classes).... Well, actually, all the classes were at (the hospital)...and I don't have a car. And they're at night. And I didn't have a coach.... And then at night, it's kind of scary. So I didn't do that. But I wish I would have. I think probably me holding my breath probably made the contractions actually worse."

Women read books, newsletters, and pamphlets they collected from a variety of sources. Women who did not attend classes informed themselves by reading. Participants talked about "my little library":

> "At each prenatal visit, they would give you a newsletter that corresponded to the week of gestation. So those were good. I read them all...I have friends that have sent me a library of pregnancy books, so I felt like most of the things that I read I had already read in other things but it was, again, more reassurance and information. And it was ... the newsletter was brief enough that you had a good capsule of information and it didn't take a long time to get read. So those were good."

A woman who had a previous miscarriage found that reading increased her fears:

> "I think I read too much, though. The doctor's always, 'Stop reading so many books, please'. Because I would be reading things and it would be like, oh that

> book ... stories ... and birth reports and reading about stillborn birth and everything was perfect. And I was like freaked out over that."

Women said they received "too much" advice, which was unsolicited and often contradictory and was labelled "noise". Women described information overload and when that occurred information was sorted into accepted, rejected, modified or the woman "shuts down". Three women describe this experience:

> "Oh, tons of advice! So much advice you wouldn't believe....So I finally just... I shut down... because I was getting media overload."

> "Everybody gave me advice and everybody did. And everybody gave me scary stories. Nobody gives you positive stories. Everybody gives you something that's scary."

> "I think, for myself, it was fun for me to talk to people and to hear their advice. But I really started to respect what I was starting to read, which is that every pregnancy is individual. And so what may work with some people doesn't work with other people. And so I kind of took all that I heard and kind of just used what felt, made sense at the moment, and some of the things I just did myself. I do it my way. And it seems like it worked OK."

Advice was often more acceptable from health care providers and peers with children because it was considered more current. Role models included the woman's mother, grandmothers, aunts, sisters and other women with children. Woman described how they dealt with advice:

> "I have a tendency to not listen to family members and friends, because, you know, a lot of times their experience is not really what you're experiencing, and things that they did is not the advice that I got from the doctors. I tended to listen to my doctors, and the advice outside of them -- I didn't take it to heart. You know. I would hear it, but then I'd get it real firm through the doctor."

> "Because a lot of things she (my mother) said ... it's different from when I was born until now, she said. There's a lot of things she did not know. She didn't know about the breast-feeding.... I informed her more on what was going on than she could tell me."

Pregnant women took precautions to protect the baby and stay healthy. These precautions usually involved change in lifestyle, eating habits or avoiding taboos heard from other women. Women started taking precautions before they started formal prenatal care. One woman described her rationale for taking precautions:

> "And everything that you think or eat or drink or whatsoever, your child absorbs. And so I was just very conscious of that, and I just really think that, for that reason, that my son is the way that he is today, or the person that he is today."

Another woman described taboos that respected women had told her to avoid:

> "So I was kind of skeptical about taking baths and things like that... oh, they said I shouldn't eat spicy foods. I always like food spicy. That it would harm the baby, and I had really bad heartburn. And they said, oh, you have heartburn because the baby has lots of hair and .... You shouldn't bathe or wash your hair or get in the tub.... They said I should just wash off. Well, but the doctor said I could bathe. 'Doctors don't know everything'. I mean, even now ... I can't tell people ... I washed my hair like, she was making two weeks old. And my family had a fit. They said , 'You're going to be sick and they're going to have to keep you in, and you won't be able to take your baby, because all your pores are open and you pour that water in your hair'. I mean ... if you really don't sit down and think about things ... you could be very frightened and scared.... When I washed my hair ... I mean, I was really frightened that something was going to happen."

Questions were considered an important way of gaining both information and reassurance. One woman illustrated how active women were in obtaining information:

> "I listen to everything that everybody else has said. I'm always asking questions."

Another woman, who mentored young African American women and had several negative experiences with stereotyping during her pregnancy, questioned whether some African American women don't ask because they feel "why bother?"

> "Why ask? You figure they've already made an assumption. And that might be why women don't ask about information at the doctor's when they're

> pregnant, because they figure they've already lumped you into a category. But I think it's very important.... Because whatever happens to your body is going to affect that child."

A third woman explained that the provider needed to ask questions because a first time mother would not know what to ask:

> "You know, being a new mom, sometimes I don't know what to ask.... I'd never been pregnant before. So, how can I ask you things when I don't ... you know, you've seen a lot of people and you may know ... and you can perhaps say, well, have you experienced this or have you experienced that?"

Another method utilized by women to prepare for the birth was to write a birth plan in their Lamaze Class. Women brought the plan to the hospital with them to help them advocate for what they wanted. It appears that the hospital personnel did honor these plans most of the time. Two women described the importance of this plan for them:

> "We wrote a birth plan that we received in a Lamaze class, the things we wanted and the things that we did not want...I want them to comply by that, to tell me if they couldn't and, you know, what else they could do, and so the care that I received was great."

> "Well, you know what helped me out a lot, too, was that I had a birth plan prepared before I went to the hospital, where I had a list of do's and don't's and things that I wanted."

Women sought out resources to prepare for the birth and care for their child. Some women observed and were concerned that many African American women seem to not have the information and resources they need during the pregnancy. One woman questioned why this might happen:

> "I really hate to say that they're not getting the information, because I didn't have that problem.... But even in the waiting room, I would see African American women, and I would be reading like Prenatal newsletters. And one time... this woman ... asked me what was I reading, and I said a newsletter

> that my nurse practitioner gave me. She said she had never got one, and she was six months pregnant. And I couldn't understand that... every visit I went to they gave me a prenatal newsletter... So I don't know if it's because my husband was there, or maybe because ... I'm educated that I knew what to ask for. And I don't think it has to do with education, because I had never had a baby, so I wouldn't have known that they were giving out newsletters and different information."

Other women expressed concern about being the only African American couple in classes:

> "And so I don't know if the doctors are not ... I don't want to say doctors aren't telling African American women about Lamaze or about different classes, but all the classes I attend at (the clinic), I was the only African American in all my classes, and I went to six or seven different classes about babies."

Attaining Care.

Attaining care was a major activity during pregnancy and included timing, adequacy, confidence-in, comfort-with, amount of information, self-monitoring or self-care, and the need for special care related to prior problems. Timing of care was related to the initiation of formal care which occurred when the diagnosis of pregnancy was made. Women described how they "knew" they were pregnant: for some it was a "feeling", some had symptoms (nausea), some were late with their period, and for some "my partner/husband told me". Timing is also related to the intentionality of getting pregnant, was the pregnancy in the plans, would the pregnancy be continued when there were financial or health concerns, or was the woman physically able to carry the baby because of past miscarriage or pre-existing health risk or problems, i.e. cancer, fibroid surgery, bulimia, age. Two women who had previous miscarriages described a heightened awareness of the pregnancy:

> "I felt it. It's the weirdest thing. I've never been very in tune with my body or when I'm ovulating, but this time my period was like four days late, and I just really knew... I felt that I was pregnant".

> "I've had one miscarriage two years before, and I didn't want that to happen. I wanted to have this baby. It was like, that was just my last chance of having a baby, so ... I started my care really early."

Adequacy of care is from the perspective of the pregnant woman. Perceptions are at times affected by past experiences or stories from others. If the woman perceives that a "mistake" has been made or something has been omitted self-monitoring activities increase and confidence decreases. Women chose their prenatal care provider and care for their infants based on prior experience, comfort with a provider, or whether there were problems which required a specialist. Some providers were chosen when the woman was seen for a problem, they already had seen the provider for routine care, or they were assigned to the provider. Women continued with a provider only if they liked the person. One woman expressed this group of women's commonly held opinion regarding the importance of feeling comfortable with the provider:

> "It is very important for me to be comfortable with the person that I'm seeing and the person that my baby will be seeing."

Some women had multiple providers and had to insist on seeing the provider they wanted. Confidence-in and comfort-with care was affected by past experience, expectations and how much information was provided, as well as whether the woman's questions were answered. One mother felt she was "being misled". Women made judgements about providers based on whether the provider came close, seemed comfortable with them, answered their questions, gave information regarding the size

of the baby, or seemed rushed. Two women talked about their providers:

> "In fact, I had requested this particular nurse practitioner because I knew no one else from that department. But I did remember her from a regular Pap, yearly Pap, and she was the one that I felt the most comfortable with. And so when they said I could have the option of the doctor or nurse, I said I'd rather go with someone who I knew already and I felt comfortable talking with, because you know, everybody I talked with said, they're not going to be there to deliver the baby anyway, so that's not going to be the issue. It's more finding someone that you are comfortable with and be able to ask questions."

> "I was not a high-risk pregnancy, that I would just see a (Nurse) practitioner...She was really good. She was really nice...She took the time and answered questions, and she stayed with you as long as you ... had questions... and she always, each time you went in, you always got to hear the heart beat.... I found her very comfortable to be with because she's real comfortable, real relaxed, and ...you know ... you want real relaxed ones for OB.... I had seen some other ones.... you weren't very comfortable.... It was almost like, say, way up there talking to you, far away, standing across the room, and, you know.... she'd stand close and she'd chat with you.... Just real easy and down to earth. And I deal much better with down to earth people than people who are trying to talk up and over my head."

Problems either with the pregnancy or with a provider sometimes triggered a change in provider. One women explains:

> "But toward the end we were just getting misled, we were getting all this different information so many times by her, we finally decided not to have her anymore."

The women expected to receive a lot of information during care. Not enough information was considered a problem, especially when the woman felt that there was not enough time during the visit, that she was being rushed, or that the provider was running late. One woman was sure that her blood pressure was elevated during the two visits in which she saw different Nurse Practitioners because she was not given any information about her condition. She described this experience:

"I think the last two weeks of my pregnancy ... I didn't see the regular nurse practitioner.... And it seemed my pressure was up both times. And I think it had to do with ... them not explaining stuff to me.... they kept saying, 'Oh, your pressure's up, you've got to get it down, we've got to get it down'. But they never told me if the baby's heartbeat was strong, or how much she had grown. And then when they sent me to Labor and Delivery to be monitored, my pressure ... was fine, and I really think it had a lot to do with not communicating and telling me how much my baby had grown. Whereas the other nurse practitioner I had always through to the end told us everything ... anytime she did something she told us what it was for and how much the baby had grown."

The clinic "Advice Nurses" were called frequently for reassurance and information and were considered helpful and more accessible. Problems occurred when advice nurses gave inconsistent information to mothers. Self-monitoring was on-going and increased when mothers felt that the care was inadequate or the information was inaccurate. Mothers read a lot, spoke to other mothers and kept track of when they should have certain tests. One mother who had a history of prior health problems had to remind the doctor to order a test:

"I had to ask for that test you know. I would think that the doctors would know if you're at this month you are supposed to take that test...she had forgotten."

Women did not accept information or advice if it did not make sense to them and would call back for a second opinion or insist on speaking with their regular provider directly. Special care was desired when the woman had a previous miscarriage, prior surgeries, cancer, or other pre-existing conditions, i.e. bulimia. A woman who had a previous miscarriage expressed her appreciation:

"But I was really glad in the way that... the nurses and doctors took the time to listen to me, and also take into consideration my past.... But they were worried enough and saw the state that I was in, that they decided to switch me to High Risk, and that really put me at ease. It was a little bit more personalized care,

and I had a black woman doctor, a resident doctor, and I was really happy about that."

Readiness.

The outcome of getting ready was a feeling of readiness. Some women were ready soon after they were diagnosed as pregnant. Others, especially women who had a previous miscarriage or pre-existing health problem and thought that they could not get pregnant took longer to get ready. All women in this study felt ready by the time the baby was born. Support from partners and family were important in helping the woman get ready. Some women also felt that having prior experience in caring for babies was helpful.

Dealing With The Reality

During pregnancy and the early postpartum period women were active in handling symptoms and health problems, dealing with hassles related to their pregnancy or health care, appreciating and distinguishing from their own mothers, sorting through issues related to their partners, and seeking reassurance for their worries.

Handling Problems.

Pregnancy symptoms and/or problems were categorized as pre-existing, prenatal, labor and delivery, or postpartum. Preexisting and prenatal problems were usually related to the mother, whereas labor, delivery and postpartum problems were related to either the mother or baby. Strategies were used by participants to deal with symptoms/problems. Among those with pre-existing problems was one woman who had anorexia and bulimia, one who had breast cancer six years before, one with a

fibroid tumor removed several years before, one who had a heart murmur, one with chronic asthma taking prednisone, and several who had previous miscarriages. Prenatal symptoms/problems included cravings, "morning sickness" (nausea and/or vomiting), indigestion, heartburn, swelling of feet and hands, fatigue, frequent urination, bleeding and spotting, and back and abdominal pain. Two women had fibroid tumors growing along with the baby which caused abdominal pain. One woman developed gestational diabetes. Two women had one or two episodes of high blood pressure which they attributed to stress and did not require medication. Several women said that their husbands had all the symptoms. Two women with prior health problems explained that they thought that they could not get pregnant or carry the baby to term:

> "Before I became pregnant I was weighing 103, so, that's why it was such a problem for me in the beginning. I didn't know if I was going to be able to carry the baby because I was 15 pounds underweight."

> "I was sure I couldn't get pregnant because I had cancer before, six years ago, so they thought I was sterile from the chemo and, of course, since I've been with the same person...I haven't used birth control in 10 years, and of course by now, of course you think you can't get pregnant after 10 years."

Another woman who had a previous miscarriage described her fears:

> "And I don't really want to go through another miscarriage, because that was devastating ... you know, when I had it. I didn't know that I would even, you know, go on to have another one. It was really ... it was hard to deal with...It took all of my confidence away. It really made me think. You know how people take things for granted? Getting pregnant and having the baby. With this one, when I got pregnant, I never really accepted that I was really pregnant until the fourth month, until the fourth month. And you know why. I was three months thinking I'm pregnant or whatever."

Labor and delivery complications included five women who had Caesarean deliveries, one in which the placenta had to be surgically removed and several who had tears, some of which required sutures. C-section deliveries are known to be higher in women of higher socioeconomic status and educational levels. Postpartum problems delayed the mother's recovery. One woman had a Caesarean delivery, developed a wound infection and pneumonia and was on intravenous antibiotics. One woman went to the Emergency Room with chest pain, but the electrocardiogram was normal. Two women had a lot of pain in their wrists which made it hard to carry their babies. One woman described her experience:

> "I had a Caesarean, so they gave me eight weeks (maternity leave).... but, my doctor extended my leave because, where they had the IV's, my wrists are still very sore.... So sometimes I can't even like pick up a pencil or something... I dropped my baby one day."

One baby developed a low blood sugar that the mother decided was from breast feeding, so she switched to formula and the problem resolved. Another woman had swelling of her hands and feet and very painful breasts, which resolved when she stopped breast feeding. Feeding was a source of problems and stress. A mother with a history of health problems described her baby's multiple health problems beginning at three weeks of age:

> "Everything was perfectly fine in total with her, up until three weeks old.....and it's been a time basically ever since. We've gone through the gastrostomies, complications..... seizures... asthma.... eczema.... And I found out in March she has a mild case of cerebral palsy".

Hassles.

Hassles were described by most mothers in this study and implied a lack of control over their environment, including stereotyping, negativity, "public property", and interracial families. Stereotyping was both directly experienced and felt. Negativity was felt in the comments or actions of others and women expressed a desire to stay away from negative people. Women talked about the assumptions they had to deal with when they were pregnant and how it made them feel:

> "You're judged before you even open your mouth."

> "A lot of people ... make assumptions .... So it's not fair because it's like, well, what about us who get prenatal care, what about us who read and are well educated -- it never talks about that ... it always talks about us who don't get any, and whose babies are this and whose babies are that.... And I didn't think I was going to get the best of care because of that. But then it turned around that I did get the best of care, and it was just that one person. And I could tell that the lady on the other line was Caucasian. And it was just offensive to me that she would ask me ... why would you ask me if I'm going to abort my child when I'm calling to see if I'm pregnant?"

> "They lump you ... especially being pregnant you get lumped a lot... I had a bad experience. When my mom was sick... she didn't have any medical. And we didn't know what was wrong with her, so we tried to get her MediCal.... I went down to take the paperwork and fill it out. Automatically they thought I was coming in for welfare, because I was pregnant.... I'm thinking, you didn't even ask me what I want. You just assumed, because I walked in here and I was an African American, that I was coming for aid because I was pregnant? It was a black woman.... and she said, 'Yes.... I assumed you were another black woman who got pregnant, don't have no money, no MediCal ... you came in here to get help'."

Two women described negative incidences with doctors and how these incidences impacted on their care:

> "And I really thought ... she just don't want me to have a baby because I'm black.... she was prejudiced and trying to stop black women from having babies and stuff.... that ... fear... of white doctors. I did not want to see any white

> doctors because I was like, they could try to give me AIDS by giving me a test or ... just things like that.... it was hard for me to try to see, oh, she's just doing her job.... I don't want to feel this way, but you know, I feel like things like that happen."

> "I've had doctors ..., when we were trying to go to Infertility. Dr. ___, started giving me this speech about, didn't I think there are enough young black mothers in the world, and, you know, children to unwed mothers and all this stuff.... And then I requested a new doctor, because she didn't even know who I was, obviously, because I'm not young (laughs). You know, and I'm not single. And ... it's like, who are you?"

The idea of public property described a common experience that other people perceive that a pregnant woman's body belongs to the community. Participants described feeling resentment that people, often strangers, think they can touch a pregnant woman's abdomen and "invade your personal space" without asking permission:

> "I mean, you'd just be amazed how many people would stop and give you advice on the street. And what I didn't like, people invade your space when you're pregnant -- your personal space. They feel like they can just walk up to you and touch you. ... But one time I was in an elevator and this woman just walked up to me and put her hand on my stomach.... And I said, can you please not do that. And she said, oh, I just wanted to touch."

> "And sometimes I try to shrug it off as ignorance, not as someone being racist or racism.... when I first found out I was pregnant and I was in the elevator .... One lady walked up to me and said, 'Oh, I heard you were expecting'. And I said yes. And she said, 'Aren't you single'? And I said, no, I'm married. And so, like her attitude automatically changed. I think that if she thought I was single, it might have been a different question. But when I said no, I'm married, she was, like, oh, congratulations. Are you excited and this and that?"

Interracial families had unique hassles and issues. Five women were married to a man of another race, four were married to white men and one to an Hispanic man. Mothers in interracial marriages stated that they felt caught between two worlds and not accepted by either. They felt either patronized or hassled. They expressed feeling afraid for their children, because they believed that the child will need to have great

strength to survive in a hostile environment. One woman expressed her concern:

> "I don't want him to grow up with a complex because he is half white and half black. But it's going to happen. You know, I can't shield him from everything."

These women said that they felt denigrated by comments such as, "Mixed children are the best of both worlds and beautiful". One woman interpreted these statements as meaning it was better not to be 100% black:

> "I think what I can't stand is getting from people -- 'Oh, she's so beautiful. She's the best of both worlds!' The mixed baby thing.... when I was pregnant, people were like... 'you and your husband will have such beautiful babies. Mixed children are the most beautiful' ... That's something that drives me nuts, you know.... And I'm like, I'm supposed to feel that's a compliment or something, to tell me my baby's not 100% black, so she's more beautiful. Do I really feel good about that? You know, it just drives me nuts, the way people think. And black people and white people do the same thing..... You know, she's going to have the best of all worlds. She's going to know her history. She's going to be proud. And I'm going to raise her as a black woman, but ... it is going to matter in the world."

In addition to their strong commitment to provide their children with strong ties to the African American community and to black history, one woman in an interracial marriage expressed the belief that a strong identity and values were the answer:

> "As long as I believe, and I'm strong and I present him with both worlds so that ... he knows who he is.... I mean, it's like I'm all black. There's no ifs, ands, or buts about it. I am 100% black. It cannot be changed. And I knew who I was. I was comfortable with who I was. And therefore I was able to continue to walk in society without all the hang ups about being black and not getting to do what I needed to do. I've done everything that I should have done and I'm a productive and responsible citizen. You know. And, therefore, he will be productive and responsible.... I will give him the same values and the same foundation the best way that I can."

Relationship With Mother.

A woman's relationship with her mother, including appreciation of and distinguishing from her mother, were issues each woman worked through during her pregnancy and after her child was born. Women said that their mother was their role model for how to be mother:

> "I just want to be, I guess, more like my mom was with me... And she was the kind of mom that didn't interfere, but she offered her suggestions and advice ... you know, I never had to tell my mom, you don't understand. I never had to tell her that. I never had to tell her, you want me to lead your life.... That's the type of things that I would like (my child) to remember me by. I don't want to be a meddling mom."

> "Since I've been older, I appreciate everything she did. 'Cause, being young, you don't know what your parents go through or whatever.... Mom is always there, no matter what.... And so my mom has been my ... role model.... Everything I know is from my mom. You have to trust your mom. You act just like your mom."

A woman developed her meaning of motherhood partly by her new understanding of what her mother's experience might have been like. Women described the importance of this relationship:

> "Actually, my Mom being here -- it gave me a new appreciation of the love that I have for her, you know -- to see how she must have done it... So it was tough for my Mom and I have a new level of respect for her".

> "Oh, most definitely (my relationship with my mother has changed)! We have a wonderful relationship. Before, in all honesty, my mother and I couldn't stand each other, basically! We could not have a decent conversation without arguing. And I just remember, after I had (the baby), she hugged me and kissed me and, boy, that was just the ultimate thing for me. I was just so excited, its been just wonderful ever since."

Distinguishing from mother referred to a woman's recognition of herself as an individual who could decide to weigh and reject aspects of her mother's mothering

which she did not agree with. Most women expressed the commitment to not make the same mistakes their mothers had made:

> "My Mom. You know, but my mom and I are so different.... not wanting to be like my mom, so self-sacrificing and, you know ... my mom will give you the shirt off her back, and I think she's too nice. And so, my mom being that way, and also my seeing her get hurt by being so self-sacrificing. And I said I'd never want to do that for love or family or anything. You have to just, like, stop giving."

> "I don't think I have any role model for being a mama. No. Because I ... well, maybe so ... but there's just some things that my mom did as far as raising me that I won't do."

> "So I think, on the positive side, there were certain things that she did that were good that served as a good model for me. And certain things I said that I'm going to do different. But I think my mom was probably the most powerful mother figure for me."

Partner Issues.

Issues related to the woman's partner included the amount of support available, issues of sexuality, and the father's role in the care of the child. Partner support issues illustrated the mothers' appreciation that they have support from their partners and the key role the father plays in having a child. Mothers wanted the fathers to be very involved with their children, but expressed ambivalence about allowing them to do the care. Three women talk about the importance of their partners in dealing with the stresses of being a new mother:

> "I don't know, to me it's easier for me because I have a spouse. I don't think it would have been easy if I had been a single parent. I think it would have been harder on me."

> "(My husband) He's so concerned about her well being that he wants to be here and experience everything. As a matter of fact, he went to every appointment that I had. You know, every time I went in for my prenatal care, he was there."

> "I tell you, because he's perfect for me, because if I didn't have a man like that -- having a baby is so much harder than I thought it would be. It would be impossible. I mean, not impossible. I see how women do it alone. But it's tough. It really is. It makes it so much easier when you have your partner there to share in the responsibilities. I can't imagine being alone doing this especially without family."

Issues concerning sex and desire were brought up in one of the focus group sessions. A number of the women stated that they did not have any sexual desire for their partners even after the six week postpartum visit and felt guilty about their lack of desire:

> "Don't you have somewhere else to go? I always was sick. I always was headache, bloated stomach, I'm not feeling too good, I feel like I've got diarrhea. I always had an excuse, and ... It was an excuse, because I did not want to be touched.... god, I didn't want nobody to touch me, nobody looking."

> "At six weeks ... my husband told me. I said, look, I don't care if it's six months. You just don't have the urge ... I said, now, I don't even think about it. Well usually ... well, I had a couple girlfriends who had babies and their husbands said, when they seen their wives having babies, it turned them off."

Worries.

Worries were many for pregnant women and especially new mothers. These worries were focused on the well-being of the baby and mostly related to feeding, returning to work and finding safe day care for the baby. Less frequent worries were related to financial and family issues. Learning to deal with worries was very common and mothers desired reassurance and encouragement. Two women described the pervasiveness of worries, one who had a healthy pregnancy and one who had a previous miscarriage:

> "And as far as him, I want him to grow up secure. I want him to be safe. I know that there's no guarantees about child safety these days. I mean, there's just so many things -- if it's not the kidnappers or the molesters, you know ...

it's the drive-by shootings."

"I've made it this far. And you know, just feel so many things that still could happen. And I was ... so upset. And so I was just scared ... all through my pregnancy, scared that something, you know, could possibly happen to my baby. I wasn't so worried about myself; I was just worried about him."

Day care was a major worry for these mothers and a reason several were not returning to work for awhile. Some fathers changed their work schedules so that they could take care of the baby. Sudden infant death syndrome (SIDS) was a fear mentioned by several mothers. One mother talked about her multiple fears for her baby:

"And I guess a lot of it (worries) is from media stuff .... there's a lot of worries that she'll just be cared for and not abused, or anything like that ... that's just one worry. Also that she makes it through the days. SIDS really hit home to me, too, because it's ... no one really knows how it happens. So when she's sleeping, I'm always watching her. But I have to constantly tell myself she's going to be okay. But those are the only big worries. Financial -- they're worries, but I know things will work out. They're not the biggest worries."

Settling-In

After the birth of the baby, mothers go through a period of "settling-in". Settling-in includes issues of sleep, figuring out baby, adapting, defining the role, getting support and trusting others. The strategy of settling-in occurred from the time the baby was born to the time a mother felt comfortable caring for the baby and was beginning to make her own decisions. Most women said they felt comfortable caring for the baby by one month postpartum and were making independent decisions by four months. Four mothers described their settling-in:

"I started feeling more relaxed and more comfortable with, you know, just feeding her and everything. The first two weeks... not feeling adjusted to the way ... I had to wake up at night. You know, feeding her, 2-3 hours, that was to me the adjustment."

"I didn't really get that until my husband went back to work. And then I just called him and said, come home, I need help with this stuff. This is too much. I don't even have time to do my paperwork. And he was just like, you're not going to have time to do your paperwork.... So, that day, you know, I was kind of shocked, but I lasted.... So, even though it was hard, I just said, hell, I've got to do this. So I lasted that day, then I lasted the next day. Then I started saying, honey, aren't you going to go to work? You know, to try to practice. Because I realized that it wasn't that it was so hard or impossible, it's just that it was a shock because there hadn't been a change until that day because there had been all those people, I was still running my errands. You know, it was just like, there's another person here. So ... it's different now."

"After my mom left, I was ... you know, after a couple weeks, I was like, I got this. When I was actually up and out of bed and showered and halfway finished cleaning the house, and it was like 12 noon, and I was like -- Yes! I've showered before 3 o'clock; I'm getting the hang of this mommy thing."

"Two weeks after he was born.... because for me it was the nursing thing. That was my big thing. To get the nursing thing down. And once I'd accomplished that and he was nursing well and he was already putting on weight, and new things ... and he was okay ... I mean ... I was less nervous.... I relaxed and it got easier. I stopped worrying as much, you know, until he started getting mobile."

Sleep.

Sleep was a major issue for these new mothers, but "you get used to it". The chronic lack of sleep is particularly difficult when the mother returned to work. Two mothers told how the lack of sleep impacted their lives:

"The only thing I would say is the sleep deprivation. Because nobody really tells you about that, and you can envision sleep deprivation by your own choice, like, oh well, if I have to go to work tomorrow, maybe I'm still going to stay out late tonight, or stay up and watch this. That's very different than you don't know when you're going to be able to sleep, because somebody else decides."

"Sleep is like .... oh no ... why is she woke again. But then, you kind of get over it."

The first time the baby slept through the night, mothers woke up afraid that something was wrong with the baby. A mother described this experience:

> "She goes down at 12:00. Some nights between 11:00 and 12:00, and she'll sleep three hours. But last night she went down at 12:00, and she didn't wake up until 6:00 this morning. I woke up at 3:30, and I picked her up out of the bed because I was a nervous wreck."

Adaptation.

"Figuring out baby", grieving and dealing with lifestyle change are the major parts of adaptation. Figuring out baby had its complimentary part of baby figuring out mother. Three mothers characterized this as "natural" or "instinctual":

> "I definitely feel like we know each other. And I feel like he knows me and he knows my moods and ... he can sense when there's something wrong, like if I become upset or if I'm feeling sad, you know, he starts laughing a little bit more or ... he becomes very playful at certain times, which makes me happier."

> "The maternal instincts do kick in. I always said that I would never hear her crying at night; that was my concern too. But when she would wake up, who would hear her? Like you automatically clue in on your child.... And I think it's wonderful. I wouldn't trade her for the world. It's a great thing."

> "I don't know, maybe it's just kind of natural being a mom.... just knowing what to do to take care of him when he needs something.... it seemed like I just feel what he needs, and hopefully I can be able to give him what he needs."

Adaptation occurred in the couple's lifestyle and in their sense of belonging to a larger community. Flexibility was needed by the mothers as they adapted to a growing baby with changing needs. Three mothers depicted some of the changes required:

> "The only thing I really find really frustrating is not being able to just like jump out of the house like I used to and go and do something else. Baby and myself and the diapers and the formulas -- it seems like it takes an hour to get out of the house now."

> "Because I don't have a problem with having him in my life, as far as not being able to do some of the things I used to do.... You have to grow up. You

> can't keep doing a lot of certain things, anyway.... so that never bothered me. I can't just pick up on a moment's notice and just go somewhere because I have to think about him. That change didn't bother me because, if I'm going somewhere, most of the time he can come too."

> "We're handling it the best we can. Now. We're dealing with it; we have no other choice. (laughs) There's no other choice. We both look at her sometimes and we're like, you know, we can't believe it -- she's such a little miracle."

Grieving was expressed by several mothers about missing the sensations of having the baby inside the womb and the grieving they anticipated on leaving the baby when they returned to work. Two mothers comments illustrated this feeling:

> "I do remember missing, you know, not being able to feel him kick inside of me anymore. I do remember missing that sensation."

> "I ... hate having to go back to work and miss being with him."

Role Definition.

Mothers began to define their new role early on in terms of attributes. Important components of mothering included caring, patience, providing security, and instinct. Attachment to the infant was strong. Four mothers' comments represent some of these attributes:

> "There's just some natural personal instinct that helped a lot in terms of being a parent. And there's no amount of experience that can compensate for whether or not you have that instinct or that style of work of relating to other people. So I felt comfortable with that."

> "I'm not going to have the patience, I'm not going to have the maternal instinct..."

> "They sure look for you, and ... my baby is so attached to me."

> ""Oh, I know I take good care of him. I feel like I'm a great mom....I don't feel all that comfortable still, but ... I rely on my mother's intuition, and I ask other moms like my sister and my sister-in-law."

Decision-making became more comfortable for the mother with time and she no longer needed someone to tell her what to do. She used her own judgement to make decisions. Two mothers explained this change:

> "You know what, the thing that I've learned is that ... you can call doctors or call nurses, and you know, you can hear what is supposed to be the ideal thing and so on and so forth. But you have to kind of do what you do feel is best as a mother, what you feel is best for your baby."

> "At about two months I started making my own decisions.... I had like a little 24-hour virus...And she got a little sick, but she had diarrhea for two days... No, I don't call anybody. I say, I'm going to buy some Pedialyte and give my baby some Pedialyte, because she has diarrhea. So when I go pick her up, my sitter says, 'You can give her this, but it says on the back to consult a physician if under two years of age'.... But then I got concerned because she said it, so I called.... and they said, no, 'You have to bring her in now'.... And I'm thinking, well, nothing's wrong with my baby. She's playing, she's laughing. So I said, well, let's take her in and see what they say. I get in there ... I wait. They examine her and they say, give her some Pedialyte. I was so angry.... So now I came to the point where I'm going to do what I feel is necessary, and if she gets sick or gets hurt, then I'm the one ... It's on me."

Family Support.

Support from family and friends was crucial to a smooth transition. Most mothers did not realize how important this would be. One mother who had a C-Section described her special needs for support, but two mothers who had no problems also recognized this need:

> "Now (my aunt) really was a help.... all my older aunts and everybody was just really helpful. Because, you know, having a C section, it took me a while to get in the hang of doing things... I think she was three weeks old when I changed her diaper for the first time. I couldn't do the bending over thing; it was just horrible. But she was well cared for."

> "My mom, she's been having to come home, and she relieves me maybe for a couple of hours or whatever. She'll take her nap and I'll watch him. She'll get up in the middle of the night and she'll watch him. And I can always put him in the bed with me, then she hears him crying and she gets up and take him in

with her when my stepfather goes to work."

"Now, she's been a perfect baby. She's not colicky or anything, but she needs attention, and I wish she had a grandparent and nieces and nephews, and all the kids around her."

Trusting Others.

Trusting others with the baby was very difficult for new parents. The only person the mother trusted was her husband/partner. Even other family members were not trusted for a time. Family and friends, especially friends who do not have children, did not understand why the mother would not let someone else take care of the baby. Two mothers' comments illustrated these concerns:

"I hate to leave him with strangers."

"The only person I've left him with is my sister and my mom. I left him with my mom maybe for like an hour. I wasn't gone long at all.... I don't like leaving him alone with anybody. I don't even like leaving him alone with my husband. (laughs) Not that I feel that my husband's not capable of taking care of him.... I feel like there's part of me that's gone when I leave him alone."

Mothers were concerned that the baby would not get the attention he or she needed from other people. One mother found a way to allay her fears:

"I found a provider, and the woman comes into the home.... And it's a little bit more expensive than putting him in day care, but, I don't know, I'd rather pay the little extra money and know that he's getting ... one-on-one attention. And so he eats when he needs to, he sleeps when he needs to.... I give him so much attention around here. He gets so much attention. I just couldn't imagine the thought of him, during this time of his life, not getting the attention when he needs it or wants it."

Some women's partners changed their work schedules so that the baby would not need to go to day care. One mother described how this arrangement made her feel more comfortable:

"Well, the only good thing about this, though, is that my husband -- his hours at his job -- he works three days a week, 12 hours a day, so he will be the primary caregiver for her while I'm gone. That relieves me.... I don't have to worry about her going to strange hands, or whatever."

Dreaming

Women dreamed about the future throughout the pregnancy and postpartum period. Dreaming was an active strategy, in which women made plans to realize their dreams. The mothers' own dreams were focused on improving their financial status so that they could provide a good home in a safe neighborhood and be available to their child as the child grows. Two women's statements were representative of this group:

"My dreams are for me to finish school, get my MBA, to become an entrepreneur or run my own business, so I can be more flexible for my child. I want to be able to be there. I want to be one of those parents who can go to PTA meetings, who can go to school programs, who can take off in the middle of the day and say, 'Mom, we're having this at school, can you be a chaperone?' I want to be that.... I plan for our life to be great.... But my main goal is to keep her in a family structure with a mother and father, on one accord."

"I see myself, in the next five years ... I want a house.... We're going to have a house and we're going to go travel.... we're going to go to museums and stuff. You know, just do different things.... All I see is me and him being healthy, and happy.... He's going to be active .... I haven't wanted for nothing. But we're doing what I had and then some."

Women talked about the importance of supporting the child in his or her dreams and desires. Dreams, desires and hopes for the baby and the future were optimistic and realistic. Mothers expressed concern about safety, hopes to overcome the ills of society and give their child the strength and means to cope. Three mothers illustrate these dreams for the child:

"So my dreams for (her) is whatever she wants to be, I'm going to hope that I can support her, hope that she does whatever it is she wants to do."

"I want her to have a good future and to have a lot of love and care. And to, you know, to learn a lot. Education has been really important to me, and so I want her to have that kind of richness in her life. And I want her to be a happy person... I know, when I was making this decision to have a child, you get kind of scared when you see the things that happen in the world and people telling you, oh, things are getting worse and there's more violence and whatever. But I think people cope with the things in their life if they're raised right. So, and I hope the best for her. I just want to be there for her, and provide for her -- let her do what she wants to do."

"I hope the world will change. I don't have much faith right now.... so I want her to be strong. I want her to be independent. She's going to have to be strong to deal with the world and to deal with being bi-racial..... In other words, I just want her to be healthy and happy and strong, because if you're weak in this world, you'll just crumble.... Life will do you in if you're weak. Life is not for the weak. She's going to have to be a strong, and independent little girl. And smart. She can be beautiful too, but she can't be a bimbo."

Through dreaming, the woman developed a sense of what it meant to be a mother during her pregnancy. Women described their meaning of motherhood in terms of being responsible, protecting, supporting, being needed, and intense enjoyment. Responsibility for another was mentioned frequently as an attribute of mothers. To be there for their child was very important and to support the child in being good and choosing right from wrong. Being needed by their child was a good feeling and was part of the responsibility felt. Three mothers described their meaning of motherhood:

"I think it's a little more than what I expected.... It's just so special ... I'm the one that's got to care for that little boy, and he depends on me. And it's just a wonderful feeling, it really is. I thank God ... for my baby."

"Being supportive. To give the love until she's able to take care of herself. And just being there for her.... a mother is someone that the child always can depend on, doing ... saying whatever things you need to say.... And my thing is to show her the right way. You know, to be there, to let her know that that's something you don't do, or to guide her. You know, just to be her support."

> "It means that I have someone who's going to love me unconditionally, who's going to lean on me for support, who's going to need me to teach them right and wrong in the world.... I'm going to have to be a positive role model for the rest of my life because she's going to look at me and whatever I do, and like she's going to feel like she can do ... and if I'm negative she'll be a negative person, but if I'm positive she'll be very positive, and she'll be able to excel in life. And that's what I want to do is ... for my child ... to look at me and say, hey, I can be anything in the world I want to be. Or I can make it in life."

The mother's relationship with her child was described as intense. Enjoyment was expressed by all the mothers. Some of them were surprised at how much they enjoyed being a mother and watching the child grow. Two mothers expressed this enjoyment:

> "I know that I tend to care a lot about people in my life, and so I ... it's probably going to be one of my intense relationships.... I already feel like this intensity with the baby. And a lot of love for her. You know, I felt love for her, carrying her, like I wanted to take good care of myself. And now, having her, I even feel that more. This is precious."

> "The way they look at you. And it's just ... with so much love. I think that's what I get a kick out of the most.... Oh, when I'm having a blue day ... I find him to be very charming.... He'll just look at you with this warm, warm smile, like, 'oh, mama, I just love you'. And it feels good. And I forget that I'm having a blue day.... And how he plays. And to hear him laugh..... They're wonderful.... was I really enjoying life before this? Was I really happy? I know I was happy, but why? Because this is the greatest joy!"

Protection was an important part of the role. Some mothers expressed the belief that they were overprotective or that others thought they were. Several mothers were very uncomfortable when people touched the baby's head or hands without their permission. Four mothers described the importance of protection:

> "Maybe I'm just too overprotective ... because it's my first baby."

> "People that I don't know from Adam come up and they're like, 'Oh, a baby', and touching her. That drives me nuts.... Number one, when they touch the hair, I say, please, do not touch on the head.... I don't know you! I don't want anybody's bad vibes ...... going to my child."

> "And see, what kills me is, don't touch my baby's hands and face. Because my baby puts his hands in his mouth. And it's like ... ugh. You know, I don't want to offend anyone. But it's like, oh no, not his hands, he puts his hands in his mouth. Don't touch his hands. Oh no."

> "And this lady touched him. And I was sitting there. I mean, every nerve on my body was standing on end, because I could not believe that she had the audacity to touch him. And I was so aghast, I couldn't even say anything.... (now) when I take him out, I put a blanket over him so people couldn't see him. Because people just gravitate towards babies, especially when they're tiny."

Mothers have thought about what they want for their children and themselves. Desires, hopes and dreams for their own lives were expressed in terms of future plans to make a good life "for my child". Mothers expressed a strong sense of their own selves and a desire to support the child's individuality. Two mothers' comments illustrated these aspects:

> "I just want him to have a good life. I want to get him started off ... in the right direction. And be a responsible young man and ... be a good person. And I just want him to have a good life. I want to be able to give him what he needs to have a good life."

> "And we'll have a full-time baby sitter, because I'm that kind of mom.... you know, I don't want to stay at home every day all day and ... bake cookies. Now, I will bake cookies and we will have tea and play paper dolls and all that kind of stuff, but I have to be somebody outside of that too. And I don't want to do that when she doesn't need me anymore, like I don't want to say, oh well, you know, I'll stop being the woman that I am and be your mom, and then when you're five years old, then I'll take you to school and I'll try to remember the woman I was, or reinvent myself or something. I figure that if I am who I am, and then I am a mom at the same time, and that's how it always is, it's more fair to her and more fair to me."

Relations with other women, especially other African American women, were identified as very important to bringing up a child. Connections with other women were important both to provide support for the mother and also for the child to have

women to relate to. When other family members lived far away, this need was felt more intensely and women sought out other resources for support. Several participants stated that they agreed to participate in this research so that they could meet other African American women with babies. The importance of connections was described by these three mothers:

> "I admire women who have babies, because I had never known what women went through to have babies. And I admire every woman who has had a baby. It's a true test of your womanhood. Especially women who have more than one baby."

> "I definitely think my relationship with my sister has changed. I wasn't as close with my sister before I had my baby. And now ... we're really close, which I never thought would actually ever happen, but we're really close now. And that makes me ... that makes me very happy."

> "So, it's ... it really is a community thing, and you really do need women around you. And I'm sorry that I realized that so late. You know. I really am. Because I go through my life and I don't need anyone. And I'm sorry that I didn't realize that. I don't want my baby to suffer because of it, either. You know, so I'm going to really have to make an effort to get out there and meet women and bond to women. I'm not saying it's going to be the friend of a lifetime, you know, but just to be able to have some resources."

Mothers expressed a need to be more active in the community, so that the world would be a better place for their children. This sentiment was articulated by one woman:

> "And hopefully, I'm going to start becoming a little bit more politically active like I was in college to make some changes, you know, because I've become such a pessimist in the last 10 years. It's like I hate everything and there's just no hope for anything. But now, with the baby, it's like ... there has to be hope, and I have to make a change whenever I can, what little I can do. Well, just because of the baby. I could have went on my whole life not caring what happens to the world, but now I feel like I have an investment and interest in the future because of her."

Conditions

Women proceeded through these four strategies differently depending on the conditions of 1) "intentionality" and 2) the presence of "pre-existing health problems" (Figure 4). Intentionality denotes whether the pregnancy was actively pursued or whether it was fortuitous, indicating that the woman or couple were not consciously trying to get pregnant at that particular point in time, but the pregnancy was not unwelcomed and it was not described as accidental. The presence of pre-existing health problems included a history of previous miscarriage or pre-existing health problems for the mother.

The first strategy of "getting ready" began for some women before the actual pregnancy was confirmed or when the diagnosis was made. Women who had a prior history of health problems seemed to delay getting ready, but all women in this study were ready by the time the baby was born. Anxiety was high for women who have had previous problems. There was a heightened awareness of the pregnancy and symptoms, particularly for women with previous miscarriage. Women who have had a previous miscarriage recognized that they were pregnant earlier than other women and started prenatal care immediately. Women with a pre-existing history of health problems thought that they could not get pregnant, either because of the medications they were taking (prednisone), the treatments they had in the past (chemotherapy), or that they were unable to carry a pregnancy to term (bulimia). This group of women tended to recognize the pregnancy later than women who did not have health problems. Both groups of women with prior history of problems received high risk

care and this care helped to decrease the anxiety they felt to a more manageable level. Women with pre-existing health problems were less involved in taking classes, at least in part because they thought that they were unlikely to have a natural childbirth. Most women actively prepared for pregnancy, labor and caring for the baby through taking multiple classes, reading lots of books, pamphlets and newsletters, sorting through advice from multiple sources and observing other parents.

The strategy of "dealing with the reality" began during the pregnancy and continued into the postpartum period. For this strategy the condition of whether there was a history of previous problems was also key, rather than the intentionality of the pregnancy. For women with pre-existing problems, there was an expectation that any symptom or problem they experienced was a sign of pathology requiring active intervention. For these women worries were great and anxiety high. These women expressed a desire for special care and extra support, yet these women often described their relationships with their own mothers as not close or ambivalent. For the women with no history of prior problems, there was an expectation that symptoms and issues which occurred in the pregnancy were normal and to be expected. Although there still were worries and anxiety expressed, women again felt worries were a normal part of pregnancy. Relations with their own mothers were described as good or close. All participants described dealing with various hassles during the pregnancy or in their lives in general, which were often labelled as racist, stereotyping or negativity. All women actively dealt with handling problems which they faced.

In the strategy of "settling-in", all participants appeared to have similar

experiences. The settling-in period stretched usually from the birth of the baby to the time when women were comfortable and confident in caring for the baby, were making some decisions independently or with their partner, and were beginning to trust others with the care of the baby. For most women in this study this period was completed about four months after the baby was born. Women had a high level of commitment to being a mother, good support from partners, families and friends, and a clear definition of the role of mother. Lack of sleep was a major problem for many months. Figuring out baby was a reciprocal process for parents and baby and a confidence builder for mothers. Women who planned to get pregnant and had no previous history of problems seemed to settle-in quicker and easier.

The strategy of "dreaming" permeated throughout the other three strategies. Although women with intentional pregnancy were more frequently married and of high socioeconomic status, all women shared a strong sense of self, a positive definition of the role of mother, a high degree of hopes and dreams for a "good life" for the baby, strong desires for connections in the community, especially with other African American women, a positive description of the meaning of motherhood, and demonstrated confidence and strong attachment in caring for their babies.

Consequences

Women engaged in these four strategies under the conditions of intentionality of the pregnancy and a prior history of miscarriage or health problems of the mother. As the women proceeded through these strategies, their focus was on promoting the health, well being and happiness of their children. Women were very active in these

processes and wished for a mutuality and partnership with providers in their care and respect and encouragement from people around them. The outcome of engaged mothering was a healthy, happy, safe, strong and secure child.

CHAPTER VI: DISCUSSION

Meaning of Findings in Relation To Research Questions

Four research questions which guided this study were answered using grounded theory methodology: 1) How do African American women describe their transition to motherhood? 2) Who/What facilitates and inhibits a successful transition to motherhood for African American women? 3) What protective behaviors/measures do African American women utilize to facilitate a healthy transition? and 4) How do women take care of themselves during pregnancy and does a woman's perception of racism have an effect on how she cares for herself or the care she seeks? The process of engaged mothering under the conditions of either intentional or fortuitous pregnancy and in the presence or absence of previous health problems or miscarriage described the transition to motherhood for this specific group of African American women. Engaged mothering denotes the active involvement and mutuality this group of mothers sought during their pregnancies and first year postpartum. Facilitators of a successful transition included support from partners and families, especially from the woman's mother and other significant women in her life, information from health care providers with whom she feels comfortable, relevant information obtained from classes, books and other written materials, advice from respected sources, choosing and observing role models, and from asking questions. Inhibitors of a healthy transition included inadequate support, unsolicited or negative advice, lack of commitment, insufficient or contradictory information, lack of sufficient resources, and

the hassles of being stereotyped, facing negativity from others or being treated like "public property". Women engaged in protective behaviors during the pregnancy which included changing their eating habits, exercising, and avoiding taboos passed on to them by other women. Taboos included prohibitions against bathing and washing hair for a specified period of time postpartum and avoiding certain foods and activities. Some taboos were ignored, but women did not publicly ignore them. Other taboos were respected, even when not believed, to avoid disagreements with family members or "just in case" they were true. One taboo which many mothers expressed distress about was that people should not touch the baby's head or hands without the mother's permission. Mothers were concerned that "bad vibes" could be transmitted by touching the head and germs transmitted by touching the baby's hands.

Although there were no significant relationships found between a woman's perception of racism score and the adequacy of prenatal care or the choice of health care provider, women described the effects of racism on their daily lives and on the criteria they used to choose the provider. These criteria were employed in an attempt to avoid or decrease a woman's encounters with racism in their care. Unfortunately, other health care personnel, such as the nurse in Labor and Delivery or the receptionist in the clinic, could not be chosen and were often the source of hassles which these women faced. Many women stated that African American pregnant women were stereotyped as young, single, on welfare and as not taking proper care of themselves during pregnancy. All participants in this research study had adequate prenatal care and were active participants in their care. Attaining prenatal care was just one way in

which these women prepared for motherhood.

Two statements stand out from the data for me: "African Americans are not all alike" and "I want to give him/her a good life". The first statement expressed an African American woman's rejection of being stereotyped, an assertion of uniqueness, and a request for respect. Women described their experiences of being stereotyped by both whites and by other African Americans. Statements such as "All blacks eat junk food when they are pregnant", "You're not black enough", or "That's white behavior" were examples provided by women to illustrate the frequently experienced assumption that all African Americans behave in one way. The uniqueness of the person, as well as the common themes of experience, need to be visible. This group of women did not agree on the current state of society. Some expressed powerful stories of racism in their lives. Other women stated that racism was no longer a problem for them and they chose to interpret behaviors and actions, described by others as racist, in a different light. Issues of racism, discrimination, prejudice, or stereotyping were not solicited in the first interview. Many times women brought up these issues without prompting. Other women discussed these issues after they completed the Perceptions of Racism Scale. These issues were directly discussed in the second and third interviews.

The second statement "I want to give him/her (the baby) a good life", expressed the essence of the dreams that the women described for their children. These dreams were not grandiose and were focused on the child. Mothers dreamt of having/owning a house with a yard; giving the child experiences of going to museums,

traveling, and getting a good education; teaching them about their history; helping the child reach goals and dreams; being available to go on school trips, "being there" for the child; understanding, teaching them right from wrong and positive values; and protecting them. Mothers described their own dreams to finish a college or graduate degree, start a business, or find a better job. These plans for themselves were usually followed by the statement, "... so I can do more for or spend more time with my child". Several women said that they changed their career plans after the baby was born to get their teaching credential so that they would be home more with the child.

Although some women said they expected themselves to be perfect mothers, most realized at some point that parenting is a learning process and the parents "grow" with the child. Although there seemed to be a general acknowledgement that bringing up a child "is a community thing" and there is a desire for support from others, especially partners, and family, too often the "support" was not interpreted as supportive. Too many experienced negativity and conflicting, unwanted and unsolicited advice, which was termed "noise". There was a desire for close relations with other African American women, but also surprise that women tell "horror" stories to pregnant women. Participants expressed a strong desire to receive more encouragement during the pregnancy and postpartum period, and have their wishes respected regarding the care and upbringing of the child. Mothers also realized that they needed help in "letting go" and trusting that partners and others could adequately care for the child.

Significance

This descriptive study outlining the transition to motherhood for a specific group of African American woman adds to the literature on maternal role attainment theory and the description of motherhood in the black feminist literature. The results of this study also add a positive description of African American motherhood based on the experiences of a group of mostly middle-class, educated women.

Motherhood as Transition

The transition to motherhood is a longitudinal process which spans the time period between either the woman's decision to get pregnant or to continue a pregnancy once the diagnosis is made, and the time when mothering is incorporated into her identity. For some women the transition was planned and hoped for, and for others it occurred earlier than planned but was still welcome. A successful transition includes the woman's sense of well-being and comfort in caring for her child, mastery of the maternal role and the development of new skills, and a sense of well-being in important relationships (Chick & Meleis, 1986). In this study, women exhibited success in the transition through their active involvement in preparing, caring and dreaming. Women developed a sense of comfort in caring for their child, sought out sources of support and connection within their families and the community, and planned for and actively pursued their dreams and vision for a good future for themselves and their child.

According to Schumacher and Meleis (1994), conditions for transitions usually include meanings, expectations, level of knowledge and skill, the environment, level of

planning, and emotional and physical well-being. Women described their meaning of becoming a mother which evolved out of their experiences and dreams. Expectations developed from hearing other women talk about their experiences, observing other mothers, reading or watching videos, and by fantasy. The level of knowledge was high amongst this group of women because of their active involvement in preparing during pregnancy through classes, written materials, role models, questioning, obtaining advice and formal prenatal care. Skills were developed in time through figuring out the baby and for some women through previous experience in caring for children. The environment for this group of women increased their stress during pregnancy. Women were faced with and dealt with incidents of racism, stereotyping, and negativity frequently during their daily life. The environment mediated the transition through both providing support and increasing stress. The level of planning, illustrated by the condition of intentionality of the pregnancy, affected the transition since women who were actively trying to get pregnant proceeded through the transition easier. A second condition of prior miscarriage or history of health problems of the mother diminished the woman's sense of both emotional and physical well-being and was an inhibitor of the transition.

Engaged mothering is a process in which African American mothers get ready to be a mother, deal with the reality involved, settle-in with their baby, and dream and plan for a good life for themselves and their child and family. The outcome of engaged mothering is incorporation of mothering into the woman's identity, and a healthy, happy, safe, and secure child. In this study, all women demonstrated

incorporation of mothering into their identity through their descriptions of the meaning of motherhood and through behaviors demonstrating enjoyment of and attachment to their child. One woman's baby developed multiple and serious health problems beginning three weeks after birth and still not resolved at 20 months of age. Despite this outcome, she still demonstrated the process of engaged mothering. No other negative cases were identified in this group of women, although it is possible that some of the women who only had one interview may have had problems develop later with their mothering. Six participants were interviewed only once during the postpartum period.

Several critical points in this transition may require nursing intervention. Early in the prenatal period, even at the first nursing encounter, an assessment needs to occur regarding the woman's history of prior miscarriage or health problems and the intentionality of the pregnancy. Worries will need to be solicited and appropriate reassurance and support provided. Nursing interventions may not be successful if offered before the woman has passed the critical point, i.e. after the time the previous miscarriage occurred. Additional options of preparing for motherhood may need to be utilized for women with a history of previous problems, since this group of women were less likely to attend traditional classes. Special care or additional support may need to be provided for women with a history of problems. Nurses need to ensure that the provision of care is done in a culturally congruent manner and be sure that African American women receive information about the progress of the pregnancy and the size and condition of the baby at each visit. After the baby was born, women had many

questions and a need for reassurance. This is a time when nursing interventions are welcome and heeded.

Comparison With Rubin's Work on Maternal Role Attainment and Maternal Identity

Rubin (1977) defined four developmental tasks of pregnancy: (1) seeking safe passage for her child and herself through pregnancy, (2) insuring the acceptance of her child by her family, (3) "binding-in" to the unknown child, and (4) learning to give of herself. The strategies of getting ready and dealing with the reality appears to encompass "seeking safe passage". There was no support in the data that this sample of women were concerned with insuring acceptance of the child by the family. Women assumed that the child would automatically be accepted by the family. "Binding-in" (as a process, not a state) to the unknown child" was expressed through the codes of readiness, anticipation and meaning. Learning to give of herself appeared to happen immediately with recognition that a woman was pregnant and was a part of all four strategies. For the women in this study readiness to be a mother was delayed only for those women who had a history of either miscarriage or health problems. The end-point of this process, according to Rubin, is the maternal identity. Rubin described the binding-in and maternal identity as dependent on each other, affected by both the infant and by society, especially family: "A conceptual model of the binding-in process might well be like the weaving of a tapestry" (Rubin, 1977, p.67). In Rubin's work, the stimulus for this process to begin is feeling the infant move. Complete identification with the child occurred by one month postpartum. In my data

this process started before movement was felt and women stated that they were comfortable and fairly confident in caring for the child between two and four weeks. The women I have interviewed are dressed well, losing the weight, beginning to exercise, and are very sensitive and responsive to their baby's cries. Maternal holding did not decrease dramatically after the first week, as described by Rubin, in contrast mothers stated that they were always holding the baby.

Several behaviors identified by Rubin included mimicry, role-playing, fantasy, introjection-projection-rejection, and grief work. Mimicry was not evident in the data. Role-playing sometimes occurred if a woman had prior experience with infants, but was not demonstrated by all participants. The code "preparing" was closest to this concept, but was broader than role playing. Role models existed and were usually the participant's mother and sometimes peers. Fantasy is somewhat similar to anticipation -- with expectations, worries, pressures, burdens and dreams all impacting. The behavior of introjection-projection-rejection occurred throughout pregnancy and is part of the code preparing. Several sources of information were used and accepted, modified or rejected based on what made sense to the woman and whether the source was trusted. Grief work is part of the strategy of settling-in and related to both the grieving of not feeling the baby inside and the necessity of leaving the baby to return to work. This code is not as related to the mother herself as it is toward the well-being of the baby.

Comparison With Mercer's Maternal Role Attainment Theory

In Mercer's theory, MRA is a process in which the woman becomes comfortable with her identity as a mother and by achieving competence in the role. Four important concepts were outlined by Mercer, 1) the mother's "self-system" composed of the ideal self, the self image, and the body image -- there was no data to support this concept, although mothers did express a strong sense of self and a desire to support the child's sense of identity; 2) the reciprocal interplay between the mother's self-system and her "role partner" (infant) appears too focused on this dyad to reflect the experiences of the mothers in this study -- the code "figuring out baby" describes more interaction among mothers, partners, other family members, friends and coworkers than reflected in this concept; 3) "role strain" -- was only evident in the data in relation to the lack of sleep and finding day care when the mother returned to work; and 4) the mother's perception of role competence is demonstrated in the strategy "settling-in". Taking care of the baby meant more than knowing how to change a diaper, feed or bathe the baby. Figuring out baby was a reciprocal process of the parents understanding the baby's needs and the baby figuring out the parents, their moods and responding to them. The components of MRA are demonstrated in the data of attachment to the infant, acquiring caretaking skills, and expressing pleasure and gratification in the role. Beyond these components, responsibility for the child, adapting to the addition of the child in the parent's life, counting on partner support, and trusting others to take care of the baby were also important.

The four stages of MRA described by Mercer include the anticipatory stage which was illustrated in the strategy of getting ready; the formal stage was illustrated in the strategy of settling-in, when mothers were still referring to their books, calling the lactation consultant or the advice nurse with every problem for a period of two to four weeks; the informal stage was illustrated in the strategy of settling-in with the codes of adaptation, role definition, decision-making and trusting others; and the personal stage illustrated by the code of decision-making. Women in this study appeared to move into the informal stage earlier at around one month postpartum, and the personal stage at approximately month three or four. Mercer found that 85% of mothers internalized the mothering role by nine months postpartum. This group of women felt competent earlier -- they said that they felt competent after the first two to four weeks -- but demonstrated independent handling of problems and more independent decision-making at about four months.

African American mothers in this study had the additional issue of hassles to deal with -- stereotypes, negativity from others, and feeling like and being treated as "public property." Mothers in interracial marriages had additional stressors. These issues were only touched on in the above theories as contextual and cultural issues. The meaning of motherhood is not addressed in the theories, but in this study meaning was elicited in interviews. The dynamic interplay between preparing, caring and dreaming started even before the pregnancy and continued after birth. The idea of "stages" does not describe this process. Concerns of mothers focused on their baby and on the African American community at large. Activism has been described as a

component of African American mothering, but not in descriptions of MRA. Rubin's concept of maternal identity is more consistent with the data in this study.

Limitations/Alternative Explanations

This study is limited by several factors which require explanation. Participants in this study, with the exception of one who lived in the Washington, D.C. area, were living in the San Francisco Bay area. All but two received their prenatal care in a health maintenance organization. Most of the women were about 30 years old, married, had an associate degree education, and a middle class income which they described as adequate to their needs. This study purposefully does not include women under twenty or low income women. The participants did include women with both high and low risk pregnancy factors. We do not know if the same processes would apply to women in other geographic regions of the country or in rural areas, or to younger or poorer women.

Although the study was proposed to include some women in the last trimester of pregnancy, no women were recruited for this study during the prenatal period. All the women in this study were employed during their pregnancy or stopped work because of problems in the pregnancy. There were many demands on their time and energy during the pregnancy, including attending prenatal appointments and classes. Women were more interested in the study after the baby was delivered. A major task of the early postpartum period is the mother's integration of the labor and delivery experience and resolving different expectations about pregnancy, childbirth or the baby (Mercer, 1990). Additionally, women were at home with their new baby and perhaps

had more flexible time and more focused interests at that time. Mothers often expressed a desire to have the interview before they returned to work.

Implications for Nursing

The results of this study provide support for changes in the way nurses and other health care providers interact with and provide care for and information to African American pregnant women and new mothers. Additionally, the data calls for a re-evaluation of the provision of formal prenatal classes as the primary mode of preparation for labor and delivery and child care for African American women and an explicit assessment of the intentionality of the pregnancy, the worries that women are experiencing, and the sources of information and support the woman has available to her. Nurses need to recognize that a history of a previous miscarriage or health problems of the mother cause increased stress and a delay in getting ready and may require intervention on the part of the nurse to facilitate the transition.

Worries

Women discussed many worries both during the pregnancy and during the postpartum period. Women who have had a previous miscarriage were very afraid that they would have another one. They did not relax or engage fully in the pregnancy until the time passed at which the previous miscarriage occurred. They needed extra support and reassurance until the time frame passed. Nurses need to recognize this potential need and assess for these worries. All women expressed worries and these should be solicited and acknowledged by health care providers.

Classes

Attending classes during the prenatal period is a standard intervention to prepare women for labor and delivery and to care for the child. Several barriers were described by mothers which prevented them from attending. For some mothers access was a barrier, classes were too hard to get to, the woman did not have transportation, or she could not afford the fee. Other women stated that the offered classes were "not relevant", either they thought it was information that was not needed, they would forget what was taught, or they got information from another source. Several women talked about either their partner or themselves feeling "too tired" to attend the class after work. Having no coach was given as a barrier for a few women, since many standard classes given to prepare a woman for labor and delivery require a coach. Women who did not attend classes or who only attended Lamaze wished that they had attended class because they believed that the class would have helped them prepare or feel more comfortable.

Since nurses frequently are the instructors in prenatal classes, it would behoove us to critically examine the classes for relevance, ease and comfort in attendance and to consider other formats which may be more culturally appropriate. Many of the women in this study expressed a strong desire to have a support group for pregnant African American women. Many women stated that they were tired of always being the only African American in groups, where they had to continuously answer offensive questions about what they ate or what they did in their culture. In a support group women could both get support from other women going through a similar experience

and get information to help them prepare. Women would not need to worry if they did not have a "coach" to bring with them. Ten of the participants in this study exchanged telephone numbers and plan to continue to meet together.

Providers

Women were very clear on the criteria they used to choose and evaluate health care providers. It is important for providers to adapt their behavior to be congruent with the needs of African American clients. Women were very sensitive to non-verbal communication. Providers need to be friendly, not stand far away or at the examining room door, and give a lot of and consistent information. Health care providers need to recognize that women are actively involved in their care and continuously engage in self-monitoring. It is critical for all providers to acknowledge and critically examine their assumptions and biases to provide culturally competent care to African American women which will not add to their stress.

Consistent staff

Some mothers stated that they frequently received different information from health professionals which they interpreted as being inconsistent. When they received inconsistent information they would either call and ask the same question of another provider or advice nurse, or they would insist on speaking directly with their provider. A few women did not see the same provider at every visit, which was upsetting because they had developed a trusting relationship with one provider and were not comfortable with someone they did not know or who practiced differently. Some women stated that their blood pressure was elevated on visits with unfamiliar providers

because they did not receive the same amount of information. When women felt that they could not trust what they were being told or if the provider did not order tests at the expected time, women increased their self-monitoring activities. Mothers desired consistency to reassure them.

> "I would have felt comfortable if there was one person I could have talked to, like say you were the advice nurse, and I got to familiarize myself with you. And any question that I had, I could talk directly to you. That would have been a lot better.... It would have been very helpful if I could have had one person to talk ... one particular advice nurse.... I think that would have made it a lot easier for me."

Additionally, women felt that they needed intensive nursing follow-up in the first two to four weeks postpartum. In this period they experienced uncertainty and had many questions. They worried about jaundice in the baby and several said that they were unable to see the signs even when shown by the nurse. They felt uncomfortable calling providers or advice nurses and felt some impatience on the part of some providers when they did call. Women who were breast feeding called the lactation consultants frequently during the first two weeks.

Peer Counselors/Advocates

Some women were very concerned about the low attendance by African American pregnant women at classes and at prenatal visits. They heard that few African American women were tested for some diseases during pregnancy and they observed that many women did not receive as much information as they did. One participant surveyed other pregnant African American women at the clinic to see if they had received the newsletters and if they were informed about the size of their baby. This participant found that many women were not receiving the information

that she had received and she wondered why.

> "So it makes me wonder if some of us get information and some of us not, and what can we do so all African Americans get the same information."

Two women had the services of a Doulah, a peer counselor with training in childbirth issues, during their pregnancy and found this service more personalized and very supportive.

Support Groups For Partners and Grandmothers

In the third focus group women expressed a need to have educational experiences for both their partners and their mothers. Women felt strongly that their partners needed both information about how the woman would feel during pregnancy and after the baby was born, as well as the normal changes they would experience so that the partner would understand. They also felt that fathers needed education in how to care for a baby, so that the woman would feel more comfortable letting him take on this responsibility. Mothers expressed ambivalence about the fathers' role. They both desired the sense of partnership in parenting and were reluctant to accept the partnership. Women stated that they needed help from providers to understand that these feelings were common and to help them let go.

A woman's mother was a very important support person during pregnancy and the postpartum period. Women stated that the mother's information was not always accurate because the mother's experience of childbirth was so long ago. Women desired current information. Women also often experienced conflict with their mothers over how to care for themselves or the baby. A woman's mother often was present during the labor and delivery and served to provide support, along with the partner.

Women felt that their mothers could be much more supportive if they either had specific educational classes or their own support group to give them the latest information. Additionally, some women who did not attend classes received all of their information about pregnancy and childbirth from their mother.

Future Research

Since this study was conducted primarily in one geographic area, with a specific group of African American women, further research needs to be conducted in other geographic areas and with more diverse samples. In this study mothers were interviewed from one to three times over a three to ten month period, from ten days to twenty months postpartum. A follow-up study to describe the transition through the first two years would provide more complete information and possibly uncover other key time periods requiring nursing interventions. Studies on motherhood and the experiences of pregnancy need to be conducted cross culturally with diverse groups of women to determine which processes are shared and which processes may be specific to a cultural group.

Another area of needed research on African American motherhood is to study the concept of "Othermother" and "Community Othermother" described in the Black Feminist literature to see if these concepts of motherhood persist today. The prevalent telling of "horror stories" to pregnant women by other women needs further study to determine the purpose and meaning of this behavior. Do these stories prepare one for the worst, and then the woman feels relieved that her experience was easier, "it was not what I had expected". Is it meant to discourage women from getting pregnant

until they really are ready? Does it all seem so unbelievable that the pregnant woman develops a positive attitude and a commitment to the pregnancy which a supportive network facilitates? Or is it that women after a time only remember the worst and exaggerate it?

Conclusion

This grounded theory study has described the transition to motherhood for a group of African American women in the San Francisco Bay area as engaged mothering within a racist environment. The results of this study are consistent with current descriptions of motherhood from Maternal Role Attainment Theory, but adds to this theory the important context of racism, stereotyping and negativity that African American women face in addition to the usual stresses and issues of pregnancy and motherhood. The data from this study also suggests that the conditions of the intentionality of the pregnancy and a history of health problems or previous miscarriage may affect the transition to motherhood and needs to be elicited during assessments.

The description of the transition to motherhood for this group of African American women calls into question nursing's focus on the dyad of the mother and infant as the client in need of nursing intervention, and illustrates the importance of the family and the larger community, especially other women in facilitating a successful transition. Additionally, women in this study were active in attaining care during pregnancy and prepared for labor and delivery and becoming a mother in numerous ways. Women desired a mutuality and partnership in their relations with

health care providers, but when they felt this was not possible changed providers, sought other information and increased self-monitoring activities. Nurses need to recognize that formal care and classes are only one way women participate in preparing for motherhood, and find ways to maximize the effectiveness of the other strategies women engage in. Most importantly this study demonstrated the importance of nurses and other health care providers recognizing the impact of racism on the lives of African American women, confronting the common assumptions that all African Americans are alike, and assessing each woman individually so as to provide respectful, effective and stress reducing care.

This study was conducted utilizing a theoretical framework of transition theory to study the process of becoming a mother over time, and incorporated the concept of Afrocentrism to enhance my ability as the researcher to understand and describe this transition from the experiences and perspectives of African American women. The use of individual and focus groups interviews allowed for an interactive approach which elicited the meanings and the context of the environment and history which contributed to this transition. This framework was more culturally congruent, which according to Collins (1991a), values the concrete, uses dialogue to assess knowledge claims, and incorporates the ethics of caring and personal accountability. The data analysis was shared with participants and a dialogue occurred which strengthened the results. Validation was particularly critical in this study, since I am not African American, and it was important that the analysis accurately portrayed this group of women's experiences in the transition to motherhood. Even with validation and the use of this

theoretical framework, we need to continue to acknowledge that any research study can provide only partial knowledge claims. Further research utilizing this framework is needed to provide a balanced description of the variables impacting on the health status of African Americans. Such description has the potential to actually improve health and decrease the pervasive discrepancies in health status between African Americans and other cultural groups in this country.

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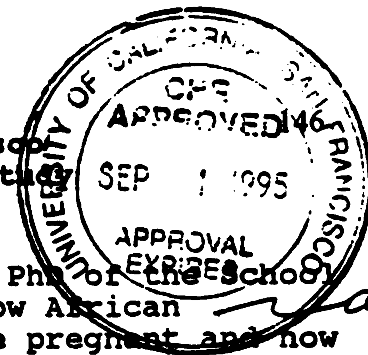
Appendix A

Consent Form

Recruitment Letter

Interview Guide

University of California, San Francisco
Consent to Participate in a Research Study



A. Purpose and Background

Linda Sawyer, RN, MS and Juliene G. Lipson, RN, PhD of the School of Nursing are conducting a study to find out how African American women care for themselves when they are pregnant and how they prepare themselves to become mothers. I am being asked to participate in this study because I am an African American woman who is currently pregnant with or has delivered my first child.

B. Procedures

If I agree to participate in this study, I will talk to Linda, either alone or in a group of 5 to 8 other women in a comfortable and private place agreeable to me. The conversation will be tape recorded. At the end of the interview I will be asked to complete a paper and pencil questionnaire about myself, including questions about my family, education, and prenatal care, and about my perceptions of racism. The total time required will be from one to two hours. A second interview will be arranged at a later time, if I agree, lasting approximately an hour to expand on my experiences after my baby is born.

C. Risks/Discomforts

Participation in the study will involve a loss of privacy, particularly if I am part of a group interview. The researcher will ask me and the other people in the group to use only first names during the group session. They will also ask us not to tell anyone outside the group what any particular person said in the group. However, the researcher cannot guarantee that everyone will keep the discussions private. My records will be handled as confidentially as possible. For example, when the tapes are transcribed to written form, the tapes will be destroyed. Study records will be locked in a cabinet at all times. My name will not be marked on the data; only code numbers are used. Only Linda Sawyer and her supervisor, Juliene Lipson, will have access to the data. I will never be identified with any stories or quotations in any reports or publications. For some people talking about personal experiences may be difficult or unpleasant. I will be free to talk only about those topics which I want to.

D. Benefits

There are no direct personal benefits to me. The information that I provide will help health care providers understand the transition to motherhood and the experiences of pregnancy, so that prenatal care for African American women can be improved.

E. Costs

There will be no costs for me to be in the study. My participation or refusal will in no way affect any benefits I may be receiving.

F. Payment
I will be paid $25 in cash for participating in the study immediately after I complete my participation in the study.

G. Questions
I have talked with Linda Sawyer about this study and have had my questions answered. If I have further questions about the study, I may contact the researcher at:

Researcher:
Linda M. Sawyer, RN, MS, Doctoral Candidate
Home telephone 510-526-7912

Supervisor/Researcher:
Juliene G. Lipson, RN, PhD, Associate Professor
Office telephone 415-476-3981

If I have any comments or concerns about participation in this study, I should first talk to one of the researchers. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8 a.m. and 5 p.m., Monday through Friday, by calling 415-476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, California 94143. The approval # for this project is H5191-11586-01.

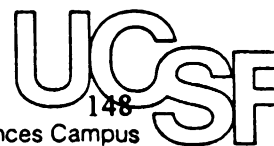
H. Consent:
I will be given a copy of this consent form to keep.

Participation in research is voluntary. I am free to decline to be in this study, I may refuse to answer questions at any time. I may stop the interview at any time. My decision whether or not to participate will have no influence on my present or future status as a patient at Kaiser Permanente Medical Center in Oakland, California.

____________ ________________________________
Date Signature of Study Participant

____________ ________________________________
Date Signature of Researcher Obtaining Consent

Address (only if I wish to receive a copy of the final report of the research):



University of California, San Francisco...A Health Sciences Campus

School of Nursing
Department of Mental Health,
Community and Administrative
Nursing
San Francisco, California
94143-0608
415/476-1504
FAX: 415/476-6042

Dear

I am conducting a nursing research study on the experience of pregnancy and becoming a mother for African American women and would like you to consider participating in this study. The actions and behaviors which African American women use to stay healthy and protect their unborn infants has not been studied. Understanding the experiences of women during pregnancy will help health care providers to improve prenatal care and the health care experiences for African American women during pregnancy. Additionally, by studying normal pregnancy we may better understand how to protect mothers who are considered high risk so they can increase their chances of having a healthy baby. I am also interested in how the effects of racism may affect a woman's health and her pregnancy.

If you are willing to participate, you may choose to either talk with me privately or join a group of 5 to 8 African American women to discuss how you take care of yourself when you are pregnant, what the experiences of pregnancy and prenatal care are like for you, and what would help you in your pregnancy. We would meet in a convenient, comfortable and private place for one to two hours. I would use a tape recorder to help me in analyzing our conversation and accurately capture what you think is important. I will ask for a second interview at a later time if you agree, to talk further of your experiences after the birth of your child. At any time you may refuse to answer a question, ask me any questions or stop the interview. At the end of the first interview I will ask you to complete a short paper and pencil questionnaire about yourself and on your perceptions of racism. You will be reimbursed $25 to participate. You will not be identified in any way to protect your confidentiality. When the study is finished, I will write up a combined story of what women tell me to present to other nurses, doctors, and health care providers. You may receive a copy of the final report.

Thank you for considering to participate in my study. I would be pleased to answer any questions you may have. My telephone number is 510-526-7912.

Sincerely yours,

Linda M. Sawyer, RN, MS
Doctoral Candidate in Nursing

Suggested Interview Questions and Probes

1. How did you feel during your pregnancy? Did you had any problems or complications?

2. Did you feel that you were ready to be a mother?

3. What kinds of things did you do to stay healthy when you were pregnant?

4. When did you start your prenatal care? Why did you decide that was the time to start?

5. How was the prenatal care -- did you feel it was what you needed? What would make it more helpful?

6. What other things did you do besides going to the doctor/ midwife/nurse practitioner to care for yourself and get ready to be a mother?

7. What kind of help/support did you get from family/ friends/others while you were pregnant? What did you need that you didn't get?

8. Were there any things you were told not to do or to avoid when you were pregnant, i.e. food, activity.

9. What does being a mother mean to you? What do mothers do?

10. How do you feel about your own mother?

11. What people helped you to grow up or were important to you?

12. How did, or will, your life change after your baby is born? Would anything have helped you be more prepared for the changes?

13. What are your hopes and dreams for yourself? For your child (children)? What will it take to reach your dreams? What are the barriers to reaching your dreams?

Appendix B

Instruments

Demographic Questionnaire

and

Perception of Racism Scale

Please answer the attached questions. It is important that you answer all questions in the Perception of Racism Scale for it to be useful in the research study.

All answers will remain confidential and anonymous.

Thank you for Participating in this Study.

Code ____________

Personal Information

1. How old are you? ________________

2. Partner Status

   1. [ ] single
   2. [ ] partnered, not married
   3. [ ] married
   4. [ ] separated
   5. [ ] widowed
   6. [ ] divorced
   7. [ ] other ______________________

3. How many people live in your house? (including yourself)

   ____

4. Who lives in your house? Give numbers when appropriate.

   1. [ ] yourself
   2. [ ] Grandparent
   3. [ ] Father
   4. [ ] Mother
   5. [ ] Father-in-law
   6. [ ] Mother-in-law
   7. [ ] Spouse
   8. [ ] Sister
   9. [ ] Brother
   10. [ ] Brother-in-law
   11. [ ] Sister-in-law
   12. [ ] Niece
   13. [ ] Nephew
   14. [ ] Cousin
   15. [ ] Aunt
   16. [ ] Uncle
   17. [ ] Friend
   18. [ ] Children
   19. [ ] Other (who)_______

5. Employment Status

   1. [ ] work, full time
   2. [ ] work, part time
   3. [ ] not working
   4. [ ] looking for work
   5. [ ] work & student
   6. [ ] student
   7. [ ] homemaker
   8. [ ] retired
   9. [ ] other, specify ______________

6. What kind of work do you do? (list all the types of work that you do and last occupation if not currently working)

   ____

   ____

7. Spouse/Partner's Occupation:

   ____

8. Your <u>Highest</u> Level of Education (specify if degree, diploma or other certificate received)

1. [ ] less than 8th grade ____________________
2. [ ] less than high school ____________________
3. [ ] high school ____________________
4. [ ] vocational training ____________________
5. [ ] some college ____________________
6. [ ] Associate degree ____________________
7. [ ] college graduate ____________________
8. [ ] master's degree ____________________
9. [ ] doctorate ____________________
10. [ ] other (specify) ____________________

9. Approximate annual <u>family</u> income

1. [ ] $10,000 or less
2. [ ] $10,001 - 30,000
3. [ ] $30,001 - 50,000
4. [ ] $50,001 - 70,000
5. [ ] $70,001 - 100,000
6. [ ] Above $100,000

10. Source of Income (choose all that apply)

1. [ ] Work
2. [ ] Savings
3. [ ] Loans
4. [ ] Family helps
5. [ ] Welfare/AFDC
6. [ ] Scholarships/Education grants
7. [ ] Child/Spousal Support
8. [ ] other ____________________

11. How many people in your household work? (including yourself) ____________

12. Do you help support family members who do not live with you?

1. [ ] Yes
2. [ ] No

How is the person(s) related to you? ____________________

____

What city or state do they live in? ____________________

____

13. Is your income adequate to meet your needs?
 1. [ ] Yes
 2. [ ] No

 Explain: ____

 ____

14. When did you first see a health care professional about your pregnancy?
 1. [ ] first three months of pregnancy
 2. [ ] second three months
 3. [ ] last three months
 4. [ ] when I started labor

15. How many times did you see a health professional about your pregnancy?

 ____

16. Did you change the health professional you were seeing while pregnant?

 1. [ ] Yes
 2. [ ] No

 Explain: ____

 ____

17. What health professional did you see while pregnant? (check all that apply)
 1. [ ] Physician
 2. [ ] Midwife
 3. [ ] Nurse Practitioner
 4. [ ] other (specify)______________________________
 5. [ ] none

18. Was there a kind of health professional you wanted to see while you were pregnant, but didn't or couldn't?
 Explain:____

 ____

Perceptions of Racism Scale

On the next two pages you will find 20 statements.
1. Read each statement carefully.
2. Choose the word that best tells how you feel about the statement.
3. Put an "X" in the space following the word.
4. Do this for each statement.

1. African American women experience negative attitudes when they go to a white doctor's office.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

2. Doctors treat African American and white women the same.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

3. Racism is a problem in my life.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

4. A pregnant white woman is treated with more respect than a pregnant African American woman.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

5. I am not affected by discrimination.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

6. Sometimes if you are African American in a white doctor's office, its as if you don't belong there.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

7. Racial discrimination in a doctor's office is common.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

8. In most hospitals, African American women and white women get the same kind of care.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

9. Doctors and nurses act the same way to white and African American pregnant women.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

10. If an African American pregnant woman comes to a doctor's office, it's assumed that she is on welfare.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

11. African Americans have the same opportunities as whites to live a middle class life.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

12. Officials listen more to whites than African Americans.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

13. If an African American woman and a white woman are applying for the same job they have the same chance of being hired.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

14. There has been significant progress in ending racism in the 1980's.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

15. A white woman has more educational opportunities than an African American woman.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

16. African American women get pregnant to receive more welfare benefits.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

17. African American women can receive the care they want as equally as white women.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

18. Judges are harder on African Americans than whites.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

19. African American pregnant women have fewer options for health care.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

20. Officials listen more to African Americans than whites.

Strongly agree___ Agree___ Disagree___ Strongly disagree ___

Appendix C

Additional Participant Quotes

Getting Ready

Anticipation

"And, for the most part, it wasn't a bad experience, in comparison to what I heard from some of the women at my Lamaze class. There were a couple of them that had horrible, horrible, horrible deliveries. And I'm going, hey, I've been blessed. It really wasn't as bad as I had even begun to think it was."

Preparing

"It may be natural, but its still...its very scary. And you don't know what to expect, you really don't. And even afterwards, I wish I would have known a little bit more about what you're going to go through afterwards."

"I don't feel I was prepared.... I was, you know, terrified, of course, being a mom.... just worried about would I do the right thing for him and this and that. Maybe I should have ... I think maybe I should have taken some classes. It probably would have helped me, prepared me a little better to feel more comfortable... The only one I took was the breast feeding Class.... But I probably should have taken ... some childcare classes, but I didn't. But things worked out. It worked out pretty good, I think, for ... it probably would have made me feel more comfortable.... But I did read a lot. I read a lot of books, so I just read everything I could while I was pregnant."

"That's a question I really pondered, because I'm trying to figure out why ... no other African Americans attended class.... but I don't know what we can do to get information to the African Americans. Because a lot of people I've talked to who've had babies, they never went to Lamaze, or they never went to baby classes. I know a couple of women who never took prenatal ... didn't get prenatal care until they were five months."

"I felt like I was being taught by someone who was teaching me because they were a mom and had did it, as opposed to they were trained on this topic, like someone who's a mom and they were interested in the birth process, and so they took some classes, and then they're sharing that information with us, as opposed to someone that I got lots of information I needed. I mean, I had seven books, these tapes and all these people. I had a lot of resources. And if somebody only had that Lamaze class, I think they'd be really pretty bad, if that's all they had, that would be pretty bad."

"But I kind of wish I would have went through the Baby Care, because I'm not an expert, although I've helped to raise two younger sisters and I have a lot of little cousins and stuff. But when you have your own child, it's different, you know. And there's questions that come up that you want to ask, but the doctor might not always be available, or you kind of feel like you shouldn't be calling (the clinic) every time

you have a question, if you don't know ... Basically just not taking the time to sign up for it. That's the only thing I could see. It wasn't like I was skeptical about it or anything like that, because I'm sure it would have been a good class. I think the class would have been good. I don't know. I just didn't sign up for it."

"I didn't take any of that (classes). Which ... I wish I would have, because I found myself, when I was having contractions, I would stop breathing instead of breathe out. I would hold my breath. (laughs) So now I wish I would have, because maybe it would have helped me a little bit better."

"I guess there is a lot of advice out there, but evidently, in my community, I think there needs to be some other kind of avenue to get ... for you to get advice. Like Lamaze. And out of 10 couples, I was the only African American couple. And I think about all the African Americans who have babies, especially at (the clinic). Maybe 3% go to Lamaze.... I don't want to say doctors aren't telling African American women about Lamaze or about different classes, but all the classes I attend at (the clinic), I was the only African American in all my classes, and I went to six or seven different classes about babies."

"Clearly my friends. My same age peers ... many of my friends had already had their first child by now, and most of them were on their second child..... It was helpful even before we decided to have a baby, because just seeing what they had gone through and recognizing what would be some of the normal demands and what would be some of the joys of having a baby. They just served as really good models. And because it was so current -- that they had their babies, say, within the last two years or so -- they could really be helpful and say, this is what they do nowadays.... Whereas, with my mom or other family members, many of them had their kids years ago.... like my mom would say, I don't know what they're doing nowadays, but this is what they said back then.... Some things never change, but some things are different now in terms of how they do it. And many people of my mom's era didn't breast-feed. ... breast-feeding is probably one of the biggest tasks, I think, of having a new baby, if you decide to do it. And so, talking with my friends has been really really helpful because I think almost every one of my friends breast-fed their babies, and that was really helpful, very normalizing ."

"Everybody gives you advice.... Well, especially on my job, boy, I mean, every mother there.... even all the customers that came in the store ... everybody was just so ... protective of pregnant ladies... I couldn't do anything.... Everybody's like watching me ...don't do anything.... It feels good, you know, that people are concerned about you when you're pregnant.... I mean, everybody was like ... on my case."

"Some people who said, 'well, it's not going to be all that easy, and you think you know what you're doing'. I'm like ... why won't they just shut up. Will you just be quiet. I said, I don't want to hear what you have to say. Keep your comments to

yourself. If you have nothing positive to say, don't say nothing at all. You know, I said, what you did, how you raised your child -- that was back then. This is now. This is different. This is my kid. Well, I've had people come up and say, why you name your child that? This is my child because I wanted to ... I like it. They were ... well, you don't know what you're doing. And whadatatda. I'm like, he only been here two weeks. I only been a mother for two weeks! I'm not finished yet. I will never be finished. I said, just give me a chance."

"I'm just that type that I'm not going to call for every little thing. First, I'll kind of ask family members, and if they don't know, then I'll call the consultant. Like last night, I wasn't sure if she could have the Vick's vapor in her vaporizer. So I asked my mom. She wasn't sure.... And my aunt, she has a son that's four. I said, well, maybe she knows, because she has a child that's not too old. She wasn't sure. She's like, put salt in it. I said, I'm calling (the clinic). So I called, and the nurse -- the advice nurse -- she gave me ... she told me, don't put the Vick's in there. Just water is fine. And she told me to make up a saline for her nose to pump it out better. So that worked. So she said, drop some in her nose, and it will make the mucous come up better. So that was good."

"I have a friend who doesn't have any children -- I don't think she even plans to get pregnant any time soon -- but she always had advice. And I couldn't understand that. And, several occasions I said to her, you know, when you have your own child, then you can dictate what you will do. But for the meantime, you can't tell people what they should do with their children."

"I tried to eat right..... I didn't eat a lot of junk food. I ate a lot of fruits and vegetables. And I walked, I exercised.... Just tried to take care of myself, do everything they asked me to do, like take vitamins and iron, stuff like that."

"Most people I talked to, they said that it's better to keep moving, keep ... like get your exercise and stuff and not just sitting around and waiting, waiting for the baby to come. It's better to just keep going, keep moving."

"I just really don't think a lot of people take... child bearing, child birth or pregnancy as seriously as it really is, because as far as myself and my lifestyle and my religion and everything that I do is that, when I first found out that I was pregnant... I had a Doulah that was with me throughout my pregnancy.... And so I was very conscious of the things that I ate, the things that I did, the things that I watched on television, that I listened to. Every night before I went to sleep, I had different meditation music and baby heart beat music that I would listen to. And, you know, for that reason, even during my childbirth and delivery with him -- it was rough, but I went in with the mentality, like, I'm not going to have drugs. I don't want to do this. I want to have it as naturally as possible. And the only thing that kind of set me back is that he was two weeks late, so I had to be induced. But I went

through and had the delivery naturally. And I'm happy that I did that, because when he was born, I mean, his Apgar scores ... he got a 9. When he came out, I mean, his eyes were just big as saucers."

"But you know, the fact that you go by that -- because you have no idea what you're going to go through. Because I couldn't think of a birth plan I was, like, I don't even know what to think to prepare for."

"The women... and these were not just white women ... these were black women in the lab too, who were surprised that I wanted to be checked. They said, you know, you'd be amazed how many African American women come in here pregnant who won't sign the consent form to have an AIDS test ran.... I've had a couple people I know who didn't go get prenatal care and they said they didn't know they were pregnant until they would deliver. Being pregnant -- I can believe that the first couple of months ... the first three months could pass by and you not know it. But after then, you have to know something because your body is doing a total change. It's drastically changing. So how can you go nine months and not know you're pregnant. Or how can you go six months without any prenatal care?"

Attaining Care

"I don't know how we can do it, but I think it's very important that you attend. Especially being pregnant, you get prenatal care right away; you take every test that's possible out there. Because whatever happens to your body is going to affect that child."

"But I saw Dr.___ this particular time, and I feel really comfortable with her because she asked me a lot of things, and that made me feel that she was concerned."

"Well, you know what helped me out a lot, too, was that I had a birth plan prepared before I went to the hospital, where I had a list of do's and don't's and things that I wanted."

"But you know, the fact that you go by that -- because you have no idea what you're going to go through. Because I couldn't think of a birth plan I was, like, I don't even know what to think to prepare for."

"I was about three days late and I kind of ... kind of knew I was pregnant. (laughs) Well, more or less his dad knew it. He told me. He said, well, I think you're pregnant, and I kind of denied it. But I kind of felt it. And then I went and took the home pregnancy test, and that was it, and then I arranged to go to the doctor and had a real test."

Dealing With the Reality

Handling Problems

"I was considered high-risk because of my age, for one thing, it's 40. It's my first child."

"You know, during my pregnancy, my asthma was pretty good. I was in the hospital once for asthma when I was five and a half weeks... pregnant with her. And I think basically my asthma wasn't that bad. It was just being, you know, cautious, because I was having such a hard time at the beginning of the pregnancy. That's probably why they admitted me, because I didn't feel that I was that bad off. But I guess they did. But otherwise my asthma was pretty good during my pregnancy, and I'm really ... you know ... I'm glad about that."

Hassles

"And I was going to this doctor, but I didn't like the way he, you know, at the time, I had MediCal, when I first started out ... became pregnant. And the way they treat MediCal people sometimes is really horrible. They give everybody the same appointment time, and then you're just there ... My appointment was at 9 o'clock in the morning, and I was there until 1:00. And it's just like, you're sitting in a group like you're at a drug rehabilitation center or something."

"It's scary, because a lot of women who I talk to -- like just going through different things, African American ones who I would see -- they wouldn't have gotten the same information. Like I asked a woman on the elevator, did she know how big her baby ... what her baby's head was, or had they measured? And she said, yeah, they did, but they never told her."

"And I've always been raised in a multicultural neighborhood. and so I felt like, if I was doing it, Jane down the street lived the same lifestyle I lived, and because our skin tone was different, to me she was no different than what I was. And so I can understand how ... yeah, you would think that you would still better if you were in ... not even just all African Americans, but if it was more than just you -- with you always being the one to stick out."

"I had an experience ... I don't want to say it was a ... well, it was a bad experience, but I guess it was an eye opening experience. When I first became pregnant, and I made an appointment ... when I called to find out about my pregnancy test. The woman who answered the phone said, I said I'm calling, my name is _______. And I gave her my number. And I don't know if it comes on the screen that I'm African American, but she said to me -- oh, I don't know if this is good news or bad news for you.... and I said, so what does that mean? Oh, you're pregnant. She says, is it congratulations or was this not a planned pregnancy, so you can abort it?

And I felt like -- did you say that to me because I'm black? You found out, by looking at the screen, that I was an African American woman, because I had a Caucasian woman in my office call back just that line to speak to her and to give her some information, and she couldn't find her information. But she said to her automatically, congratulations, are you calling to see if you're pregnant? And I thought, did you say, she said that to me because she pulled up on my screen that I was young. I mean, I'm not that young, I'm 29 ... but that I was African American, and she assumed I was single. And then when I said... well, am I pregnant? And she said, yeah. And I said, OK. And then she said, so do you want me to set up an appointment with the doctor? And I said yes. So what do you want -- a prenatal appointment or do you want to talk to someone about aborting the baby? Why would you ask me that question? That, to me -- that was offensive to me. Especially when my friend called back and you congratulate her automatically, without even pulling up any of her information? You're not even finding out if she was a member?... I always thought that you couldn't tell what color I was by my voice on the phone... I got this feeling that she found out that I was African American once she pulled up my records. Because she asked me for my number right off the bat. But she never asked her. And so I felt ... I was really angry about that."

"I used to kind of just take it in and go home and be upset. And I would say, Mom, you know, people are so stupid because they just assume because I'm black I'm _____, and that used to really bother me growing up.... One day, even ... I was pregnant. I was in the store and these people kept watching me. And I kept saying, why are they looking at me? And then ... and I felt they were watching me because I was an African American woman. They wasn't sure what I was in the store for. I was pregnant. You know, I was with some younger African American women, some teenagers who I mentor. And I felt like ... this is why some African Americans are angry because you feel like people just stare at you because you're black. And they assume you're going to do something negative. And it's horrible. It's a horrible feeling."

"In my church I'm mentoring these young... I'm trying to teach these African American young women ... that they have to look inside themselves and know that they're important, and they're important to themselves. And you are somebody. And if you try to have that attitude, and you walk around with that attitude regardless of ... even though I told them, it bothers me sometimes ... I said I'm not going to lie to you and say that people looking at me doesn't bother me. It does. Sometimes it rubs me the wrong way, and I get an instant attitude with people. So then they'll automatically say, oh my god, she's got an attitude, she's this, she's that, because I do sometimes. But I've learned that I know that I'm important, and that I'm a person. But sometimes you have to keep focusing on that because some people just don't know. And they don't mean no harm.... And I think just even a lot of my Caucasian friends feel the same way. Sometimes they get put in a lump sum because they're with a black friend. Or if we're a group of us and there's like one or two of them, sometimes they've told

me that they felt like other Caucasians have looked at them like ... you know, poor what trash, or you want to be something else. And it's sad that we live in a society like that, but we do. And I think it does have something to do with people's... especially women being pregnant and their pressures being up. I think it has a lot to do with it. And people not ... and them not asking questions because they assume they're going to be lumped into one category, so why ask?"

"I know you haven't asked me a question about discrimination in care, but there is discrimination, like, within races.... And she inserted the IV wrong and it backed up. And they didn't even find that until after (the baby) was born. And so I didn't even get the medicine that people thought was coming through the tube. But this was all purposefully.... and my friend said ... 'oh, so she didn't think you were black enough'. And I said, yeah! That was it! Because I was in there, just being myself, you know, and sometimes people think that that's not who black people are. And then, you know, there's my husband and he's white... I don't think of myself that way, because who's to say who's black enough? That's why I asked about... asking different kinds of black women ... because even black people think they know who black people are. And they go, oh, that's being black, you know. Like if somebody says, oh, you talk white. Like. Oh, so you own the language that gets you nothing. And other people own the language that gets you an education and a job. You know. Do you really believe that. And some people really do.... You know, because, you know, we all exist on these different levels, but to disrespect somebody based on your own personal racism, you know, because she used her power. So it wasn't prejudice. She was being racist. She used her power as a nurse in that hospital to do something against someone even though it was of her own race....and we had all of those people working, and then have one person like just kind of screw up the experience because she wants to be a jerk, basically .... But I can't really say that I felt that it was because I was a black woman, you know. I would say it was the type of black woman I was, you know."

"And then being in an interracial marriage seems to make it more difficult for me because people automatically assume something if they see ... if you're married to a white man, it's like ... there's so much stress involved in it, I really couldn't even start, because that's something that's been bothering me every night for six and a half years, and I've lost friends by marrying my husband.... We've had it tough, you know. And we stick together, to each other. He's like my best friend. But it's like there's only so much ... you can lean on your mate for. You need women, companionship. And I would like to meet more African American women. That's why with this study, I thought it would be maybe a good way for me to make a few contacts, and with women that have just had kids also."

"But the only thing that's going to be tough for us is, like I said, the interracial factor. I really think that that's going to be a problem.... When I was pregnant I was told you are going to have a beautiful baby, the best of both worlds. But that just

drives me up the wall. But we're going to have problems of that nature.... But it's like, you know, dealing with the outside world. We're here in our home, it's like we're content, you know. But it's dealing with the outside world that makes it more difficult."

"I want to do what's best for him, but I don't want to shield him from a lot of things that can happen.... you see programs on TV and you see interracial kids saying things like...oh, I don't like my father. Or, I don't like my mother. And then ask the question why, 'because my mother's black or because or because my dad is white.' You know, they can't identify with their mom or their dad. Or, it's like they hang out with one group of kids at school. Like they'll hang out with a majority of white kids at school, and ... but it seems like my kid -- because, you know, he has black in him -- that I'd feel like, if he's hanging around with more one than the other, then it's going to make him... resentful against me or against his dad. And I don't want that. I want him to be able to be comfortable with both sides -- my side which is black, and his dad's side, which is white -- I want him to be comfortable. And I'm afraid that he might get picked on at school. He might not find the kids that he can bond with, that he's comfortable with. I'm afraid of that... We talked about it, and (my husband) doesn't ... think it's going to be a problem. He goes, 'honey, don't worry', you know. But I am worried, because I know how some kids can be very cruel, and I don't want him growing up despising either me or his father. Uhm. Things happen. You don't always fall in love with someone of the same race as you. To me, love has no color, but it actually does. In today's society, I feel like it does. Because me and my husband will get ... we get, you know, looks ... all the time. And it's really not comfortable. And I want him to feel comfortable.... it bothers me. I'm concerned, but... my husband is a very easy going person; he doesn't seem to think that there's going to be a problem. I, on the other hand, I'm a negative thinker. Anytime I think something, it's always negative, which could be a problem too."

"Love and education is the key.... I think out of the love and the education comes the strength. I think it's the people who are sort of like floundering or so messed up, somewhere along the way they didn't get the education. They had the love but they didn't get the education."

Relationship With Mother

"My mother. My mother. My mother's the best. I mean, she's raised four kids by herself. I'm her oldest out of four.... I know she knows that she did a good job. I mean, we've all turned out very well in light of what a lot of people are turning out like in this day and age. But, you know, she taught all our patience, she taught us all our love for children."

"I guess kind of mold myself to talk to her (Mom) differently, because, for years, I guess until we were teenagers, that's when she began to be our friend, when

we were teenagers. But when we were little, you just saw her as mommy. She was the boss, and you talked to other people. Like I would talk to my aunt or to my mentor. I wouldn't too much talk to her about things, because she was very protective..... And you become protective like that... (our relationship) it's even stronger now. Because I call her a lot more now. We talk a lot, but I call her just on a daily basis now, whether it's to tell her that the baby did or that today, or to ask her a question, or just to see how she's doing."

Partner Issues

"And it's good that my husband has the job that he has, the successful job that he has, that is allowing us to be able to basically afford me staying at home right now, which is good.... because we both want me to be at home with him. We're really not too comfortable with the day care situation that we've heard about. So we really haven't looked into it. So we prefer me to stay at home until he's a certain age where we feel comfortable leaving him with somebody else."

"He was kind of uncomfortable at first with me being pregnant, I guess, because all his kids were all grown up and stuff. And he still kind of feels, well, we're kind of old to have kids, you know.... He says that, but boy, he comes home and he's just so excited about his son. You know, he's so happy. Constantly trying to tell me how to take care of him."

"And then my husband comes home, when he comes home from work. And he takes care of the baby. He can't really feed the baby right now because I'm still nursing. But he does as much as he can. And he plays a very active role in his life."

"And I notice, my husband -- this is his first child, so he's ... excited about whatever she does for him. But she loves him, so it seems as though she loves him so ... he can feed her whatever ... comfort her or whatever. And she has no problem. But he's excited about her, so I think that he will be really excited if ... when he gets ready to give her the bottle and she takes it from him."

" Now that she's on the bottle, he feels like he's more into it now because he can bottle feed her. But at first, we had to go ... we went through a little bit of, like ... 'She likes you more, she doesn't like me'. And I'm like, no, don't say that. So I was really kind of anxious to kind of get her on the bottle too, so that he could feel like he was a part ... a part of both. You know, parenting experience... and he was. But now it's better. Sometimes, when he's watching TV or a game or playing Sega ... she's in that chair. She's right next to daddy. She's joining in with him, so ... And then at night... when I need at least an hour's sleep, he's up with her."

"His dad, he works ... he picks his own hours, you know ... usually some days when I'm off, he'll try to take that day off, you know, so he can spend it with me and

the baby."

"Maybe if I had a little help. If her father would have played a role in it. But ... you know men. Uhm. He was there maybe ... let's see ... in August, he was there for that surgery. But it's like a pop-in, pop-out thing. He never was (a support) ... he never gave me a break. Like, he was never there maybe during the day and I'll be there during the night. He wasn't there. Actually, he wasn't even there for the surgery time. He was at work. I had to call him. Uhm. And when he did get off work, he came for like maybe 15 minutes, saw her, and then he was gone, and that was it.... It was never a continual thing.... I always had the burden myself. I'm always dealing with the burden myself. So that would probably have helped me. I wouldn't even have gone anywhere. But the fact is that maybe I could have got a little sleep in the room knowing that he was watching her..."

"Because, throughout my pregnancy, I hated my husband. I didn't like hate him, but ... we didn't get along for ... I mean, I'm telling you. It was like, he would be coming in from work and it was like, god ... and I'd turn off the feeling. And I really felt like that. And he felt the same way about me, though."

"But about the sex part that you asked about.... But then the other thing is that you're breast feeding them milk and then your breasts and everything. And it's like ... no ...I think that my husband feels kind of like weird because he sees me breast-feeding.... I've heard about that. My girlfriend, her son ... she had two boys and she breast-fed them. And they had two big rooms, and instead of putting the baby in the room, one of them -- the father slept with the oldest and she slept with the youngest. And she breast fed both her kids. And he said after that, that breast feeding was a turnoff to him. It turned him off, you know. And instead of being open with it and talking about it, he waited a long time."

"I really hated it too. And the thing is, I started having ... being intimate with my husband ... I don't want to say out of guilt ... but I just really wasn't interested. And even now, you know, because he's just turning ... he's about to turn six months .... I'm like that too. And it's so bad because he's been waiting ... I still don't really have the urge. And he's like ... especially since I came back from the doctor and everything was okay. You know, he comes up, you know, nuzzles up under me and everything. And like a baby would ... like be sitting there. And I feel like I'm ...Uh ... give me a couple more days. I've heard of that there's like a little innate jealousy."

"Before I didn't want nobody to look at me, though. I was so ... fat."

Worries

"So that's a constant fear and a constant worry of mine. And I think that's a change because now I'm not worrying about myself anymore. I'm worrying about a

being that I am now responsible for, and that's probably one of the biggest burdens."

"Because I'm thinking, wow, how am I going to go back to work if she doesn't take the bottle? I can't let her starve all day."

"I guess my age was one of the things. I kept thinking, I'm older now and things may not be right. So, you know, that was part of the concern, that I had to make sure that everything was right. And I honestly feel that things were really good and I just didn't know it."

"Because everybody was saying, once you go in there and scream and stuff, they ain't going to help you, they ain't going to like you. And I was like, I ain't going to scream. I ain't going to scream."

"I was terrified. I was worried because I was older and the chances of my baby not being normal, you know, was high. And I was just worried about, was he going to be ... you know, anything could be wrong with him. I was just so concerned about ... just hoping he'd be healthy.... Then when I saw him, he was the most beautiful baby."

"Well, the responsibility, period, of a new baby, you know. The fact that she's a little person dependent on me. That in itself is already overwhelming. And I feel that when I go to work I'm going to be worried all the time. I don't know why ... because I want to be here, I guess. And I can't. You know, it's just not feasible right ... I have to work for a living. And that's the one change that I will have to deal with is ... I guess my emotional feelings toward handling the fact that I'm not ... I can't be with her. I would ... if it was my choice I would stay at least a year until she's walking, but I know I can't do that. So I have to deal with that."

Settling-In

Sleep

"You be tired.... I didn't think that it would be important to have someone come over and make dinner and stuff. You are so tired that first week or two. First of all, I didn't really know nothing about a baby, so all of it was new. And after ... just imagine ... if I had to get up to make dinner for myself and my husband, and take care of her, that first couple of weeks -- there's no way in the world I could have done it. Even though women do it. And I don't know how. Because I was extremely tired."

"That's probably been the only problem other than the sleep deprivation (laughs). But I guess I'm coping OK with it, because I have enough energy to get through the days and nights...You know, it was really hard. But now, the last few nights she's been doing better."

"And he's been sleeping throughout the night, so he was about three months old when he started sleeping throughout the night. And it was great. It was really good. And a lot of people said, oh, that's early for a breast-fed baby, because normally babies still like to eat every three hours. But he slept through the night and he's been in his crib -- because he was sleeping with me and his dad. Like a week after he was born. But he's been sleeping in his crib for about a month now."

"You get accustomed to it. Especially when you go back to work. Well, see, that was to me ... three hours, to me, was a long nap. Well, now she sleeps ... first time she slept through the night ... I woke her up. I wanted to know what was wrong! I woke her up. Did I roll over on her? I thought ... I didn't know what was going on."

Adaptation

"So I figured, well, I guess he's getting enough milk. He's gaining weight. It must be OK. So I didn't worry. I didn't panic. You know, I ... he never fussed after he ate, so I figured he was getting enough. And when I started pumping, I realized that he was getting enough. He was getting enough."

"When he gets over excited, he starts spitting up, which I was concerned about too, because I didn't know if he was spitting up more than the usual, if it was norm -- you know, if it was normal to spit up so much? But they said no, babies ... as long as they're not throwing up."

"I have a schedule, and I'm just so in tune with his schedule."

"He likes routine. My grandmother does things ... she feeds him at a certain hour, and he just goes to sleep at a certain hour. He goes to sleep every day at 11:00, between 10:30 and 11:00. And he likes routine."

"You learn to be a one arm bandit."

"I've learned how to do a lot of stuff with one hand."

"But I think that, after time passes, you just kind of get used to a kind of feeling, knowing what he needs. Like, in different cries that he has and stuff, you know. If there's something really wrong, you know ..."

"And I think it's true what I had heard about -- there not being a lot of attention about how to integrate being a parent and having a career as a woman. And that's probably ... for me that's the biggest challenge ... is how I'm going to integrate both of those together. I don't think I could do things the way that I did, though, before having the baby. The work, the long hours at your office, or having spur of the moment rendezvous with my husband and not having to worry what time you get home at night.... And so, I think that part of our lives we'll constantly be trying to figure out how to integrate both of those."

" I think the whole concept of having a child, your life is forever changed. I mean, you ... I mean you think of everything differently."

"The other changes will be ... I guess because we wanted her so bad, I never really thought about what kind of changes that I feel that I have to deal with. I just figured that I'd just -- whatever happens, you take it in stride... The rest of it, the changes, I don't care. I'm willing to just deal with them as they come."

"I know my life has changed because of the baby -- I mean, I'm definitely a different person, I definitely can't just pick up and go when I want to, you know. But I do still get a good amount of free time for myself... my mom is close, I do have family close, and I know ... I wouldn't put up with friends ... I mean, I have friends who all the time say, oh, well, I'll keep him, I'll come watch him. And it's like, no, and it's not because I don't think they're good people. One young lady has two children of her own, but I ... it's like I'd rather have him with family."

Role Definition

"And I remember just getting so agitated that I thought -- I'll never let my kid cry. That was one thing else that deterred me from having children young, was because I didn't think that I had the patience... or I knew that I didn't have the patience for a crying, a constantly crying, screaming baby, before ... probably even before now. And even now I know that if he were to scream for any length of time... that someone

would have to take over, because it does something to my nerves."

"I'm being more alert to what's going on around my surroundings. I'm more alert about my spending, because first I was like -- every paycheck, I was going shopping.... But I have to be more careful how I spend my money, because I have another person to take care of.... I'm trying to hurry up and get my education so I can hurry up and get myself together, so I can, you know, take care of him.... And really, so I'm going to be a teacher, so I can take the time off when they're out of school and spend time with him."

"You know, it was from the word go ... it was from the very beginning. I always felt comfortable. It was just natural. It was very natural. You know, my mom had eight of us, so I always wondered, you know, would it be ... would I have a hard time adjusting? Would I know what to do? And she told me that it's just maternal, it's just instinctual, and you'll know. And I found that to be just true. I just automatically knew what his needs were, what he wanted, you know, what he was feeling.... It was ... it was just a natural bond."

"My thing is ... you need to know ... your child. Because when they come home with something that's wrong, you're going to be able to tell it before they hit the front door."

"I can't see it, you know, can't see any mom that neglects her kids -- it bothers me because I love kids. Even before I had my own, you know, I'm very sensitive about kids and stuff, you know. And when I see moms that don't take care of their kids, it really, really bothers me, makes me really upset."

"And then the longer that I nursed, I don't want to stop. It's like, I'm getting so attached to my baby"

Trusting Others

"I doubt we're going to be able to totally trust anyone to stay with the baby. My mom is great; of course I can trust my mother. But our friends who don't have kids ... the only person I can really trust to baby-sit her is the woman that helped as a labor coach.... And another friend ... so we only have two best baby-sitters. If they could come here and we could go jump to the movie -- we'd be worried the whole time."

"I let her (my mother) keep her for the first time this past weekend. She spent the night with her... I called every hour, seemed like it. I went back by her house to check on her. She kept telling me, get out, don't call us, we'll call you. But then once I got home and my husband kept saying, babe, you have to get used to it -- she's in good hands. He kind of reassured me that she's going to be okay and we need to

take advantage of this time, because we ain't had no sleep. So that was ... that was some good separation time. But I missed her. I missed her a lot... Even taking her to the sitter ... I know I probably got on her nerves, but if I'm spending money for the care of my child, I'm going to make sure ... and I want to be assured that she's going to be well taken care of. And she's going to get the attention that she needs, and, you know, she's going to be in a safe environment. So she has to really assure me of that, because I was really thinking, maybe I should take some leave off of work. But then I knew that financially I can't really afford it right now. And that she needs ... I need to start letting her ... not letting her go totally, but she has to get used to being away from me sometimes for some time of the day."

"And, I mean, I think twice. I don't want to leave her with even some of my friends. You know, you think about people differently, and their habits ... and it makes life harder."

Dreaming

"I have zero tolerance for anything that's going to create ... cause me stress. I think I've got enough going on in my own personal life at home and things -- I don't need work to be an addition to that. And I said, because I'm doing everything possible to go home stress free because I have a son that I want to go home and play with, and I don't want to have to ... I'm not taking work home with me... I mean, I figure ... because, even if you try to mask those emotions, you try to mask all the things that are wrong, it builds up. But babies ... they feel ... they know. I know when I go home and I'm still trying to play and I'm sort of tired and I'm not up to playing. Because (my baby) does not respond the same way. He does not play with me the same way. And I know why. And I know it's because I'm not responding the way I typically do because I'm sort of like ... okay ..."

"Watching him go through different stages is really fun. Seeing him roll over on his tummy from his back. Seeing him roll over from his back to his tummy. Seeing him try to inch forward and try to crawl. And now he's starting to stick his foot in his mouth. So it's just watching him, being here and being able to watch him."

"It seems like I have something more to live for.... he just seem like he's my whole life. And ... he means more to me than anything. So ... I just thank God that He blessed me with this child. He's like a miracle baby to me. It's just like ... I guess I never thought I'd be a mom. But God saw fit to give me my own son. I've been taking care of my family my whole life, so I guess he say, well, it's time you have your own. So that's the way I feel. I think God just blessed me with this baby."

"It's just a wonderful feeling, being a mom. It's something that I thought I'd never be.... Like I said, when I did get pregnant with him, boy, it just meant everything to me.... So being a mom is just like ... it's a great feeling. It's the feeling that I ... I just can't do enough for him, for my son. I want to give him everything. And just give him a chance. A chance ... a good chance in life."

"But he's just ... he's the love of my life. Oh, he's is just wonderful."

"Yeah, because it's overwhelming. And it's like, no matter what mood you're in, no matter how bad you feel, it's like ... you can just pick him up and smell him and it makes everything ... much better ...... immediately. And to watch him play, and to watch him learning things.... again, I'm always fascinated at how much he learns and how fast he learns it. And, you know, he wants to play. And he can give kisses now.... He gives you these little bites when we put him in the bed, and it's like ... it's like the perfect way to start my day, yeah. You know, and he waves ... he waves bye-bye. And he'll either laugh or he'll wave bye-bye; it just depends on what his mood is in the moment. And it's just ... I'm always amazed. And I can't imagine my life

without him now. And I can't imagine life without him. I can't remember life before"

"You look at them and you really see, like, the mix ... I see the mix of my husband and myself. It's like I see what our love has created when I look at him. Even if my husband gets on my nerves ... I look at her and it's like, oh ..."

"It's just so cute to me when he has his little dreams, because he chuckles in his sleep, you know, too, and it's just like, oh, what you dreaming about?"

"Just being a mom. I cry. I look at my baby and I'm like, you're mine. Uh-huh. I made you. I go, God gave you to me to play with, to be my friend, to comb your hair, to buy you clothes. Because my baby wakes up like that ... oh, good morning, (baby)... Hi, mommy's baby. And she laughs. My baby is such a happy baby. But now I can tell the difference because ... and I loved ... because she was here for Mother's Day... We dressed all up. She had her pink on. Oh, my baby. We got so many calls.... Just having her."

"You're mine. I look forward to the smiles. You know what the thing is with me is that it's just weird, when I look at him, it's like, you started out this big from me and my husband, and it's just ... it's just a miracle. I just think ... the miracle of childbirth and of just producing a child.... A miracle. Say I'm a miracle. I take a picture each week."

"But it would be really good to have a support group ....We moved (here) and I was hoping I'd meet more black women my age. But I find it really really difficult here... to meet women. I really do."

"And its a community thing, having a child. You know. I really realized, as great as my husband was for a labor coach, it was my female friend, an older woman, that I felt really got me through it, just because of the fact that she was a woman."

"I want my daughter to have, like women around her who are influences, and if I could catch a plane, you know every month, for her to be with family."

Table 1. Selected studies on African American pregnancy, motherhood and health status

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
Geronimous and Bound (1990)	Retrospective exam of mortality data. 2 age cohorts. National sample.	15-19 25-29	Unknown. Assume low SES.	Black & white	Female	National Center for Health Statistics 1980-1985 mortality data for risk factors of poor pregnancy outcome. Odds ratios.	Deaths increase with age , increase is greater for black. Whites mid-20's lowest. Blacks mid 20's higher, overall black rates exceed white by 25%.	Questionable quality of data. Indirect measure of prevalence.
NGHS (1992)	Five year prospective cohort study. n=2379. 3 sites: Washington, D.C., Cincinnati, Berkeley.	9- 10 on entry	Education, income, family composition.	Black 1213 White 1166	Female	Anthropometry, BP, maturation, staging, blood lipids. Multiple linear regression, Chi-square.	Baseline black girls are older, more mature, taller, heavier, higher blood pressure, lower triglicerides, higher HDL. Differential BP and obesity already present.	Not random, but national sample.
Geronimous, Andersen, & Bound (1991)	Retrospective exam of national data, descriptive. n=3122. National.	15-44 non-pregnant	Not stated.	Black 422 White 2700	Female	National Health & Nutrition Examination Survey II, 1976-80, BP. Logistic regression & odds-ratios.	Estimated adjusted HTN prevalence in pregnancy as B/W ratio of 2.5-1.7. By age 25, blacks twice as likely to be HTN and 4 times as likely by end of childbearing years.	Use of self-reported HTN. Accurate data set for pregnant women does not exist, estimates used.
Hargrove & Keller (1993)	Descriptive. n=21. Inner city, Southwest.	21-40	Wide range solicited.	African American	Female	Interview. Qualitative analysis. Verification with 3 participants.	Health defined as avoiding disease/illness. Strategies used to stay healthy included being overweight, reducing stress, eating well, having good habits and exercising.	Needs to be replicated with African American women in other communities.
Murrell, Smith, Gill & Oxley (1996)	Descriptive. n=14. Family practice group & city health center.	18-42 pre- & post-natal.	Education, income, marital status, insurance status.	African American	Female	Interview and oral use of the Perception of Racism Scale. Qualitative theme analysis.	3 themes: pervasive stereotypes of pregnant African American women, indifferent, inaccessible & undignified care, and the totality of racism in their lives.	Small sample, needs replication.

Table 1. (Continued)

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
Polednak (1991)	Retrospective exam of records, descriptive. Sample size not stated. 38 standard metropolitan statistical areas (SMSA).	not stated	Poverty prevalence: Family income, % female households.	Black White		1980 Census, Segregation Index, Infant Mortality (IM) rates. Step-wise regression.	IM higher for blacks in all areas. Segregation Index and poverty correlated. Segregation only significant predictor of IM.	SES may not be accurate. Potential inaccurate infant death rates between SMSAs. Possible effects from migration of mothers after birth -- need to separate neonatal from postneonatal deaths.
Polednak (1996)	Retrospective exam of records, descriptive. Sample size not stated. SMSA.	not stated	Poverty prevalence, rate of unmarried black & white mothers.	Black White.		1990 census. Degree of residential segregation (index of dissimilarity), infant mortality rates, black poverty rates, marital status.	IM rates remain higher for blacks in all areas. Results vary by region. Rate of unmarried mothers only predictor.	May be confounded by environmental- social change in some regions, needs more study. SES may not be accurate. Same limitations as Polednak (1991).
Green (1992)	Quasi-experiment, correlation study. n=165. convenience. HMO, Northern California.	Mean age 24	Education mean 13.5 years. Median family income $1501-2000/month. Marital status 65% single.	African American	Female	Interview, Lazarus & Folkman Daily Hassles Scale, Rosenberg Self-Esteem Scale, Perceptions of Racism Scale. Hierarchical Multiple Regression.	Relationship with LBW & gestational age not supported. + racism & stress ($p<.01$), -self-esteem and stress ($p<.001$), no significant relationship between racism & self-esteem.	Convenience sample. Low risk group. Possible setting effect.
Armstead, et al. (1989)	Factorial (3x3x4) experimental. n=27, random selection & assignment. Midwest, urban university.	mean age 21.41 (sd 2.62)	Wide range of parental income.	Black	Male 12, Female 15	3 film segments: anger-provoking, racist, neutral BP, mood checklist, Framingham Anger Scale, Anger Expression Scale. Analysis varied by instrument.	BP increased significantly during racist stimuli. State anger significant for racist & anger-provoking. 59% cope with racism by ignoring it.	Small sample size. Anger-provoking stimuli perhaps insufficient.

Table 1. (Continued)

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
Krieger (1990)	Pilot exploratory. n=101, random-digit dialing, phone interview. Alameda County.	20-80	Family income Educational level. Marital/Partner status. Usual occupation, employment status.	Black 51 White 50	Female	20 minute interview, demographics, self-reported hypertension. Response to unfair treatment, gender & race discrimination. Chi-square.	Black women who kept quiet or accepted unfair treatment were 4.4 times more likely to report HTN Internalized response to unfair treatment more likely to report HTN for black women only.	HTN self-reports. Small sample size. Lack of data for other HTN risk factors.
James et al. (1992)	Survey, correlation study. n=1784. probability sample. Pitt County, NC.	25-50	Low, medium, high Education Occupation Hollinghead Prestige rating.	Black	Male 665 Female 1119	John Henryism Active Coping Scale, BP, interview ANOVA	BP prevalence decreased with increased SES. Stress increased with high SES. Inverse relationship SES & SBP ($p<.03$). Hypothesized interaction of SES & JH was $p<.08$.	No information re: interviewers or physical measurements given. Possible environmental confounders.
Patterson et al. (1990)	Grounded theory. n=27 (17 black, 10 white). Theoretical sampling. Multiple settings.	17-38	Sought diversity, method not defined.	Black & white	Female	Interviews over 5 months. Grounded theory analysis.	Several pathways utilized by women to "seek safe passage' through pregnancy and birth, including searching for care, consulting, transferring, waiting, contingency planning & self-care.	Replication in other communities. Does not specify if there were differences between black & white participants.
Hansell (1990)	Retrospective data analysis, descriptive. n= 9941 live births, 6386 late fetal deaths. National.	Not stated .	Marital status. Education. Geographic residence.	Black White Native American Asian/Pacific Islander.	Female	1980 National Natality Survey. 1980 Fetal Mortality Survey. Prenatal visit quality indicators – % BP, urine, Hbg & Hct., Na+ restriction & diuretic usage advice Multiple Linear Regression..	Prenatal care & advice varies by marital status, race, parity, & SES factors. By ethnicity, Non-Hispanic White & Asian women received more care.	10 year old data. Provider or setting differences. No information on providers. Indicators may not be most reliable for quality. Medical records may not be accurate, may underestimate provision of care.

Table 1. (Continued)

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
Kogan, et al. (1994)	Retrospective data analysis, descriptive. n=8310. 48 states.	15-35	Education. Household income. Marital status.	Black 18.4% White 81.6%	Female	Self-reports of prenatal advice: tobacco, alcohol, & drug use, breast feeding. National Maternal & Infant Health Survey, 1988. Logistic Regression & odds ratios.	One-third of all women received no advice on tobacco, alcohol & drug usage & 50% no advice re: breast feeding. Black women less likely to receive advice on tobacco and alcohol use; breast feeding approached significance. Race, marital status, site of care important.	Self-reports not correlated with medical records. No information re: start of care or number of visits.
Petitti et al. (1990)	Case control. <u>Cases:</u> n=Black 377 Whites 223; <u>Controls</u>: n=Blacks 389, whites 239. Alameda County, California.	<17-35+	Education, income, insurance status.	Black & white.	Female .	Interviews. Demographics. Population-based estimates and weighting.	Start of prenatal care related to age, marital status, education, income & insurance status. Black women at all levels started care later, delays in medical coverage, lack of recognition of pregnancy.	Limited information provided on methods. Inaccuracies in self-reports confirmed.
Leatherman et al. (1990)	Descriptive. n=44, convenience. Midwestern county.	15-35+	Not stated.	Not stated.	Female	Health belief model, questionnaire ("Ohio form") Analysis by content analysis, Chi-square to determine relationships between reasons and .age, initiation of care, source of payment.	Lack of care explained by insufficient money, motivational issues, lack of transportation.	Needs replication in other geographic communities. Demographics not specified and cannot compare.
Scupholme et al. (1991)	Case control study. Cases: n=157, Control: n=2799 Miami, Florida, university hospital.	<19->35	Not stated.	Multi-cultural White & black, Hispanic, Haitian, Caribbean.	Female	Close-ended questionnaire. Frequency distributions	Single and black mothers had higher rates of LBW infants. Barriers to obtaining care were systematic, patient-related, & financial.	Analysis general. Close-ended questionnaire limited depth of information on barriers.

Table 1. (Continued)

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
Lia-Hoagberg et al. (1990)	Descriptive study. n=211, stratified sample - white 67, black 75, Native American 69. Public (1) & private hospitals (4). Midwest city.	<20, 20+	Marital status, education, income, welfare status, employment status.	white, black, Native American.	Female	Close - ended questionnaire. Frequency distributions, Chi-square comparisons.	Women receiving inadequate care perceived more frequent & severe barriers. Poverty more significant than race. Major barriers were child care, transportation, timing of pregnancy, lack of recognition, emotional response & family problems. Encouragement to seek care was important.	Replicate in other geographic communities.
Norbeck & Anderson (1989)	Descriptive study. n=208 Two university OB clinics.	18-39	Low income, education of women's parents.	Black (28%) White (35%) Hispanic (37%)	Female	Instruments: Life stress, social support, anxiety, demographic and substance use. Frequency of complications, gestational age, birthweight, apgar scores. Analysis: descriptive statistics, multiple regression, discriminate analysis, step-wise multivariate.	For the black group, specific sources of support were significantly related to outcomes -- mother and partner. For white group drugs and tobacco were significant. Hispanic women no significant predictor variables.	No power analysis documented to determine sample size needed with multiple instruments. Not generalizable beyond low-risk, low income group.
DeJoseph et al. (1996)	Qualitative study. n=3 advisory groups (18 participants), 15 individual interviews. Convenience sample.. Setting not specified.	18-32	Not specified	Black.	Female	Individual and focus group interviews. Qualitative content analysis.	Major themes: stresses women face while pregnant, how to decrease stress through personal resources, Support provided by partners, mothers, and God. Two identified needs were built into the intervention to build self-esteem and how to access support and provide acknowledgment of their lives and experiences.	None noted for purposes of study.

Table 1. (Continued)

Author and Date	Study Design, size, and setting	Population Studied: Age	Socioeconomic Status	Race/Ethnicity	Gender	Instruments/Analysis	Findings	Limitations
St. Clair & Anderson (1989)	Qualitative, descriptive study. n=185, convenience sample. Large university hospital in Baltimore, Maryland.	Mean age 21.3.	Education, employment status, health insurance.	Black 78%, white 22%	Female	Frequencies. Content analysis.	Advice received from average of 5 people, mothers, sisters and partners gave most advice. Advice often conflicted with provider advice.	No analysis provided if different for black & white women. Not clear if women actually act on the advice they are given or how they decide.
Green (1990)	Pilot, descriptive, replication study. n=50, convenience. Highland Hospital, Oakland, CA.	18-40 Mean 23.8	Education 12.3 years. Income < $5000. Single.	African American, pregnant	Female	Demographic data, self-identified stressful events and intensity in pregnancy.	Categories of stressful events replicated. Additional categories: need for housing, clinic waiting time, other. Intensity of stressors greater and more external stressors.	Small sample, convenience. Setting different. Poverty possible confounder.
Naples (1992)	Qualitative, descriptive. n=42. New York City & Philadelphia.	35-55+	Education, neighborhood.	African American (26) Puerto Rican (10), Dominican (1) white (4), Japanese American (1)	Female	Interviews, oral history. Narrative analysis.	Concept "Activist mothering" – desire and actions to improve the lives of family & community. Motherhood defined in broader context. Struggles against racism & poverty were related to community work.	Replication of study with mothers not employed in community work and from various socioeconomic groups.
Vezeau (1991)	Pilot study, qualitative, descriptive. n=5. setting: public urban hospital	Not specif ied.	Not specified.	Black	Female	Two focus group interviews. Theme analysis, validated by participants.	Mothers used the term 'greedy" as a positive term that the infant was persistent in getting what they need, were survivors, and would have a happy & secure future.	Needs replication with larger sample in diverse geographic communities.

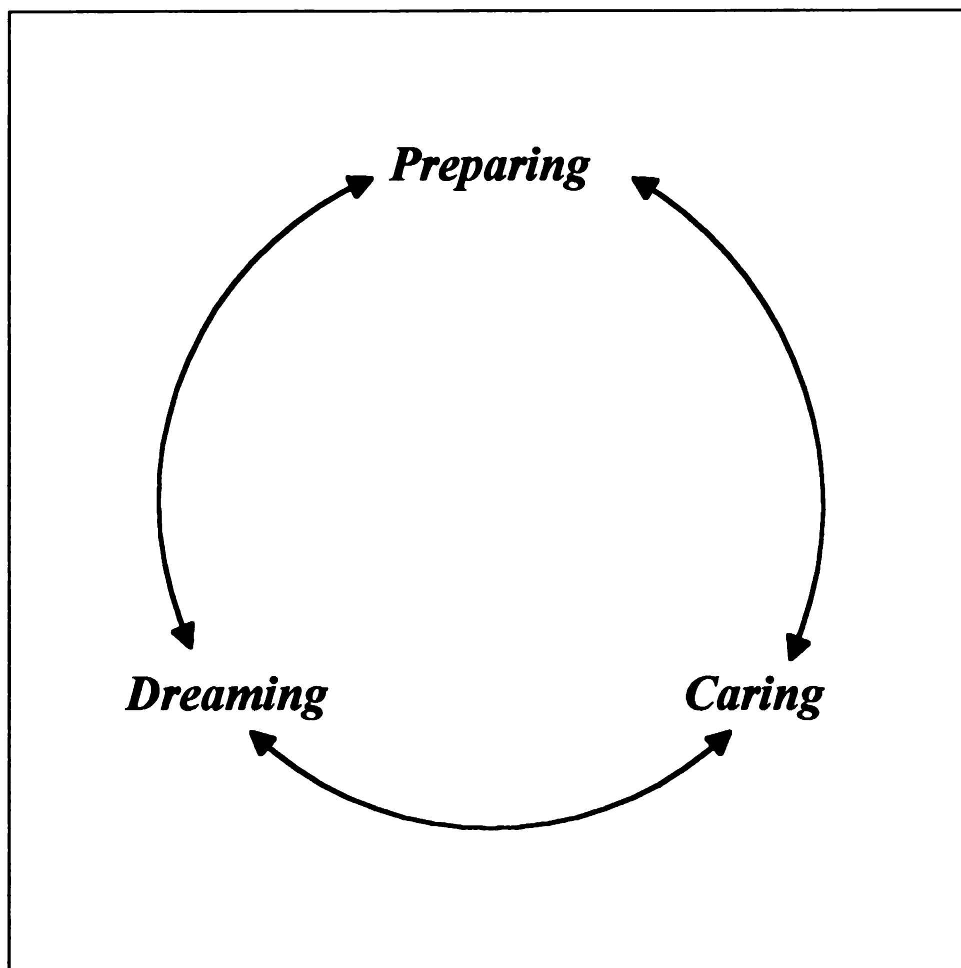


Figure 1. Dynamic process of becoming a mother.

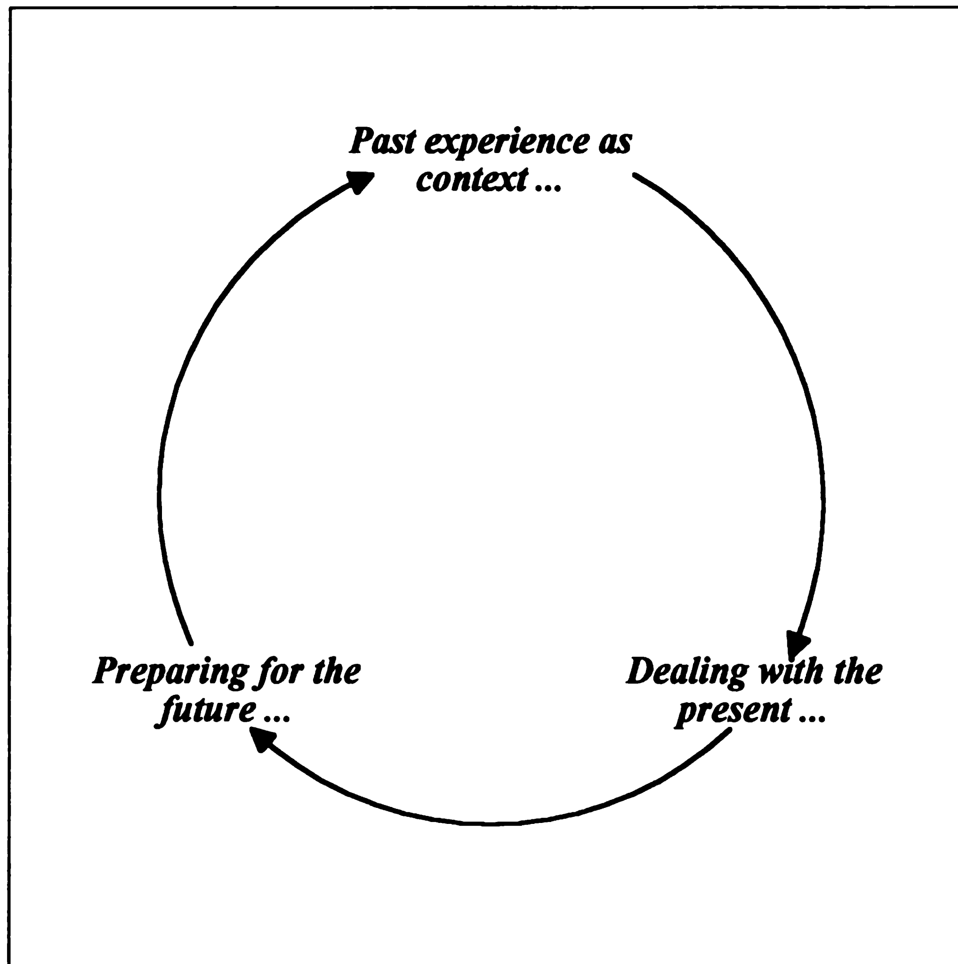


Figure 2. Continual processes of becoming a mother.

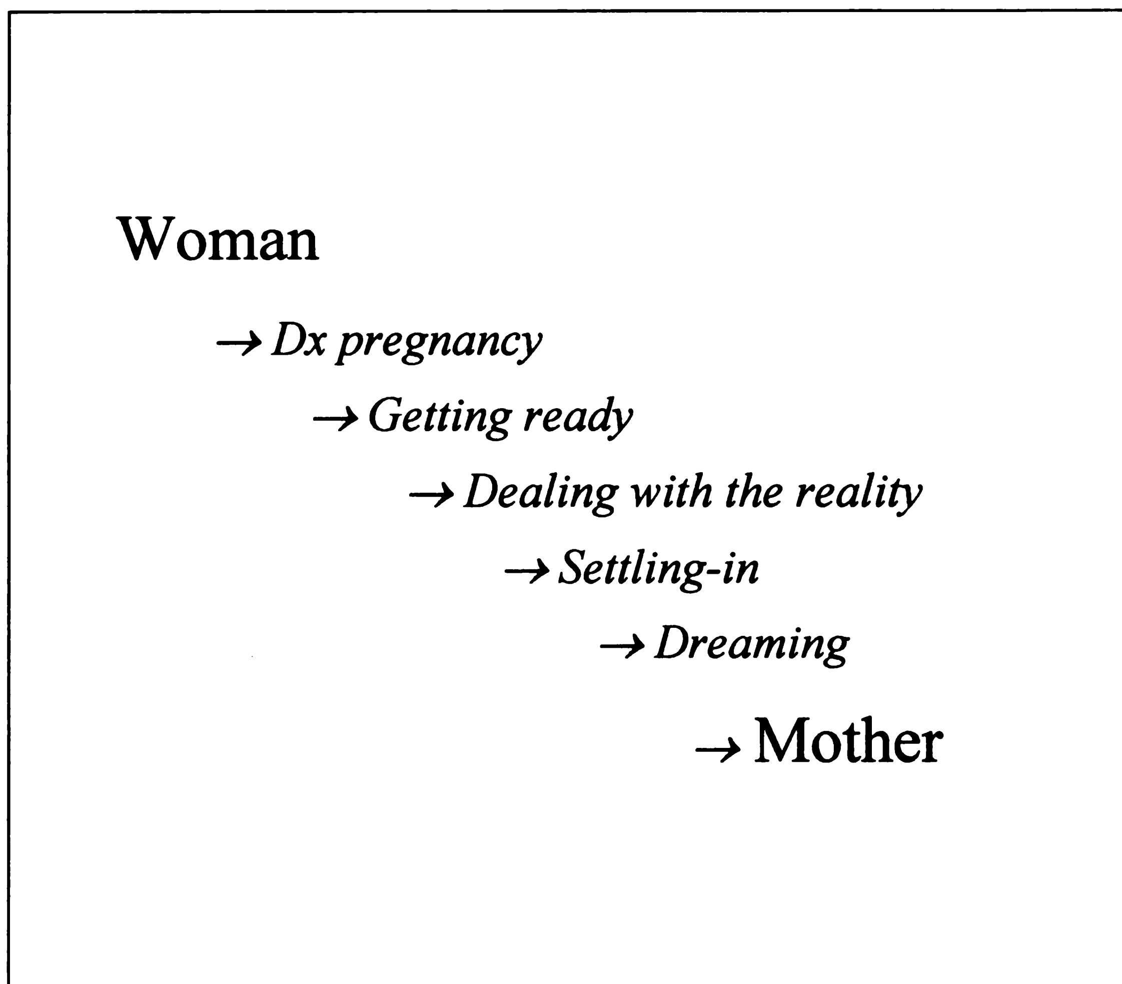


Figure 3. Process of engaged mothering, incorporating mothering into the woman's identity.

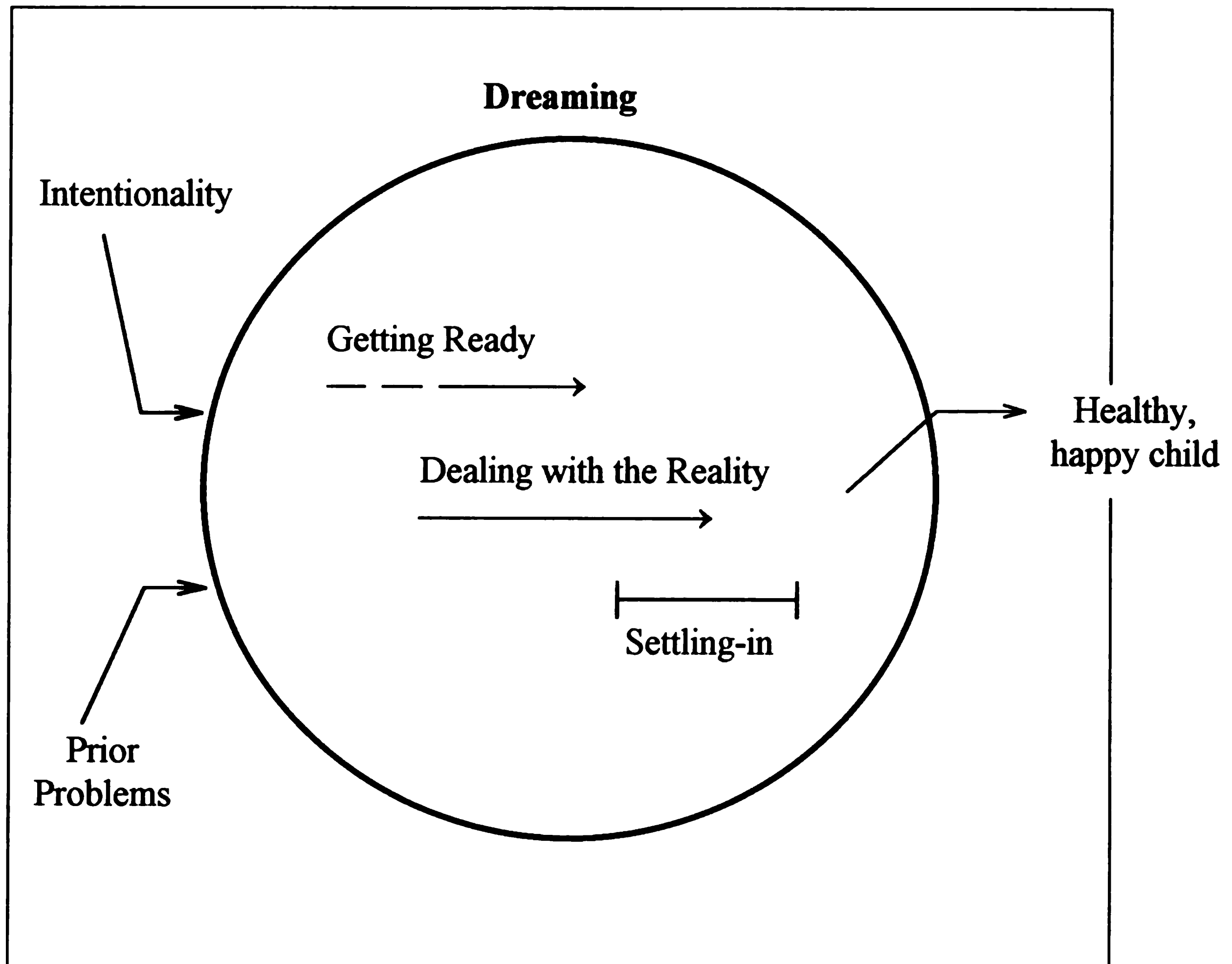
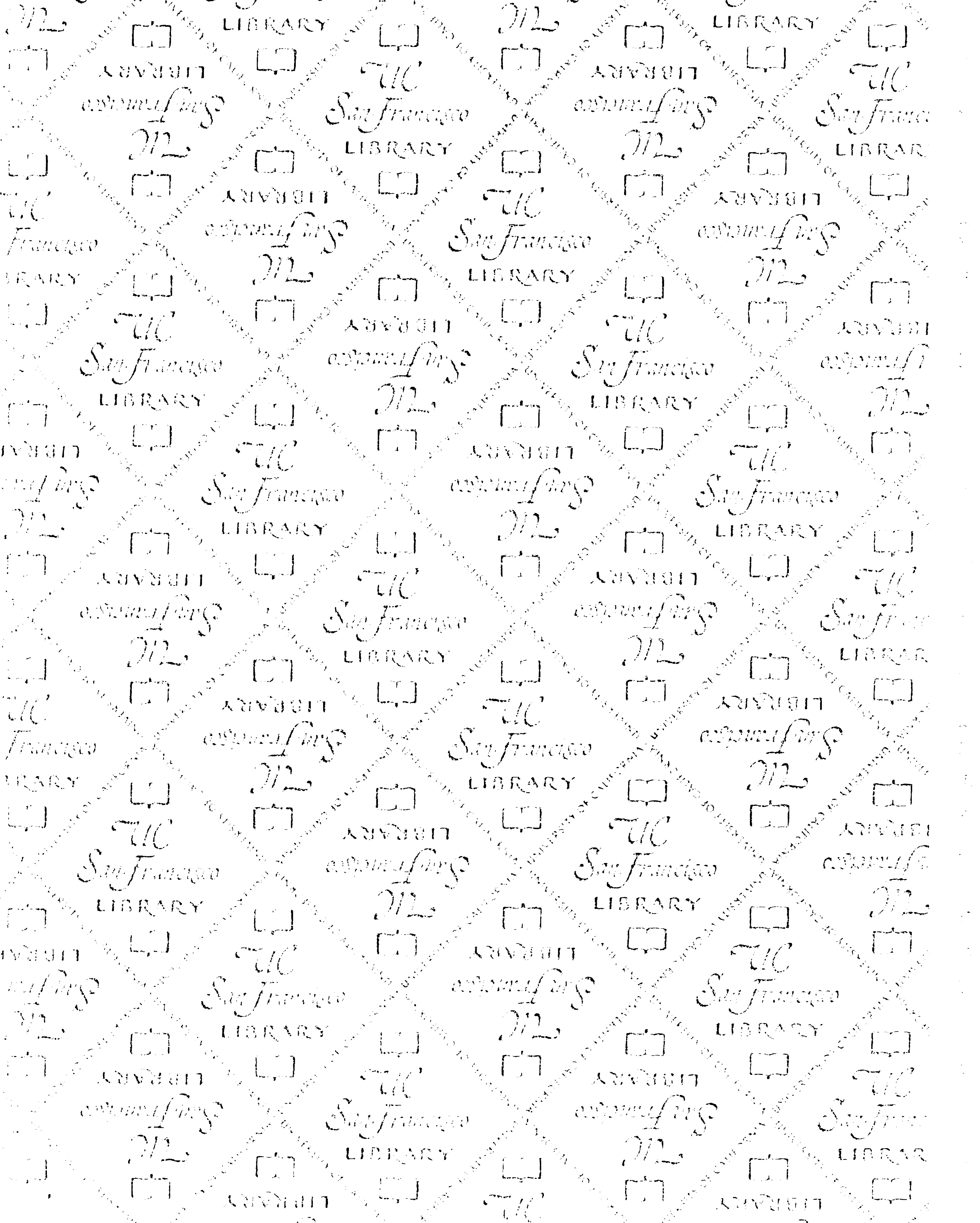


Figure 4. The process of engaged mothering.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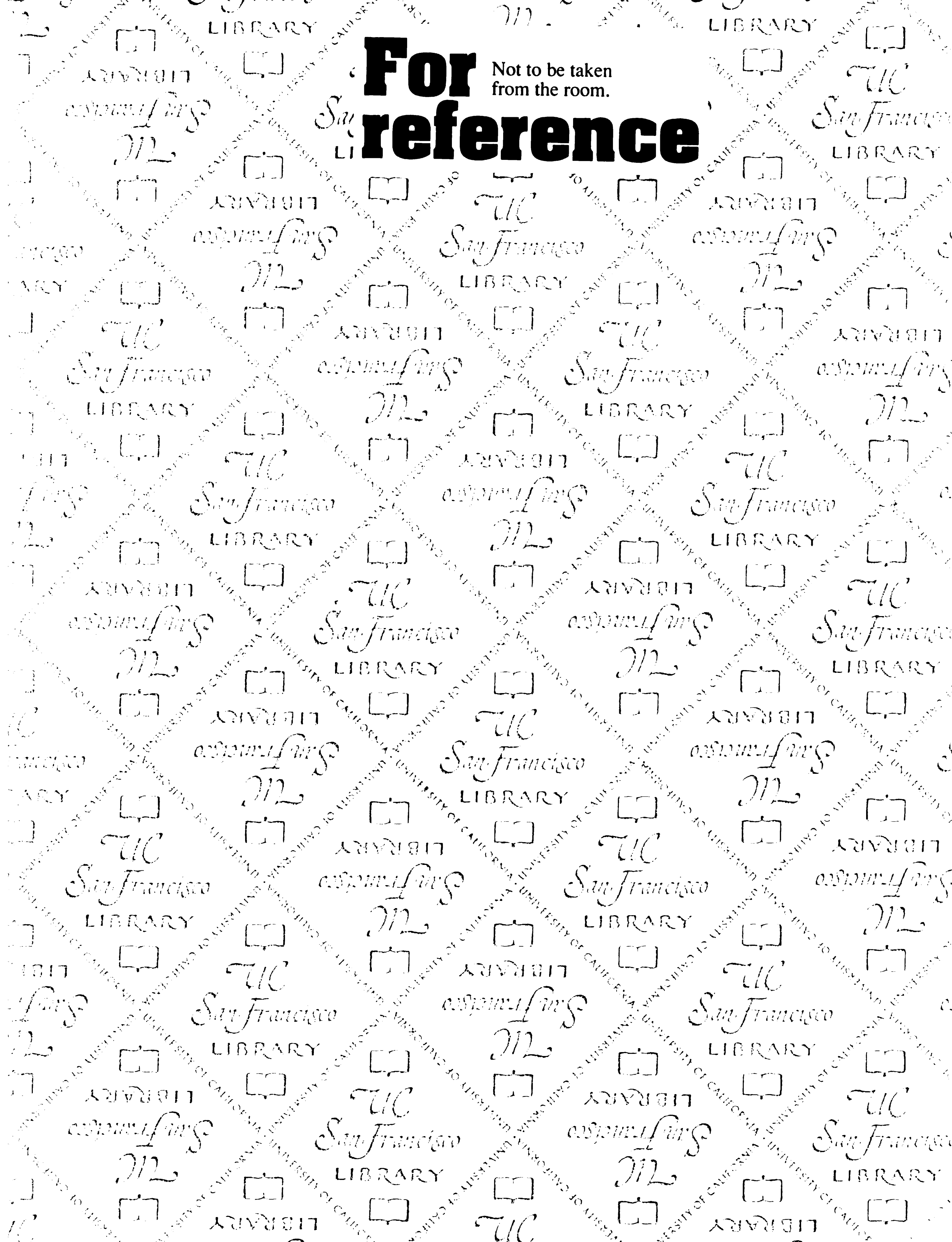
For reference
Not to be taken from the room.