This is to certify that the

dissertation entitled

THE CULTURAL CHARACTER OF
CHILDBIRTH EDUCATION

presented by

Cloe Ann Danford

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Anthropology

Ann V. Millard
Major professor

Date 11/12/98

THE CULTURAL CHARACTER OF CHILDBIRTH EDUCATION

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Anthropology

1998

ABSTRACT

THE CULTURAL CHARACTER OF CHILDBIRTH EDUCATION

By

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As a distinctive part of the dominant American childbirth ideology, childbirth education is an effective controlling mechanism of culture that guides the thoughts and behavior of childbearing women as it prepares them for a medically controlled, technological, hospital birth. Initiated by upper-class and middle-class women, childbirth education is endorsed by medical practitioners and is expected of all women desiring a hospital birth. However, childbirth classes are not attended by all American women. This is especially true for working class women. This study explores the influence of the dominant childbirth ideology on women's perceptions of childbirth education and their decision to take or not to take childbirth classes. Drawing from a marxist perspective on ideology, I have developed a model of the American dominant childbirth ideology that demonstrates the pervasiveness of the ideology in drawing in and influencing women as they experience pregnancy and develop their own childbirth ideologies. Childbirth education is seen as one mechanism through which women are drawn into the expected behaviors and practices of the dominant

childbirth ideology. Using an ethnographic approach, data were obtained from participant observation in prenatal clinics and childbirth classes and interviews with 5 childbirth educators, 31 pregnant women who took childbirth classes, and 16 pregnant women who did not take classes. The data were evaluated by means of qualitative analysis. Based on the analysis of the data, I argue that the majority of the participants, both childbirth educated and non-childbirth educated, were influenced by, and tended to use the language of, the dominant childbirth ideology. However, among some of the working class participants who did not attend childbirth classes, subtle power struggles became evident in their reasons for not taking childbirth classes and in the way they spoke of their anticipated childbirth experience. Considering the information that the participants thought women ought to know about childbirth and the power struggles evidenced by some participants, the appropriateness of childbirth education for all women is discussed and suggestions are given for childbirth education that would be more culturally congruent with women's own childbirth ideologies.

To my friend Dr. Beverly Jane Klooster, without whose constant prayers, encouragement, and support the completion of this degree would not have been possible, I dedicate this Dissertation.

ACKNOWLEDGMENTS

I thank Dr. Ann Millard, the chairperson of my Guidance Committee, for her advice and patience as she helped me through the research processes and writing of this dissertation. I also thank the other members of my Guidance Committee, Dr. Loudel Snow, Dr. David Dwyer, and Dr. Barbara Rylko-Bauer who encouraged me in my work and gave suggestions that helped me to think differently about the issues.

I thank the American Association of University Women and the Michigan State University Graduate School Scholarship Fund for their financial help. I also thank the clinical agencies that allowed me to collect data in their educational programs and prenatal clinics. And I am grateful to all of the women who so graciously shared with me their thoughts about childbirth and childbirth education.

I thank Dr. Charolett Otten who shared her knowledge of commas and helped me with sentence structure and grammar. And I thank Dr. James Bradley who helped me with the statistical analyses and presentation of the data. And finally, I thank my family and many friends who have encouraged and cheered me on by their faithful prayers and expressions of support.

With sincere gratitude I extend my thanks to all who have helped me to complete this work.

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LIST OF ABBREVIATIONS

CBE..... The Total (ECCBE and CCBE Combined) Childbirth Educated Group

CCBE..... The Clinic Childbirth Educated Group

EC..... The Education Center of City Hospital

ECCBE..... The Education Center Childbirth Educated Group

NCBE..... The Non-Childbirth Educated Group

PC..... The Prenatal Clinic at City Hospital

SES..... Socioeconomic Status

Chapter I

INTRODUCTION

Childbirth is one of life's events that affects most women in the course of their lives. This event, though usually conceived in private and culminated in a semi-private environment, is also a social and public event that is surrounded with cultural expectations and control mechanisms that give it substance and meaning. According to Davis-Floyd (1988:153), childbirth in the United States has its own set of values and rituals that "initiate the birthing woman into the dominant core value and belief system of American society."

In recent years childbirth education has been incorporated into the American childbirth ideology and, as Michaelson (1988), McClain (1983), and Simkin (1989) point out, has become commonly expected for all American women in the prenatal period. The movement toward childbirth preparation in the United States was generated by middle-class women who desired a natural childbirth experience in which they would be awake and in control of their own birthing experience (Leavitt 1980, 1986; Wertz and Wertz 1977; Morse and Park 1988). This "natural childbirth" ideal developed from post-World War II middle-class ideas regarding femininity and the primacy of motherhood (Read 1944; Wertz and Wertz 1977). Support for natural childbirth came from feminist ideology

that considered childbirth as an important life experience that should be defined by women, without medical bias (Boston Women's Health Book Collective 1972; Wertz and Wertz, 1977; Nelson 1982).

Other social movements that affected the shift toward natural childbirth were the consumer movement that challenged medical authority (Reeder 1972; McBride 1982) and a back-to-nature romanticism that questioned modern technology and desired a return to the premodern ways of doing things (Nelson 1982:339). Nelson (1982:339) points out that all of these movements were rooted in, and appealed to, the needs of middle-class women.

In the 1990's, as more hospital-sponsored childbirth classes were developed and more knowledge, which ensued from the medical practitioners, about the childbirth process was incorporated into the content of the class, a new definition of "natural" began to be accepted. This "natural" includes the use of various technological methods that allow the birthing woman to remain awake and alert with little sensation of the pain of labor (Sargent and Stark 1989; Davis-Floyd 1992). Most hospital-based childbirth education programs prepare women for technologically managed childbirth, which has become the hallmark of American childbirth ideology.

Childbirth preparation also conveys cultural ideologies including meaning, responsibilities, relationships, and behavior, as well as the mechanisms of care and support necessary to sustain the pregnancy and accomplish the birth. In addition, childbirth education communicates the culturally established parameters for the expectation, experience, and expression of pain during parturition (Kay 1982; Jordan 1983; Wertz and Wertz 1977; Morse and Park 1988). Childbirth education,

which can be either formal or informal, socializes the woman into the culture's birthing system as it prepares her for the physiological process of parturition (Jordan 1983:38).

A woman's culture is as influential in her childbirth experience as it is in all of her life's events. Like the threads in finely woven cloth, the webs of culture weave together to provide substance, to guide behavior, and to give meaning to life's experiences. More than structured behavior patterns, customs, habits, and traditions, culture acts as a control mechanism (Geertz 1973). As such, it provides the plans, recipes, rules, and instructions for governing behavior.

As Geertz (1973) points out, this view of culture as a control mechanism has its beginning in the assumption that human thought is both social and public and occurs through the flow of significant symbols such as words, gestures, technological objects, artistic expressions like drawing or music, natural objects such as jewels, or anything that is used apart from its true quintessence to give meaning to life events. Already present in the community to which an individual is born, these symbols, with some transformations throughout the person's lifetime, remain in circulation even after the death of that individual. These symbols, or at least some of them, are used, occasionally with deliberation, but most often candidly without forethought or plan in order to understand and cope with life's events. Without the controlling mechanism of this organized system of symbols and instructions, human behavior would be disordered, unmanageable, and pointless. Life's experiences would have no meaning.

The assumptions and rituals that develop from the controlling mechanism become commonplace and are performed generally without

thought. They become the "common sense" assumptions about the world that Fairclough (1989:2) defines as "ideologies." These assumptions, when drawn upon without thought, also act to directly or indirectly legitimize existing power relations. Fairclough (1989:33) contends that the dominant bloc, composed of an alliance between the dominant class and the professional and service workers who are on the fringes of the dominant class, can often be seen as the progenitors of social practices which appear to be universal and commonsensical. As these practices become "naturalized," they are accepted as the right or normal thing to do. Functioning thus, these practices tend to sustain unequal power relations within the society. Power struggles and conflict ensue when the practices of the dominant class are not universally incorporated as "common sense" assumptions. This lack of acceptance can then lead to resistance and social disorganization.

While many women in America accept the established dominant American childbirth practices as being right and commonsensical, some resist. In this study of the cultural character of childbirth education resistance is seen in the responses of some of the participants. Women who resist are still most often drawn into the hospital for the delivery of their babies and, though they may continue to resist, they are subjected to the practices of the dominant childbirth ideology.

Drawing on the work of Abercrombie, Hill, and Turner (1980), Fairclough (1989), Davis-Floyd (1988), and Martin (1987), I have created a model of the dominant American childbirth ideology that helps explain my interpretation of the cultural character of childbirth education in America. My conceptual model of the dominant ideology (Figure 1.1)

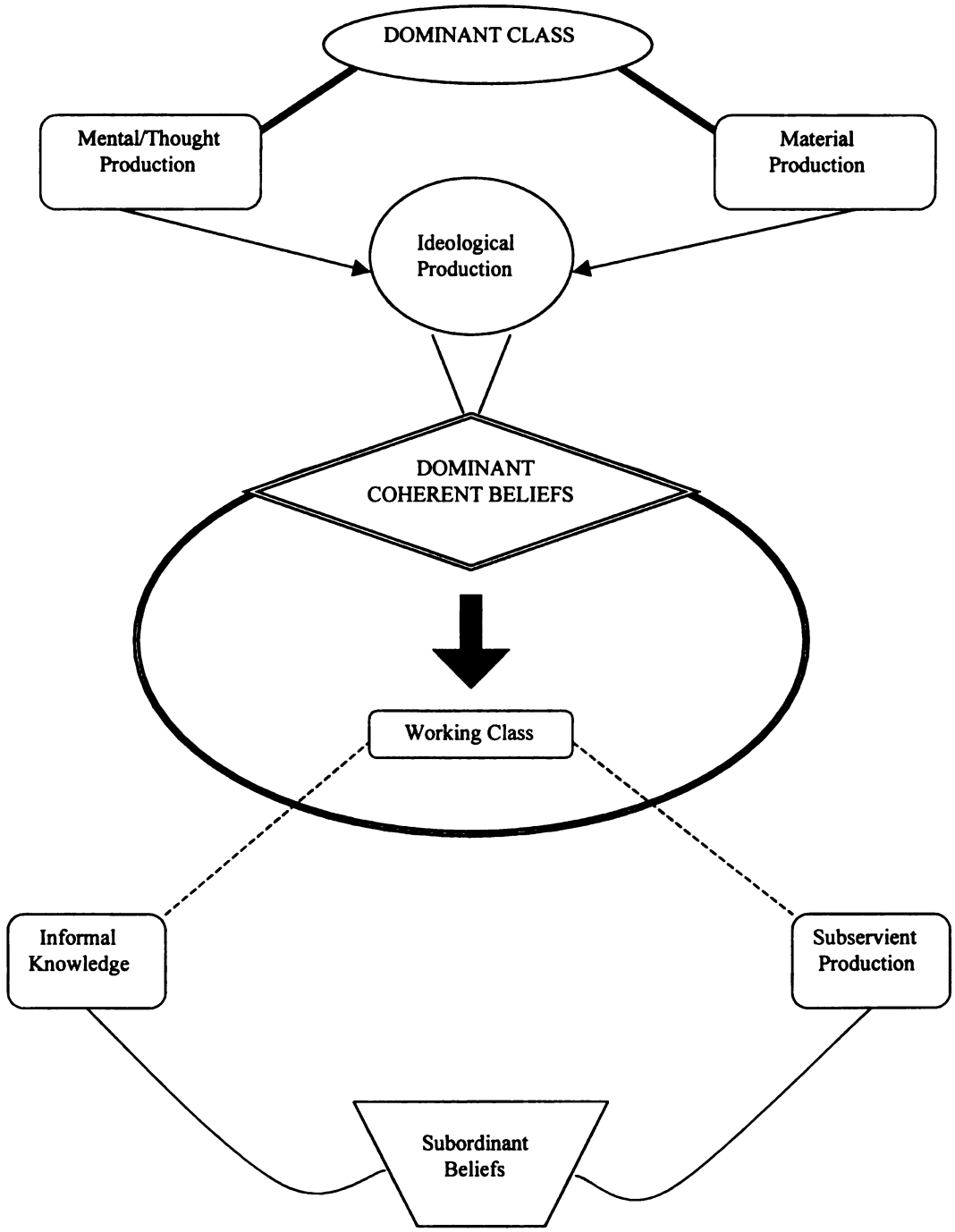

Figure 1.1 - The Dominant Ideology Model (adapted from Abercrombie, et al., 1980)

draws from a marxist perspective on ideology and forms the foundation for my model of the dominant American childbirth ideology (Figure 1.2).

According to Abercrombie, Hill, and Turner (1980), in the marxist perspective of ideology (Figure 1.1) the dominant class controls both material and mental production through which its ideologies are formed. These ideologies are then expressed as a set of coherent beliefs. These beliefs become dominant and are often more powerful and coherent than those of subordinate or working classes. The dominant ideology then works its way into the consciousness of the working classes who eventually come to see and experience reality through the ideology of the dominant class.

Fairclough (1989:36-37) claims that though coercion can be used, it is more common for the dominant bloc to draw people into the dominant ideology by making them "feel" that they are a part of it. Control is then gained through consent and perpetuated by such means as education and simulated egalitarianism. According to Abercrombie, Hill, and Turner (1980), when the working class incorporates the ideological system of the dominant class, the society is perceived as being consistent and integrated.

My conceptual model of the dominant ideology helps explain my interpretation of the cultural character of childbirth education in America. In my conceptual model of the dominant American childbirth ideology (Figure 1.2), childbirth education represents one mechanism through which the dominant American childbirth ideology is transmitted. In my model, medical practitioners (including physicians, nurses, nurse midwives, and other medical workers), and members of the upper- and middle-class who compose the dominant bloc, control education, thought,

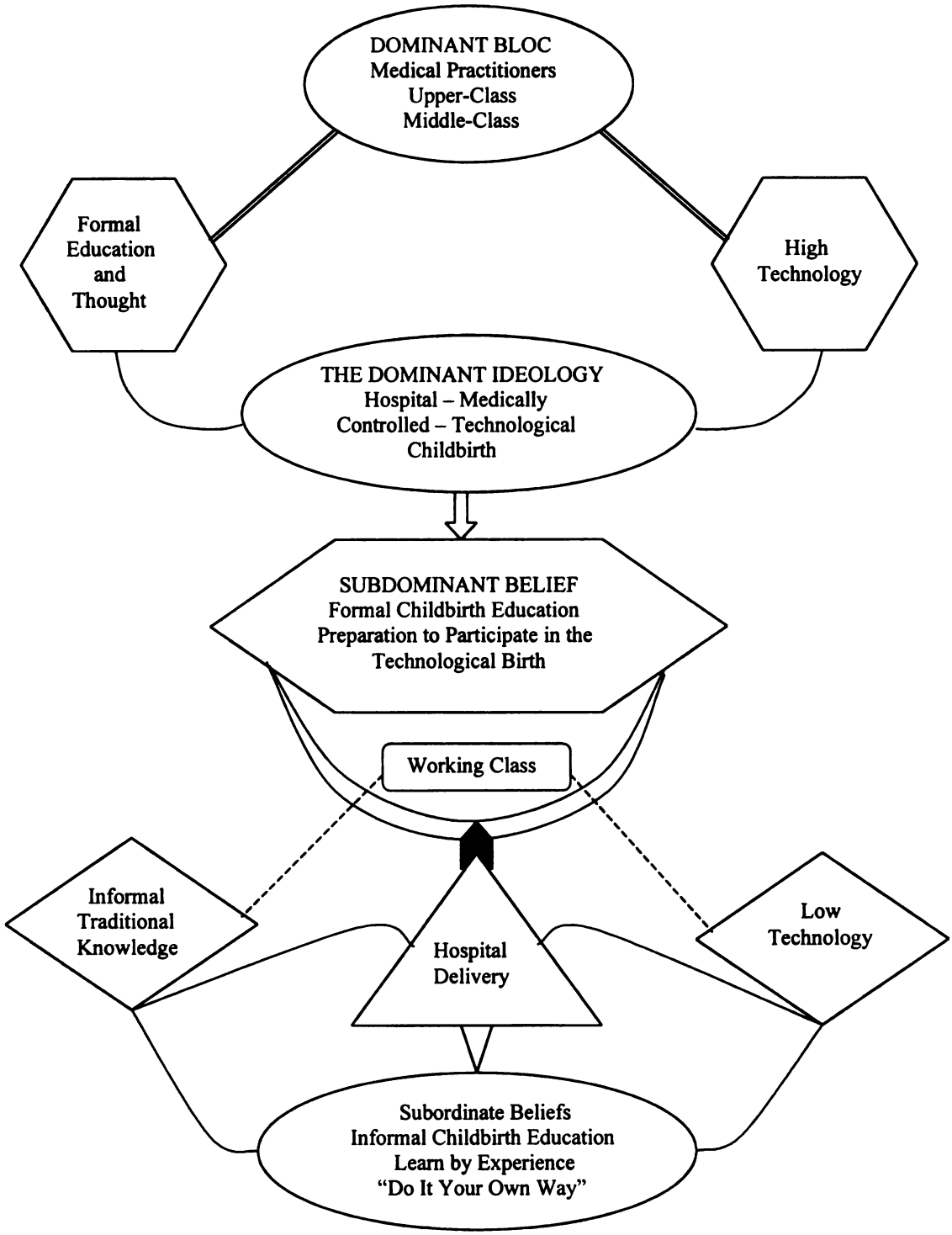

Figure 1.2 - The Dominant American Childbirth Ideology Model

and technology, and are seen as the progenitors of the dominant childbirth ideology that includes a hospital, medically controlled, technologically managed birth. In response to the dominant childbirth ideology, a subdominant ideology of preparation for birth through childbirth education evolved. Basic to this subdominant ideology, which was also instigated by upper- and middle-class women, is the assumption that the pregnant woman and her partner should be educated in order to cope with labor and delivery and participate in the decisions made in the technological management for a more "natural" childbirth experience (Simkin 1989). As part of the dominant childbirth ideology, childbirth education is assumed to be a necessary part of every woman's preparation for the experience of childbirth.

The American working class has been affected by both the dominant and subdominant ideologies of childbirth. Though they may have a subordinate ideology that includes a traditional, informal education system, especially as it pertains to childbirth knowledge gained from family and friends who have experienced birth, and, though they have only low technology at their disposal, most expect to deliver in a hospital. Thus, in seeking prenatal care for the assurance of a hospital delivery, working class women get caught in the dominant ideology and often incorporate into their own childbirth ideology the idea of formal childbirth education and participation in a technological, medically controlled, hospital delivery. The cultural web of childbirth education, as a distinct part of the dominant childbirth ideology, is an effective controlling mechanism that crosses all age, education, socioeconomic (SES), and ethnic barriers. It guides

the thoughts and behavior of childbearing women and gives meaning to their experience of childbirth.

Of course, this model of the influence of the dominant ideology does not take into account all of the complexities of childbirth ideology for either the dominant or the working class. For instance, it fails to point out that there is always a mix of attitudes and beliefs that accompany the dominant ideology. There are always a few who cling to the attitudes and ideologies from earlier times, as well as those who have dissident or non-conforming views and who, as Martin (1987) points out, resist the dominant ideologies. There are also those who are the *avant-garde*, on the edge of new ideas which usher in change (Simkin 1989). This model does, however, show how strong the dominant ideologies are and how they work as cultural webs that can hold and control the majority of the American populace. This is the cultural character of childbirth education.

In his book Language and power, Fairclough (1989) points out that the common sense assumptions of ideologies function best when they are not in conscious awareness. They are expressed in the common language used in discourse and carried out through common practices. In their concealed state, they perpetuate power inequalities. When they become known, power struggles may ensue. With this theory in mind, it can be assumed that women's childbirth ideologies will affect the way they speak of childbirth and the decisions they make concerning their own experiences in childbirth.

Previous studies by Davis and Morrone (1962), Huttel, et.al. (1972), Leonard (1973). and Watson (1977) indicated that participation in childbirth education classes increased as women's age, education, and

socioeconomic status increased. Working class women with lower education and socioeconomic status were less likely to attend classes. None of these studies looked at how the women themselves perceived or spoke of childbirth education, nor did they explore the possibility of conflicting ideologies that kept women from participating in childbirth classes. In this study, I will explore the way women speak of the childbirth experience and their perceptions of what they think women ought to know about childbirth, what women learn in childbirth classes, and what or who influenced their childbirth education decision. Through the exploration in this study, based on Fairclough's (1989) assertion that ideologies are expressed in the language of discourse, it should be possible to identify ideologies and power struggles that influenced the childbirth education decisions of the study participants.

I will show that both childbirth educated and non-childbirth educated women share many commonalities in what they want to know and how they speak about the childbirth experience. Power struggles associated with resistance to the dominant childbirth ideology are also identified and discussed. And finally, based on the findings of this study, I propose various means of childbirth education that would be culturally sensitive in preparing women for the experience of childbirth.

Chapter II

HISTORICAL BACKGROUND AND RELATED CHILDBIRTH STUDIES

Childbirth education is not a new concept in America. Early in the nineteenth century the American Red Cross and the New York Maternity Center Association established prenatal education classes in response to the high mortality and morbidity rates among women and their newborn infants living in the poor immigrant ghettos of New York City. These classes focused on health, hygiene, and nutrition in pregnancy but did not specifically prepare women for the labor and delivery experience. (Wertz and Wertz 1977; Hassid 1984; Nichols and Humenick 1988).

The focus of childbirth education began to change in 1944 when Grantly Dick Read, a British obstetrician, published his book, Childbirth Without Fear, in which he advocated a program of education, exercises, and breathing techniques for a non-medicated, natural and painless childbirth experience (Read 1944; Wertz and Wertz 1977; Hassid 1984; Earn 1962). Though Read's method was not fully embraced by the obstetrical community, it did pave the way for the "Natural Childbirth" movement in Europe and the United States (Walker, Yoffe, and Gray 1979).

During the 1950's, Fernand Lamaze, a French obstetrician, developed the psychoprophylactic method of education for prepared childbirth by which women were taught to actively relax muscle tension

and distract themselves from the discomfort of uterine contractions through a process of mental concentration and specific patterns of breathing (Ewy and Ewy 1970; Felton and Segelman 1978; Bing 1977; Arms 1975; Bergum 1989; Hassid 1984). Though the focus of this method is on breathing and relaxation rather than medications, the use of analgesics and anesthetics is allowed. The Lamaze method, introduced to American women through the writings of Marjorie Karmel (1959), has become widely supported by American physicians (Walker, Yoffe, and Gray 1979).

In the early 1960's, Robert Bradley, an American obstetrician, used the theories of Grantly Dick Read to develop a childbirth education program that included physical conditioning exercises, breathing and deep relaxation techniques. Bradley's aim was for a totally unmedicated, controlled birth that involved the husband as coach and provided a birth experience with little or no pain for the mother (Bradley 1965; Arms 1975; Bergum 1989; Hassid 1984). Though not widely accepted, the Bradley method is still an option for parents who desire a natural, unmedicated delivery.

Presently in the United States, there are many different childbirth education programs. Among them are nationally recognized organizations such as the Bradley Method, Lamaze, or the American Psychoprophylaxis Association. Others are provided by hospitals, clinics, or health education organizations. While most childbirth education programs express their primary goal as being the preparation of the woman and her husband or supporting person for the experience of labor and delivery, other objectives may be included in preparatory classes (Jensen and Bobak 1985; Sargent and Stark 1989).

According to hospital-based childbirth educators who were interviewed by Sargent and Stark (1989:40), the goals for childbirth instruction are as follows:

1. to provide a positive birth experience for the patient
2. to educate parents regarding their bodies and what to expect in labor
3. to define useful vocabulary
4. to present a good public image for the hospital.

Childbirth education programs, then, can impart more than knowledge related to the physiological aspects of pregnancy, labor and delivery. They can also convey cultural values and ideals and present a desired institutional image to gain respect for its programs and care. While not negative in itself, such information and values may act as barriers to women who have varying childbirth ideologies and may influence their decision to participate or not to participate in a childbirth education program.

Many studies have been done to evaluate the effect and effectiveness of childbirth preparation. The physiological aspect of prepared childbirth in labor and delivery, including the duration of labor, the need for analgesics and anesthetics, the mother's state of consciousness and state of control, and complications encountered, has been a major focus of program analyses.

Most of these studies contend that women who have attended childbirth classes tend to have more positive labor and delivery outcomes than women who have not taken classes. The duration of labor tends to be shorter among women who complete childbirth education programs. They also tend to remain alert, cope better with the pain of labor, need less analgesia and anesthesia, and are better able to maintain control of their psychological and emotional reactions. Women

who have completed classes also tend to have fewer complications that can occur during the labor process. (Miller, Flannery, and Bell 1952; Earn 1962; Doering and Entwisle 1975; Huttel, Mitchell, Fischer, and Meyer 1972; Gaziano, Garvis, and Levine 1979; Hughey, McElin, and Young 1978; Zimmermann-Tansella, et al. 1979).

The effect of childbirth education on the psychological characteristics of pregnant women has also been examined. Maternal personality changes, attitudinal and belief change, beliefs about personal control and ability to cope with anxiety and pain perception have been explored. The condition of the newborn and the mother's response to her baby have been evaluated. The state of preparedness, enjoyment of the birth experience, and satisfaction with the childbirth preparation program have also been analyzed.

Most of these studies have found that women who have taken classes tend to be less anxious, feel better prepared to cope with the pain of labor, and in general tend to face labor with more positive attitudes than women who have not taken classes (Huttel, et al. 1972; Davis and Morrone 1962; Nelson 1982 and 1983; Sullivan III 1992; Doering and Entwisle 1975; Felton and Segelman 1978; Earn 1962; Zimmermann-Tansella, et al. 1979.

Gaziano, et al. (1979:93) found that women who had taken childbirth classes were "more cooperative with nutritional and medical counseling," had higher scores on tests of knowledge about labor and were better prepared for the experience of labor than women who had not taken classes. Most of the women who had completed childbirth education classes expressed satisfaction with their courses (Zwirn, Reddington, Reed, and Martin 1979; Nelson 1982 and 1983). Women who had taken

childbirth classes also tended to be more positive about their actual birth experience than were women who had not taken classes (Norr, Block, Charles, Myering, and Meyers 1977; Doering, Entwisle, and Quinlan 1980).

Some of the studies assert that newborns also benefit from their mothers' childbirth education. Like their mothers, newborns who have not been exposed to the excessive use of analgesics and anesthetics during labor tend to be more alert, maintain eye contact longer, and breast feed more successfully soon after birth. They also have fewer birth related complications and have higher apgar scores than infants of women who have not taken childbirth classes (Zwirn, et al. 1979; Hughey, et al. 1978). Women who have completed childbirth classes have also been shown to have a more stable bond with their infants than those who have not taken classes (Doering and Entwisle 1975).

The characteristics of women who take childbirth classes have also been explored. Although there are some limitations to these studies, they indicate that childbirth classes tend to attract more older, well educated, middle-class women, than younger women who have less education and lower socioeconomic status (Huttel et al. 1972; Leonard 1973; Davis and Morrone 1962; Watson 1977).

Although these studies show many benefits among women who complete childbirth education classes, there are some limitations that should be considered. With the exception of Nelson (1982, 1983), none of the studies that evaluate the various aspects of childbirth education specifically consider preexisting attitudes, beliefs, or motivation factors that might differ among class and ethnic groups. For instance, Davis and Morrone (1962) tend to overlook social differences by focusing on the preparation issue only. Doering and Entwisle (1980) carefully

control their study by including only a few low-income participants, and Zimmermann-Tansella, et al. (1979); Gaziano, et al. (1979); Felton and Segelman (1978) focus on women of the same social and educational status.

Nelson (1982 and 1983) considers the attitude and motivation similarities and differences between middle and working class women as well as the changes that occur after the completion of the childbirth education program. Her study points out the need to evaluate the attitudes of women that may vary with socioeconomic status and to consider the differences in developing models of childbirth and childbirth education. While Nelson's work is very comprehensive, it neglects to consider ethnic factors that may also affect the response to childbirth preparation. Ethnicity and culture, as well as social class, are important factors to consider when developing childbirth education programs.

While analyses of childbirth education programs have not specifically explored the existence of barriers to participation in these programs, one may hypothesize that these may be similar to factors that have kept women from seeking prenatal care. These factors include lack of motivation, miscommunication or lack of understanding, lack of information about the system, expectation differences, feeling a lack of control and a lack of social support (Poland, Arger, and Olson 1987; Poland 1988; Lazarus 1990; Kalmuss and Fennelly 1990; Sable, Stockbauer, Schramm, and Land 1990; Scupholme, Robertson, and Kmons 1991; Boone 1988; Giblin, Poland, and Arger 1990). These barriers to prenatal care are common among women in lower socioeconomic levels and may also act as barriers to participation in childbirth education programs. The

ideologies that are shared among women of varying socioeconomic status, educational levels, and ethnic backgrounds need to be identified and evaluated in order to develop appropriate and appealing childbirth education programs.

Graham and Oakley (1981) point out that competing ideologies of reproduction lead to doctor-client conflict. One point of ideological conflict may occur with prenatal advice, which Oakley (1979) maintains is used to "program" women to be the ideal maternity patient. Graham and Oakley (1981) contend that communication and interaction between the woman and her caregiver are both hindered and distorted when there are diverging ideologies.

Martin (1987:184-189) also contends that competing ideologies lead to conflict. According to Martin, women respond in various ways as they become aware of their position and resist the opposition to their own ideologies. Some merely accept things as they are, assuming that nothing can or should be changed. Others lament the situation, focusing on their pain and unhappiness. They may or may not be aware of structural factors that are outside of their control or perceive that these factors could be changed. Some resist by taking no action. They merely refrain from participation in organizations, such as clinics, that they perceive to be against their interests. Sabotage is another response in ideological conflict. In sabotage women attempt to foil a process or behavior they perceive to be detrimental to them, although the attempt is not intended to be detected. Resistance can also be expressed by refusing to act as requested or required. And, some women organize themselves and actively rebel against the dominant ideology and demand change.

Martin (1987) and Graham and Oakley (1981) underscore Fairclough's (1989) assertion that ideological diversity results in conflict and struggle. The theories of Martin, Graham and Oakley, and Fairclough support the possibility that women who perceive their childbirth ideology as different from that of their caregiver may reject the possibility of being manipulated or "programmed" to behave or respond in an unfamiliar or undesirable way and may resist both prenatal care and childbirth education classes in an attempt to maintain their personal ideologies and avoid open conflict.

Perceived risk and choice of childbirth service has been evaluated by McClain (1983). McClain found that women chose childbirth services according to the risks they perceived to be inherent in alternative services. Women's perception of what they ought or want to know about childbirth, or what might happen to them if they are not prepared for the childbirth experience, may influence their childbirth education decision, just as their perception of risk influences their choice for obstetrical care.

Davis-FLoyd (1988) has studied childbirth as a "rite of passage" for American women. She points out that childbirth education is the beginning of the rite that socializes women for the childbirth experience that will change them from women to socially accepted mothers. However, while the rite of childbirth education may be acceptable to white middle-class educated women, it may not be admissible for women of varying socioeconomic, educational and ethnic backgrounds who may also have varying childbirth ideologies.

Embodied and *authoritative knowledge* may also influence women in how they view and respond to childbirth education. Jordan (1993)

defines *embodied knowledge* as that which is learned by experience. Browner and Press (1996:142) further explain that it is "subjective knowledge derived from a woman's perceptions of her body and its natural process as these change throughout a pregnancy's course." *Authoritative knowledge*, on the other hand, is that knowledge that has been legitimized and held above other knowledge sources and ways of knowing (Jordan 1993). According to Jordan, authoritative knowledge is accepted because it explains the world better or is associated with a stronger power base. Browner and Press (1996) point out that in general women accept biomedical knowledge as authoritative, but in certain circumstances they may not ascribe to the recommendations given from that authority. In their study, women accepted the authoritative knowledge most when it coincided with what they believed or what they experienced. When there was conflicting or confusing information from the authoritative sources, the women tended to follow their own embodied knowledge.

While Browner and Press's study looked at advice given in pregnancy, it may also be that women who accept the dominant childbirth ideology also value and accept authoritative information. They will be more likely to attend childbirth classes and use the language of authoritative knowledge when talking about their experience of pregnancy and childbirth. But this poses a problem for women whose ideologies are different. They will be more likely to reject the authoritative knowledge and rely on their own embodied knowledge to experience and cope with labor and delivery. Jordan (1993) and Browner and Press (1996) also point out that authoritative knowledge devalues other types of knowledge. This too can further lead to conflict and power struggles

for women who rely on their own embodied knowledge and can influence their childbirth education decisions.

Childbirth education, as Lazarus (1988:40) points out, is only a part of the complex of factors that affect the outcome of pregnancy. Certainly, other factors such as prenatal care, social support, stress, socioeconomic and marital status are very important. However, if, as Earn (1962), Huttel, et al. (1972), and Hughey, et al. (1978) contend, childbirth education prepares women to better cope with labor and delivery and therefore lessens the need for large amounts of analgesics and anesthetics and decreases the need for medical intervention that may be harmful to mother and infant, then it is also important in decreasing maternal and infant morbidity and mortality that often results from unprepared, difficult labor and delivery. It seems reasonable, then, for every woman to attend childbirth education classes.

It is clear from the review of the literature that there is a need to explore the cultural influences in childbirth education and women's responses to childbirth education programs. There is also a need to evaluate the existing childbirth education system with a view to establishing courses that respect and incorporate embodied knowledge and varying ideological perspectives to facilitate educational programs that are appropriate for every woman.

Chapter III

METHODS

The Community

This research was conducted in three different settings. A large hospital located near the center of Grand Rapids, Michigan provided two sites for data collection. The majority of the data were obtained in the hospital's prenatal clinic. The second site was the hospital's health education center. The third site was the prenatal clinic of a small inner city health center located a few miles away from the hospital. For the sake of anonymity the hospital will be referred to as City Hospital and the health center will be called The Block Clinic.

Grand Rapids is the second largest city in Michigan. According to the 1990 Census Profile (City of Grand Rapids Planning Department 1990), there are 688,399 people living in the Grand Rapids metropolitan statistical area of Kent and Ottawa Counties. By itself, the city of Grand Rapids has a total population of 189,126.

The economy of the city is predominately maintained through business, industry and service organizations. Grand Rapids is the headquarters for many national and multi-national corporations, including Steelcase Inc., Hayworth Inc., and Herman Miller Inc., all three of which manufacture office and systems furniture. The Amway

Corporation, maker of home care products; Wolverine World Wide Inc., maker of Hush Puppy shoes; and the Bissel Corporation, maker of carpet-care products, also claim the city as their home base.

Jobs are also provided for many local residents by other well-known companies that have manufacturing centers located in the area. These include General Motors Corporation, Smith Industries, Keeler Brass Company, American Seating Company, Autodie Corporation, and Rapistan. Service jobs are provided through the city's four major hospitals, four major colleges, one State University, public and private school systems, social service organizations, and government organizations such as the U.S. Postal Service and the Department of Public Health (City of Grand Rapids Planning Department 1990).

Grand Rapids provides a broad socioeconomic base for selection of study participants. According to the City of Grand Rapids Planning Department (1990), yearly incomes for Grand Rapids residents range from less than $5,000 to $150,000 or more per household. The city has 69,452 households; of these, 45,972 are family households with a median income of $32,049. The remaining 23,480 are non-family households with a median income of $16,775. There are 29,103 persons, 16.1% of the total population who live in poverty. This exceeds the national rate of 13.5% who live in poverty (World Almanac 1992). These statistics document a diverse socioeconomic group from which to select participants for this study.

Grand Rapids is also an appropriate site for this study because of the multiethnic and sociocultural diversity among its residents. According to the 1990 Census Profile (City of Grand Rapids Planning Department 1990), the population of Grand Rapids is composed of 76.4%

white, 18.5% black, 1.1% Asian, 0.8% Native American, and 3.1% other ethnic groups. Five percent of the total population are of Hispanic origin. Grand Rapids exceeds the national composition of 12.1% and the Michigan composition of 13.9% African Americans (World Almanac 1992). Hispanic residents in Grand Rapids also exceed the total Michigan composition of 2.2% but are lower than the 9% national Hispanic composition (World Almanac 1992). This higher composition of African American and Hispanic residents in Grand Rapids offers a viable base from which to select study participants with varying cultural and ethnic backgrounds.

The cultural and ethnic diversity in Grand Rapids is also evident in its birth statistics. In 1989 there was a total of 4,457 live births in Grand Rapids. Based on the racial/ethnic classification of the mothers, 3,246 of those born were white, 1,110 were black, 44 were Native American and 57 were other racial/ethnic groups (Michigan Department of Public Health 1989).

According to the Planning Department (1990), the median age of Grand Rapids residents is 29.8 years. In 1990 there were 47,191 women who were of childbearing age (15 to 44 years) living in Grand Rapids (Census Tracts Grand Rapids 1990). Of these, approximately 14.4% were 15 to 19 years, 19.5% were 20 to 24 years, 39.6% were 25 to 34 years, and 26.5% were 35 to 44 years of age (Table 3.1). These statistics indicate a wide range of age and ethnic diversity from which participants might be chosen.

Participant Selection Criteria

Both childbirth educators and pregnant women were included in this study. There were no limiting factors for the participation of the

TABLE 3.1 - Women of Childbearing Age by Ethnic Group in Grand Rapids

Age	Total Population	White Persons	Black Persons	Hispanic Persons
Total	99,271	76,058	18,583	4,479
15 - 19	6,767	4,590	1,691	428
20 - 24	9,198	6,988	1,694	482
25 - 34	18,704	14,471	3,435	797
35 - 44	12,522	9,537	2,416	504

Source: 1990 Census of Population and Housing MSA Grand Rapids, MI

childbirth educators. Childbirth education classes are offered by City Hospital in the Education Center and in the Prenatal Clinic. The childbirth educators in both of these childbirth education programs were invited to participate.

The pregnant women who were invited to participate in the study did have to meet certain selection criteria. To avoid attitudinal or ideological change either for or against childbirth education that may occur during a birth experience, only women who were pregnant with their first child were invited to participate. All but one of the women included in the study were primigravidas. The woman who was not a primigravida had miscarried very early in her first pregnancy. She expressed a desire to participate in the study. She had not actually experienced birth, or previously attended childbirth classes, and since her current pregnancy was proceeding without difficulty, I included her in the study.

Women who were thirty-six or more weeks pregnant were selected for participation because it is during this time that they begin to

earnestly focus on the end of the pregnancy and the birth of the baby (Jensen, Benson, and Bobak 1981). By this stage in their pregnancy most women have developed networks for obtaining childbirth information and will have some insight into what they think women ought to know about pregnancy, labor, and delivery. Women who opt to take the childbirth classes have completed them by the thirty-sixth or thirty-seventh week and are able to discuss the content and their perception of the value of the classes. Those who declined the childbirth classes earlier will not be able to take them at this point, thus, their decision cannot be altered as a result of the interview. One problem that can occur by waiting until the thirty-sixth week is that the participant may deliver before the interview can be attained. A few interviews were lost because the babies were born in the thirty-sixth or thirty-seventh week of the prospective participant's pregnancy. In general, however, waiting until the thirty-sixth or thirty-seventh week did prove to be effective.

To help control for extraneous and unique problems associated with high risk, complicated pregnancies, in general only women with normally progressing pregnancies were included in the study. One participant had been treated for hyperemesis gravidarum early in her pregnancy but was progressing normally at the time of the interview. After consenting to the interview, another participant opted to place her child up for adoption. Considering the stress and difficulty that such a decision can cause, I gave her the opportunity to withdraw from the study before the time of the interview; however, she requested to remain and was interviewed. Four of the participants had at various times throughout their pregnancy exhibited some problems with elevated blood pressure and

one participant was quite overweight. However, at the time of the interview all of the participants were determined to be progressing in their pregnancies without overt complications.

Due to City Hospital's policy restrictions pertaining to the allowable age of research participants, only women 18 years and older were included in the study. Since the majority of the primigravid African American women attending the clinics were 17 years or younger, this restriction severely limited the inclusion of many African American women in the study. It did, however, provide a more homogeneous study population in that it narrowed the age span of the participants.

Participants were required to speak fluent English. One Asian woman and two Hispanic women who participated in the study spoke English as their second language but had no problems understanding or responding to any of the interview questions. All other primigravid women who predominately spoke a language other than English were excluded from the study.

Marital status was not a criterion for participation in the study, but, for analysis of the study population, participants were asked if they were married, single, separated or divorced. No other criteria limited participation. Participants were selected from all ethnic groups, socioeconomic and educational levels.

Participants were self-selected rather than randomly sampled. The setting and selection criteria for the pregnant women participants and the availability and class schedules of the childbirth educators made convenience sampling necessary. Although somewhat limiting the ability to make broad generalizations from the data gathered, this type of

sampling was not a hindrance, because of the inductive nature of the study.

The Sites: Clinics and Childbirth Education Classes

The study began in City Hospital and then expanded to the prenatal clinics conducted in the Block Clinic. City Hospital, with 510 beds, is the largest of the four hospitals that serve the Grand Rapids area (City of Grand Rapids Planning Department 1990). Located in the downtown area, City Hospital serves clients of all socioeconomic levels and ethnic backgrounds, including a large component of African American women, many of whom obtain their care in the prenatal clinic and deliver in the hospital. Some Hispanic women also attend the prenatal clinic and deliver at City Hospital, but many Hispanic clients choose to attend a neighboring hospital's prenatal clinic designed especially for Hispanic and Spanish-speaking women (Childbirth Education Center Director - personal contact 21 June 1993).

Two childbirth education programs are offered at City Hospital. One is a very formal, well organized program of instruction offered by the Education Center of the hospital. Registered nurses who have been taught to be childbirth educators teach these classes. The other is a less formal childbirth preparation class offered by two of the registered nurses in the Prenatal Clinic.

The Education Center (EC) provides a variety of classes for expectant parents, including sessions on what to expect early in pregnancy, childbirth preparation, Cesarean birth, vaginal birth after Cesarean birth, twins, sibling classes, breastfeeding, child care, and play and learning classes (Childbirth Education Organization 1994-95). The EC charges fees for most of the courses that are offered, including

the childbirth preparation classes. In most cases the fees are paid by the persons attending or by their private insurance. However, the EC does accept the amount that Medicaid will pay for classes, and, in general, no one is turned away from the childbirth preparation classes (EC Childbirth Educator Interview, 12 December 1993).

The EC's childbirth preparation classes, which are part of the focus of this study, are given in a series of five class sessions. Participants attend one class per week. The classes include information concerning the physiological and psychological changes that occur during the latter part of pregnancy, labor, delivery, and postpartum, with a major focus on preparation for labor and delivery, which includes extensive training in relaxation and breathing techniques. The breathing and relaxation techniques require the assistance of a "coach," who is usually the husband or father of the baby but may be a friend or relative. As a rule, single women without partners or coaches do not attend the Education Center classes (EC Childbirth Educator Interview, 12 December 1993).

The EC offers classes to all pregnant women; however, the EC tends to draw the majority of their clients from middle- to upper-middle class women who receive their prenatal care in private doctors' offices. According to the Education Center Director (personal interview, 21 June 1993), this may be due in part to the information the clients receive from their physicians. The cost of the classes may also be a factor, even though Medicaid recipients are not turned away.

About 98% of the couples who attend the classes are white; the rest are African American, Hispanic, or Asian (Education Center Director, personal interview, 21 June 1993). The EC was chosen as a site from

which to select participants because it provided a group of predominately middle-class pregnant women who have taken childbirth classes.

The Prenatal Clinic (PC) classes are offered to clinic clients by two of the nurses who work in the City Hospital prenatal clinic. The content of the PC classes gives the same information as that given in the EC classes. However, the classes are presented in a less formal manner and do not place as strong an emphasis on the in-class practice of the relaxation and breathing techniques as given in the EC class sessions. The PC educators encourage the expectant mothers to attend the classes with a partner (coach); however, they are not disadvantaged if they attend alone. Fees for the PC classes are paid by Medicaid for women insured under that program, but no clinic client is turned away from the classes due to inability to pay. The classes are freely offered to all of the prenatal clinic clients. If a clinic client cannot attend these classes, she is encouraged to attend the EC classes. Some of the clinic clients do take advantage of the EC classes, but many opt to disregard all childbirth classes (Clinic Childbirth Educator, personal interview, 13 September 1993). The PC class was chosen as a site from which to select participants because of its potential to provide a group of low-income pregnant women who have taken childbirth classes.

City Hospital is the perinatal center for Western Michigan and provides care for high risk mothers and infants needing special or intensive care. Women from many outlying counties also choose to deliver at City Hospital because of the expertise available should complications occur. In 1994 a total of 5,376 births occurred at City

Hospital. Of those births, 652 were clinic clients (Childbirth Education Organization Minutes 24 March 1995). The PC childbirth education course provided instruction for 35 of these clinic clients (Clinic Nurse Educator, personal interview 2 May 1995).

The EC provided instruction for 1,374 couples that delivered at City Hospital in 1994. Of the remaining 3,967 women who delivered, some may have taken childbirth classes outside of those offered by the hospital's education programs, and some were multiparous women who may have taken childbirth classes with a previous pregnancy and had not repeated the classes, while still others had no formal preparation for their childbirth experience (Education Center Director, personal interview, 1 May 1995).

The prenatal clinic at City Hospital offers care to low-income women from all ethnic groups living in Grand Rapids and its surrounding suburbs. The prenatal clinic was chosen as a site from which to select participants because it offered a diverse ethnic population from lower socioeconomic levels, some of whom chose to take and some of whom chose not to take childbirth classes.

During the course of selecting and interviewing participants from the prenatal clinic, it became apparent that the majority who met the selection criteria (18 years or older, primigravida, 36 or more weeks gestation, low risk pregnancy) were white women. Finding primigravid women from other ethnic groups became a problem. While a few Hispanic women volunteered to participate, most of the Asian women identified were not invited to participate because they could not speak English. African American women who could participate were also difficult to find, primarily because most primigravidas who were attending the clinic

were between fifteen and seventeen years of age. Of those who were eighteen years or older, many were classified as very high risk due to numerous pregnancy complications and therefore could not be included in the study.

At the suggestion of the Medical Director of the City Hospital prenatal clinic, I contacted the Block Clinic with a view to adding its prenatal service as another study site that would provide a wide range of ethnic groups from which to select participants for the study. The Block Clinic is a small health care center located just a few miles from City Hospital. It is situated closer to the residential area of its clients than is City Hospital, is smaller and more personal in its approach to its clients, and is attended by many inner-city pregnant women. Of the women who attend the Block Clinic for prenatal care, about fifty percent are African American, three percent are Vietnamese, fifteen percent are Hispanic, and the rest are white (Block Clinic Medical Director, personal interview, 22 April 1994).

The Block Clinic charges its clients on a sliding scale according to their ability to pay. No one is turned away. The majority of the clients who come to the Block Clinic for care are economically disadvantaged. Persons who do not have the means to pay for their care are helped to apply for Medicaid and other support systems (Block Clinic Nurse Coordinator - personal interview 28 April 1994).

At one time, formal childbirth classes were offered at the Block Clinic by the City Hospital EC. These classes were not well attended and therefore were discontinued (Education Center Childbirth Educator, personal interview, 12 December 1993). Since formal childbirth classes are not offered at the Block Clinic, individual teaching is given by a

nurse educator at various times when the client attends the clinic for her prenatal visits. A few Block Clinic clients choose to take the childbirth classes offered by the hospital at which they plan to deliver. Some take the classes offered by the City Hospital EC, and some decide not to take classes. The addition of the Block Clinic as a research site increased the socioeconomic and ethnically diverse population from which to select participants who took childbirth classes and who did not take classes.

Data Collection Methods

I first explained the study to the twelve childbirth educators in the EC program and invited them to participate. All of the educators volunteered to let me attend their classes and interview them. Four educators whose class schedules corresponded with my schedule where chosen to participate.

I also explained the study to the two nurses who teach the PC childbirth classes and invited them to participate. One of the nurses enthusiastically agreed to my visiting her classes and doing an interview with her. The other declined to participate in the study but was very helpful in locating pregnant women attending the clinic who could be invited to participate.

The childbirth education programs of the EC and PC both consist of a series of four or five class sessions. One complete series of classes for each participating childbirth educator was observed. Though disadvantaged without a partner, I also practiced with the class participants all of the relaxation and breathing techniques as they were taught. Each class session was tape recorded and written field notes

were taken. At the end of the series of classes the childbirth educator was interviewed.

The educators chose the location and time for their interview. I interviewed one EC educator in her home. The other three EC educators I interviewed in an EC classroom. I interviewed the PC educator in the prenatal clinic interview room. An interview schedule was used for each of the interviews (see Childbirth Educator Interview Schedule, in the Appendix). Audio tape recordings and written field notes were taken in each interview session.

At the first observed class of each EC series, the childbirth educators allowed me to explain my study and obtain permission from each class participant for my observation and participation in the classes. During the third class of the series, I invited all the primigravidas in the class to participate in the interview portion of the study. Several women from each observed class volunteered to participate, but most declined. Though not solicited, various reasons for not participating were given such as being too busy or conflicts with jobs or family life. By the end of the five observed series of classes, I had slightly over half of the needed participants. The childbirth educators who participated in the study then invited me to come to their other class groups to invite participants. I did this, and, after visiting several classes, I was able to obtain a total of 16 participants who had taken the EC classes.

The EC participants chose the location and time of their interview. On their invitation, I interviewed nine participants in their homes. I interviewed five participants in restaurants near their home or work sites. One participant was an executive in a large office

building in downtown Grand Rapids. At her request, I did her interview while she ate lunch in her office. Another participant was a client in the City Hospital prenatal clinic, and she opted to have her interview there. I completed her interview after one of her prenatal clinic visits. An interview schedule was used for each participant interview (see the Prenatal Class Participant Interview Schedule in the Appendix). Audio tape recordings and written field notes were taken at each interview session.

Selection of participants from the City Hospital prenatal clinic was slightly more complicated than the selection from the EC classes. Many pregnant women pass through the clinic on any given day. Though I had hoped that the clinic staff would be able to help me identify prospective participants, in general they were far too busy to become very involved in the selection process. As soon as a client arrived in the clinic, I was allowed to examine her record. When I found a client that met the selection criteria, I went to the waiting room, introduced myself, explained the study and invited her to participate.

Two prenatal clinics were conducted each week. I observed both of these clinics weekly for nine months. On any given day there could be several eligible primigravidas attending clinic, but, more often than not, a whole clinic session would pass by without even one eligible client. Part of the problem was due to the high number of clients with complicated pregnancies who attend the clinic. Another part of the problem was the high number of teenage mothers who were seen in the clinic. Many multiparous women were also cared for in the clinic, and several women who came could not speak English.

Similar to the response in the EC classes, some of the clients declined my invitation to participate in the study. The reason for refusal was not solicited but most said they did not have time, had something else to do, or were not interested. A few declined without giving a reason. One woman stated that she got everything she needed to know from her mother and sisters, and she didn't want to have anything to do with the classes. When I tried to explain that I was not involved with the classes but just wanted to talk to women about their information sources, she adamantly repeated that she was not interested in the classes and would not grant me an interview. The other women, however, were not as adamant in their declination to participate.

When a client agreed to participate in the study, I gave her a consent form and allowed time for her to read it. The form was then signed by the client and a nurse who witnessed the signature. Each participant set her own time and location for the interview. Some chose to be interviewed during their next clinic visit while others wanted to be interviewed on the same day they volunteered. One participant invited me to do the interview in her home. I interviewed all of the other participants in the clinic interview room after one of their routine clinic visits. I used an interview schedule with each participant. The Childbirth Education Participant Interview Schedule (Appendix) was used for those who had taken classes and the Clinic Non-Childbirth Education Participant Interview Schedule (Appendix) was used for those who had not taken classes. Audio tape recordings and written field notes were taken at each interview.

After several months of interviewing clinic clients and observing the PC classes I was able to locate only 3 primigravid participants who

completed the PC classes. In order to have a comparative sample of low-income women who had completed childbirth classes, I then included both City Hospital prenatal clinic clients and Block Clinic clients who had taken either PC or EC classes. Fifteen clinic participants who had taken childbirth classes were interviewed. Twelve of these took the EC classes and 3 took the PC classes (Figure 3.1).

It was also difficult to find women in the City Hospital prenatal clinic who did not take classes and were willing to participate in the study. Over the course of data gathering, I was able to interview only 10 women in the City Hospital clinic who had not taken childbirth classes.

Finding eligible participants at the Block Clinic was a little easier than at the City Hospital clinic. In order to facilitate holistic care for their clients, the staff of the Block Clinic met before every clinic session to present each client that was expected in the clinic that day. General care as well as problems that may need special attention were discussed by all staff workers who were involved with the client. I was invited to attend the pre-clinical staff meetings, and the staff assisted me in identifying clients for my study. The Block Clinic, like the City Hospital prenatal clinic, also had a high number of teenage and high risk pregnant clients. Frequently there were no clients who met the study participant selection criteria, and I left without an identified client or completed interview.

When a client was identified as a possible participant, I went to the clinical area with the staff and waited for her to come for her clinic visit. After the client had completed the preliminary preparation for her visit with the staff, I was given time to talk with

her. I introduced myself, explained the study, and invited her to participate. Only a few of the women who were invited declined to be in the study. Those who did refuse stated they were working and could not spare the time for an interview.

Most of the women who were approached in the Block Clinic appeared to be interested in the project and were willing to participate. As at the EC clinic, some of the women chose to be interviewed on the same day they were invited to participate in the study, while others chose to have their interview when they came for a subsequent clinic visit. Though the option was given to do the interview at another time in the participant's home or other place of her choosing, all chose to have the interview done in the clinic when they came for their routine prenatal visit.

When the client agreed to participate, I followed the same procedure for obtaining the consent and doing the interview as was done in the City Hospital clinic. I did the interviews in a small examining room that had been assigned to me as an interview room. Though not ideal, the room was in an area that was separate from the prenatal clinic rooms and had a comfortable chair that the participant could sit on. I interviewed three Block Clinic clients who had taken childbirth classes and six who had not taken classes.

I interviewed a total of fifty-two participants for the study. This included five childbirth educators and forty-seven pregnant women. Sixteen of the pregnant women participants were from the Education Center childbirth education classes. For simplification, I will refer to this group as the ECCBE group (Figure 3.1). Fifteen participants were Block Clinic and City Hospital prenatal clinic clients who had

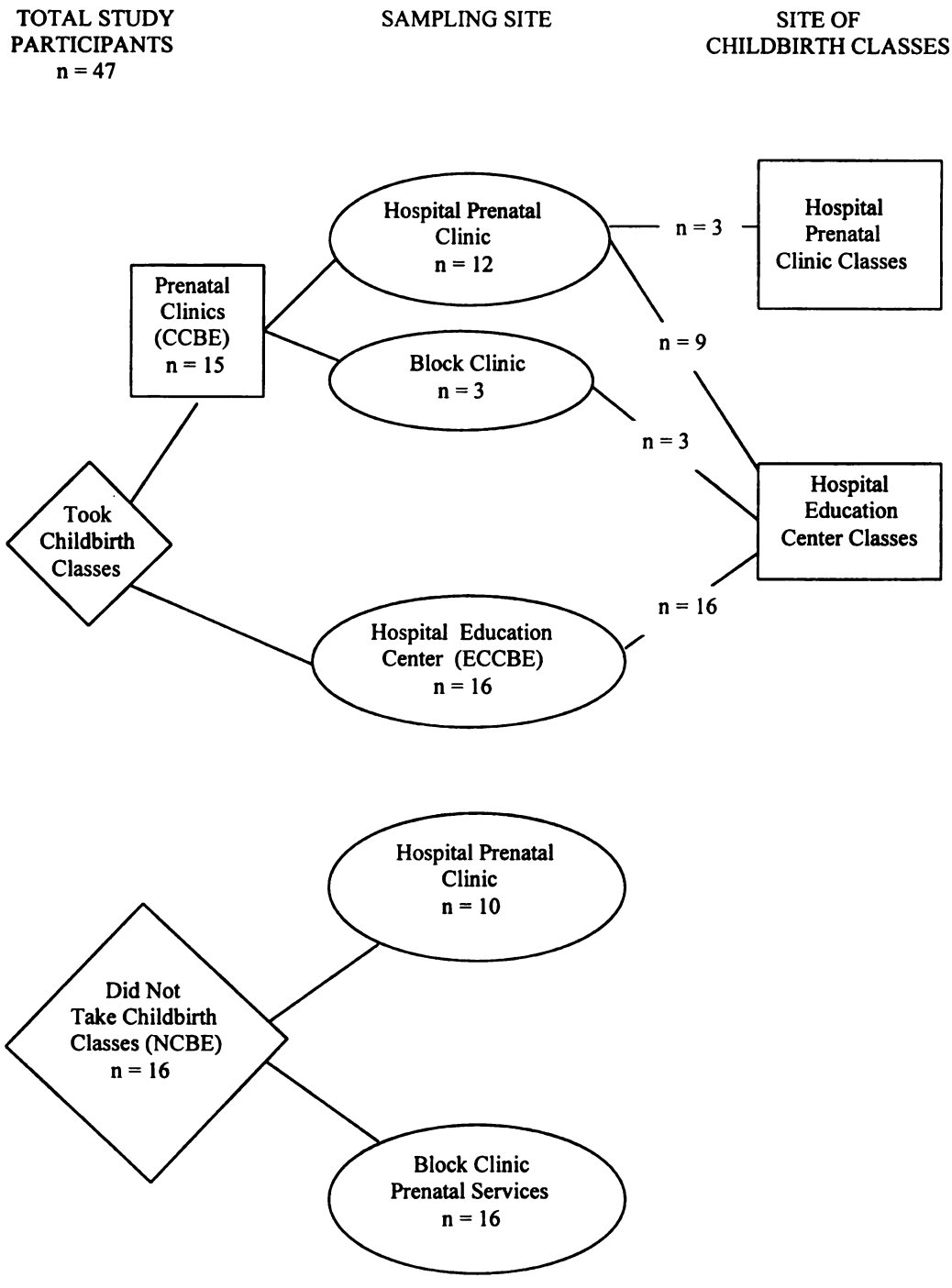

Figure 3.1 - Pregnant Women Participant Sampling and Childbirth Education Sites

taken either EC or PC childbirth classes. These will be referred to as the CCBE group (Figure 3.1). The remaining sixteen participants were Block Clinic and City Hospital prenatal clinic clients who did not take classes. These will be identified as the NCBE group (Figure 3.1).

None of the participants were paid for their participation in the study. In the explanation of the study the participants were told that there would be no payment but that their participation could be helpful in designing prenatal classes to meet the needs of pregnant women. At the end of the interview however, I gave each pregnant participant a pair of hand-knitted baby booties as a thank you gift. I did not tell the participants about the gift before the interview because I wanted their participation to be voluntary rather than granted for the purpose of receiving a reward. A special thank you note and book mark was also sent to each of the childbirth educators who participated.

Compilation of Participant Socioeconomic Status

Many scales using various measures for evaluating socioeconomic status have been developed. Some employ occupation or income as the defining factor. Others use a combination of factors such as education, occupation, income, and place of residence. For this study, I obtained information concerning the education, insurance coverage, and occupation of each participant. A tool based on one or all of these factors was needed to evaluate the socioeconomic status of the study participants.

While occupation has been shown to be the best single predictor of social status (Miller 1991), standing alone, it may not be totally accurate. Extenuating circumstances may place a participant in a higher or lower status category than occupation alone might reveal. For instance, students who might be gainfully employed, were it not for

their college or university participation, may be working part-time in a menial position that would place him or her in a lower status category if occupation were used as the sole indicator. Likewise, in today's unstable job market, persons who hold higher degrees and may have held prestigious occupational positions may now be working at lower paying, lower status jobs to carry them through to the next change in the job market which could return them to higher positions. Using occupation alone in cases such as these does give an indication of the immediate status but may not accurately reflect the over-all social position of the individual.

As Miller (1991) points out, the close relationship between occupation and social status is affected by various factors. Education and income as well as house type and area of residence can be important factors in determining social status. Though education and income generally correlate with one's occupational rank, using only one of these factors could place a person in a lower or higher status position and give erroneous information about the total study population. Due to the fact that I did not obtain specific information about income or place of residence for all participants in this study, I needed a different evaluation scale.

Two scales that most closely correlate with the socioeconomic information obtained for this study's participants are the Nam-Powers Socioeconomic Status Scores and the Hollingshead Index of Social Position. However, the Nam-Powers (1983) scale considers income with occupation and education and the Hollingshead (1959) index includes place of residence with education and occupation. Both income and place of residence pose a problem if one or the other of these two scales is

to be used for this study. Although ten of the interviews were conducted in the participants' homes, neither the place of dwelling nor the actual income was obtained for the majority of the study participants. Therefore, neither of these scales could be fully employed in the evaluation of the study participants' socioeconomic status, without some adaptation.

The Hollingshead Index (1958), though possibly useful in this study for scoring educational levels and occupational status, bases its occupational scores on men's occupations calculated from late 1950's census data. Thus, being both out of date and not fully applicable to women's occupations, this index was rejected from use in the calculation of the study participant's socioeconomic levels.

Nam and Powers (1983) devised a multiple item guide for the calculation of socioeconomic status scores which included scores for categories of years of school completed, household income, and occupational status for women as well as for men. Although based on 1970 census data, the Nam-Powers multiple item socioeconomic status measures proved to be the most appropriate scale to use for determining the socioeconomic levels of the women who participated in this study. With the data obtained from the participants, it was possible to use, without alteration, the Nam-Powers scores for years of school completed and occupational status.

Since the actual income was not obtained from the study participants, I used the participant's medical coverage as a proxy for calculating the income. This allowed me to use the income score identified in the Nam-Powers scale. Since most people who have full time gainful employment also have some sort of health insurance, this

category, rather than actual earnings, was chosen as a reflection of both employment and income. Those who do not have full-time or gainful employment are more likely to be without health insurance and, due to their low income, qualify for Medicaid. Also, women who have low incomes, regardless of medical coverage, are also entitled to the U.S. Government "Women, Infants, and Children" (WIC) supplemental food program. Income status, then, though not known exactly, can be estimated through medical coverage and participation in the WIC program and can be used as a proxy for evaluating the participant's over-all socioeconomic status score.

Developing an income score based on this limited information, however, proved difficult. According to the Michigan Medicaid Income Guidelines For Pregnant Women and Infants (1994) and the Michigan WIC Program Income Guidelines (1994), single or self-supporting primigravid women qualify for Medicaid and WIC if their income is $18,204 or less. Primigravid women living with a spouse or financially contributing significant other can receive Medicaid and WIC if the income is $22,972 or less. All of the study participants were primigravidas. Forty-three percent were married and fifty-seven percent were single. Since the total household income or the contributors to that income were not obtained, the score for the Medicaid and WIC category was calculated according to the participant's marriage status only. Single participants who received Medicaid or WIC were considered to be in the income qualifying level of $18,204 or below and given the score of 54 based on the Nam-Powers (1983:143) $15,000 to $19,999 income category. Married participants receiving Medicaid or WIC were considered to be in

the qualifying level of $22,792 or below and were given the score of 67 based on the Nam-Powers (1983:143) $20,000 to $24,999 income category.

Due to the fact that the majority of the participants who had private insurance were in the higher ranges for the occupational status scores, the highest occupation score was used as the income guide for determining the income score. The highest scoring participant was a secondary school teacher. According to the Grand Rapids Education Association Teachers Contract for 1994-1996, secondary teachers' income, based on years of teaching and educational status, ranged from $27,000 at the lowest to $42,436 at the highest for all teachers who held a Bachelor's degree only. In order to prevent over-inflation of the other higher occupational status participants, the income of $32,000, which is half way between the highest level that could be earned by school teachers ($42,000) and the highest level that could be earned by Medicaid and WIC participants ($22,000), was selected as the income by which the Nam-Powers income category score could be assigned. Therefore, based on the Nam-Powers (1983:143) $24,000 to $34,999 income category, the score of 81 was assigned to all participants who had private insurance and did not have Medicaid or WIC.

Although I realize that using only insurance, Medicaid, or WIC as the proxy for income is not totally accurate, it does provide a logical score that can be used in the calculation of the over-all socioeconomic level of the study participants and should not severely raise or lower the socioeconomic status level of any study participant.

The socioeconomic score for each participant was calculated by adding the individual's score given for education, occupation, and income (Table 3.2) and dividing the total by 3 (total number of

TABLE 3.2 - Education, Occupation, and Income Scores

Education Score:

Years of Schooling	Points
- College: 4 years or more	92
- College: 1 to 3 years	76
- High School: 4 years (graduate)	50
- High School: 1 to 3 years (completed grades 9, 10, or 11)	25
- Elementary School: Completed 8 years	13
- Elementary School: Completed 5 to 7 years	06

Medical Coverage Score:

Medical Coverage	Points	
- Private Insurance	81	
	S	M
- Private Insurance and Medicaid or WIC	54	67
- Medicaid	54	67
- Medicaid and WIC	54	67

Occupation Score:

Occupation	Points
- Secondary school teacher	98
- Corrections officer	93
- Graphic artist	88
- Travel agent	88
- Decorating consultant (interior design)	88
- Registered nurse (Bachelor's degree)	87
- Real estate marketing manager	86
- Department store marketing manager	83
- Insurance company health and disabilities manager	82
- Registered nurse (Associate degree)	77
- Secretary	76
- Sales clerk	63
- Office worker (clerical - non-secretarial)	41
- Hairdresser (cosmetologist)	40
- Housekeeping	36
- Certified nursing assistant	31
- Factory worker (trained furniture making and finishing)	29
- Factory worker (assembler)	28

Table 3.2 (cont'd)

- Day care worker	20
- Waitress (restaurant)	18
- Cook	16
- Janitor	16
- Fast food worker	16
- Restaurant worker (dishwasher - kitchen help)	06
- Farm worker (migrant farm work)	03
- No occupation	00

(Adapted from Nam-Powers 1983)

categories). The final score was then used to classify the socioeconomic level of the participant.

The socioeconomic status scores ranged from 20 to 90 and were grouped into four socioeconomic status (SES) levels (Table 3.3). It is not the purpose of this study to categorize the participants according to class, i.e., upper, middle, lower. Instead, the four SES levels were delineated so as to facilitate the evaluation of participant responses throughout the analysis of the data.

TABLE 3.3 - Participant Socioeconomic Status Levels

SES SCORES	SES LEVEL	ECCBE	CCBE	MCBE	TOTAL
0 - 40	I	1	2	10	13
41 - 60	II	2	7	6	15
61 - 80	III	4	6	0	10
81 - 100	IV	9	0	0	9
TOTAL		16	15	16	47

Language Pertaining to Childbirth

When asked the first question, "What do you think a woman ought to know about childbirth," several participants asked, "Do you mean labor

and delivery?" Others asked if it also included pregnancy and a few gave answers that pertained to child care rather than childbirth. When there was confusion about the question, I did clarify by adding, "What do you think women ought to know about pregnancy, labor, and delivery?" I included "pregnancy" in my answer to allow participants the freedom to talk about any aspect of childbirth that was of importance to them.

In their answers, some participants mentioned the "birth" but most spoke of labor and delivery and did not use the terms "birth" or "childbirth." The term "delivery" as opposed to "birth" or "childbirth" is commonly used by medical personnel and writers of childbirth education materials. Many of the books and magazines mentioned by the participants as sources of information speak of "labor and delivery." For instance, Nelson's (1995) article, "What Happens When Your Baby is Born" in Baby on the Way Basics discusses the stages of labor and physiological changes that occur during and after "delivery." Likewise, "The Three Stages of Labor" in Guide for Expectant Parents (Jamroz 1994) describes and shows detailed drawings of "the progress of labor and delivery." And, Eisenberg, et al. (1991) entitle a whole chapter "Labor and Delivery" in their book What to Expect When You're Expecting. The childbirth educators also commonly use the terms labor, delivery and birth in their classes. While some of these sources provide information that explains the treatments and care given during this time, the term "delivery" is used predominantly to describe the physiological final stages of labor, which includes the birth of the baby and the expulsion of the placenta. Therefore, because the terms "childbirth," "labor," "delivery,," and "birth" are commonly used interchangeably in written

and verbal discussions of the birth process, it is logical that the participants used them when discussing their views on childbirth and childbirth education. And since the term "delivery" is most commonly used, it is not surprising that the participants also used it the most.

The use of the term "delivery" can also have reference to the person or persons who will control the birth experience. In the dominant childbirth ideology this is most often the physician and other medical personnel involved in the birth. For some, this is a political issue of power and control in the birth experience. Although power and control issues will be explored in this study, in general, the use of the term "delivery" was not meant to imply any political aspects of control, but merely to describe the physiological changes, and the maternal experience of the birth process.

When speaking of the unborn developing baby, most health care professionals use the term "fetus"; however, none of the pregnant women in my study used this term. In an examination of the common literature, especially the books and magazines mentioned by the participants as their sources of information, I found varying uses of the term "fetus" or "fetal." The book <u>While Waiting</u> (Verrilli and Mueser 1981), mentioned by several participants, makes no use of the term "fetus." In its references to fetal development or fetal assessment, the term "your developing baby" or "your baby" is used. Other sources mentioned by participants, however, used "developing baby" and "fetus" interchangeably. <u>What to Expect When You're Expecting</u> (Eisenberg, et.al. 1991), the book most mentioned by participants, uses only the term "fetus" when labeling diagrams of fetal development. However, it also speaks of the "unborn baby," the "developing baby," or "your baby"

in other sections related to growth and development, diet in pregnancy, and prenatal assessment. The magazines Guide for Expectant Parents (1994) and Baby on the Way Basics (1995) also use the terms interchangeably when discussing fetal growth and development, diet, and prenatal assessment.

Several of the study participants spoke of wanting to know how the "baby was growing inside" or "if the baby [inside] was healthy," but none spoke of "fetal" growth and development, or "fetal" health, or "my fetus," even though they had been exposed to this term. Even the pregnant registered nurses who took part in the interviews spoke of the "baby" [inside] and not the "fetus." It does not seem surprising that the women would choose to talk of their babies rather than fetuses because a baby is a tangible, personable being whereas a fetus is more scientific and removed. It is possible that speaking of the "baby" as opposed to the "fetus" is not a specific rejection of the term but rather part of the identification and bonding process between the mother and her infant. This was not the focus of this study and will not be explored further. However, since the women commonly spoke of their unborn babies rather than the fetus, throughout this paper the terms "baby," "unborn baby," or "baby inside" will be used as the participants used them. The term "fetus" will be used only as necessary to denote the medical perspective or use of the term.

Methods of Data Analysis

If, as pointed out in chapter 1, the subordinate or working class is drawn into or absorbs the ideologies of the dominant class, these ideologies will be expressed in their conversation and their behavior. Their expressions will mimic those of the dominant class, who also

adhere to the dominant ideologies. Therefore, the level of acceptance of the dominant childbirth ideology of a medically controlled, technological, hospital delivery will presumably influence the way in which women talk about childbirth and their decision to take or not to take childbirth education classes.

To explore my study participants' incorporation or rejection of the dominant childbirth ideology, which includes childbirth classes that prepare women for a technological, medically controlled, hospital birth experience, I interviewed each pregnant woman using questions that correspond with the childbirth educator interviews. The data obtained help to determine the way the participants talk about childbirth and indicate the influence of the dominant ideology in their conversation and choice to take or not to take childbirth education classes.

I evaluated the data obtained in the interviews and observations by means of qualitative analysis. Bernard (1988:319) points out that "qualitative analysis--in fact, all analysis--is the search for patterns in data and for ideas that help explain the existence of those patterns." To determine patterns in the interview data, I first transcribed the interviews for content. I then categorized the content as it related to the study questions and research objectives. My analysis specifically focused on the questions pertaining to the participants' perceptions of what women ought to know about childbirth, what childbirth education is, and who or what influenced their decision to take or not to take childbirth classes.

To determine patterns, similarities, differences, and possible dominant ideology influences in the decision to take or not take childbirth classes, I compared the response categories according to the

respondents' age, education, SES, and participation or non-participation in childbirth education classes. I also compared the responses of the childbirth educators and the content of the childbirth classes to the participant responses to determine similarities or differences in perceptions, ideologies, or goals. The results of these analyses are discussed as they pertain to the influence of the dominant class childbirth ideology in the behavior and ideologies of the participants. Finally, based on these analyses, the possibility of culturally congruent childbirth education is explored.

Chapter IV

PARTICIPANT PROFILE: WHO TAKES CHILDBIRTH EDUCATION CLASSES?

Forty-seven women who were pregnant with their first child participated in this study. Sixteen participants were from the Education Center childbirth classes (the ECCBE group), fifteen from the two clinic sites who took classes (the CCBE group), and sixteen from the two clinic sites who did not take classes (the NCBE group).

Due to the Hospital policy regarding inclusion of minors in research, my sample was not as ethnically diverse as I had hoped it

TABLE 4.1 - Age of Participants by Clinic and Childbirth Education Group

Clinic/Group	YEARS OF AGE ≤ 19	20 - 24	25 -29	30 - 39	Total
EC Class	0	4 (25%)	6 (38%)	6 (38%)	16
PC Class	0	1 (33%)	2 (67%)	0	3
Hospital Clinic (CCBE)	3 (33%)	6 (67%)	0	0	9
Hospital Clinic (NCBE)	2 (20%)	7 (70%)	1 (10%)	0	10
Block Clinic (CCBE)	1 (33%)	2 (67%)	0	0	3
Block Clinic (NCBE)	2 (33%)	2 (33%)	2 (33%)	0	6
Total n	8 (17%)	22 (47%)	11 (23%)	6 (13%)	47

would be. However, the participants who volunteered from the education and clinic sites did provide a heterogeneous group by age (Table 4.1), education (Table 4.2) ethnicity (Table 4.3) and SES (Table 4.4).

TABLE 4.2 - Years of Education of Participants by Clinic and Childbirth Education Group

	Years of Education				
Clinic/Group	< 12	12	13 - 15	16	Total
EC Class	1 (6%)	3 (19%)	4 (25%)	8 (50%)	16
PC Class	0	1 (33%)	2 (67%)	0	3
Hospital Clinic (CCBE)	1 (11%)	3 (33%)	5 (56%)	0	9
Hospital Clinic (NCBE)	5 (50%)	4 (40%)	1 (10%)	0	10
Block Clinic (CCBE)	0	2 (67%)	1 (33%)	0	3
Block Clinic (NCBE)	3 (50%)	2 (33%)	1 (17%)	0	6
Total n	10 (50%)	15 (32%)	14 (30%)	8 (17%)	47

TABLE 4.3 - Ethnic Composition of Participants by Clinic and Childbirth Education Group

	ETHNIC IDENTIFICATION					
Clinic/Group	White Non-Hispanic	African American	Hispanic	Asian American	Native American	Total
EC Class	14 (88%)	1 (6%)	0	0	1 (6%)	16
PC Class	2 (67%)	0	0	1 (33%)	0	3
Hospital Clinic (CCBE)	6 (67%)	0	2 (22%)	0	1 (11%)	9
Hospital Clinic (NCBE)	7 (70%)	1 (10%)	2 (20%)	0	0	10
Block Clinic (CCBE)	2 (67%)	0	1 (33%)	0	0	3
Block Clinic (NCBE)	2 (33%)	3 (50%)	1 (17%)	0	0	6
Total n	33 (70%)	5 (11%)	6 (13%)	1 (2%)	2 (4%)	47

TABLE 4.4 - Socioeconomic Status of Participants by Clinic and Childbirth Education Group

	SOCIOECONOMIC STATUS				
Clinic/Group	Level I	Level II	Level III	Level IV	Total
EC Class	1 (6%)	2 (13%)	5 (31%)	8 (50%)	16
PC Class	0	1 (33%)	2 (67%)	0	3
Hospital Clinic (CCBE)	2 (22%)	4 (45%)	3 (33%)	0	9
Hospital Clinic (NCBE)	7 (70%)	3 (30%)	0	0	10
Block Clinic (CCBE)	0	2 (67%)	1 (33%)	0	3
Block Clinic (NCBE)	3 (50%)	3 (50%)	0	0	6
Total n	13 (28%)	15 (32%)	11 (23%)	8 (17%)	47

The ages, years of education, and socioeconomic status of the participants were compared to determine possible patterns among the women who took and did not take the classes. The participants ranged in age from 18 to 36 years. Their education levels ranged from 8 to 16 years of schooling. The SES levels of the participants ranged from I to IV. In all of these categories, there were some identifiable trends and differences among the three study groups in their responses and childbirth education decisions. In this section I will discuss the trends and differences as they relate to the participants' childbirth education decisions. Discussion of the participant responses is presented in chapter VI.

Age and Childbirth Education Decisions

The studies of Davis and Morrone (1962), Leonard (1973), Watson (1977), and Huttel, et al. (1972) found that participation in childbirth education increased as the age of the women increased. In my study,

comparison by age (Table 4.5) of the combined (ECCBE and CCBE) childbirth educated participants with the NCBE participants indicates that those who chose to take classes also tended to be older (mean age 24.64 years) than those who did not take classes (mean age 21.31 years).

TABLE 4.5 - Comparison of the Combined Childbirth Educated Group and the Non-Childbirth Educated Group by Age

Age	Combined CBE	NCBE	Total
≤ 19	4 (13%)	4 (25%)	8 (17%)
20 - 24	13 (42%)	9 (56%)	22 (47%)
25 - 29	8 (26%)	3 (19%)	11 (23%)
30 - 39	6 (19%)	0 (0%)	6 (13%)
Total n	31 (66%)	16 (34%)	47 (100%)
Range	18 - 36	18 - 27	
Mean score	24.64	21.31	

However, as can be seen in Table 4.6, the comparison of age among the three individual groups in my study did not fully support the supposition that the older the woman the more likely she will be to take childbirth classes. Participants who took the classes in the Education Center (the ECCBE group) were older (mean age 27.93 years) than both the childbirth educated (CCBE) and the non-childbirth educated (NCBE) participants selected in the prenatal clinics. Comparison of the two clinic groups (CCBE and NCBE) indicates that there is no significant difference in age among those who took classes (mean age 21.13 years) and those who didn't (mean age 21.31 years).

This finding suggests that age alone is not a pivotal factor in women's decision to take or not take childbirth classes. It also

TABLE 4.6 - Comparison of the Two Childbirth Educated Groups and the Non-Childbirth Educated Group by Age

Age	ECCBE	CCBE	NCBE	Total
≤ 19	0 (0%)	4 (27%)	4 (25%)	8 (17%)
20 - 24	4 (25.0%)	9 (60%)	9 (56%)	22 (46.5%)
25 - 29	6 (37.5%)	2 (13%)	3 (19%)	11 (23.5%)
30 - 39	6 (37.5%)	0 (0%)	0 (0%)	6 (13%)
Total n	16 (34.5%)	15 (31.5%)	16 (34%)	47 (100%)
Range	21 - 36	18 - 25	18 - 27	
Mean score	27.93	21.13	21.31	

further supports the idea that many factors affect the childbirth education choice. Education and SES, degree of acceptance of the dominant childbirth ideology, and other internal and external factors are among the other influences in women's childbirth education decisions.

Education and Childbirth Education Decisions

The relationship between a woman's years of education and her decision to take or not take childbirth classes appears to be a stronger factor than age. Davis and Morrone (1962), Leonard (1973), Watson (1977), and Huttel, et al. (1972) found that women's decision to take childbirth classes increased as their years of education increased. This was also evident in my study. Comparison of the combined (ECCBE and CCBE) childbirth educated group with the NCBE group (Table 4.7) shows that those who chose to take classes had more education (mean 13.61 years) than those who chose not to take classes (mean 11.31 years).

TABLE 4.7 - Comparison of the Combined Childbirth Educated Group and the Non-Childbirth Educated Group by Years of Education

Years of Education	Total CBE	NCBE	Total
< 12	2 (6%)	8 (50%)	10 (21%)
12	9 (29%)	6 (38%)	15 (32%)
13 - 15	12 (39%)	2 (12%)	14 (30%)
16	8 (26%)	0 (0%)	8 (17%)
Total n	31 (66%)	16 (34%)	47 (100%)
Range	10 - 16	8 - 15	
Mean score	13.61	11.31	

Comparison of the three individual groups, ECCBE, CCBE, and NCBE (Table 4.8), also shows the relationship between increased years of education and childbirth education choice. The years of education was highest for participants from the Education Center. The ECCBE group had a mean score of 14.37 years of education which was higher than either the CCBE (mean 12.80 years) or NCBE (mean 11.13 years) groups. However,

TABLE 4.8 - Childbirth Education Participation by Years of Education

Years of Education	ECCBE	CCBE	NCBE	Total
< 12	1 (6%)	1 (7%)	8 (50%)	10 (21%)
12	3 (19%)	6 (40%)	6 (38%)	15 (32%)
13 - 15	4 (25%)	8 (53%)	2 (12%)	14 (30%)
16	8 (50%)	0 (0%)	0 (0%)	8 (17%)
Total n	16 (34%)	15 (32%)	16 (34%)	47 (100%)
Range	10 - 16	11 - 15	8 - 15	
Mean score	14.37	12.80	11.31	

the CCBE participants who chose to take classes also had more years of education (mean 12.80 years) than the NCBE group (mean 11.31 years) who chose not to take classes. Though not the only factor, a woman's level of education does appear to influence her childbirth education decision.

Socioeconomic Status and Childbirth Education Choice

The studies of Davis and Morrone (1962), Huttel, et al. (1972), Leonard (1973), and Watson (1977) indicated that the decision to take childbirth classes increases as SES increases. Socioeconomic status (SES) also appears to be an influencing factor in my study participants' childbirth education decisions. Socioeconomic status levels I and II are represented in all three study groups. Socioeconomic status level III is found in both the ECCBE and CCBE groups. However, SES level IV is seen only in the ECCBE group (Table 4.9). Since education and SES are closely related, it is not surprising that participants with the highest SES were in the ECCBE group which also had the highest education levels (Table 4.8). The mode SES level (Table 4.8) for both the ECCBE group (mode = IV) and the CCBE group (mode = II) was higher than that of the NCBE group (mode = I) (Table 4.9).

All of the participants who had SES levels of III or IV chose to take the childbirth education classes. The relative frequency table (Table 4.9) shows that a higher percentage of the total study participants with SES level I chose not to take childbirth classes, whereas, among those with SES level II, more chose to take classes. This suggests that the choice to take childbirth classes is associated with socioeconomic status.

TABLE 4.9 - Childbirth Education Participation by Socioeconomic Level

SES Level	ECCBE	CCBE	NCBE	Total
I	1 (8%)	2 (15%)	10 (77%)	13 (27%)
II	2 (13%)	7 (47%)	6 (40%)	15 (32%)
III	5 (45%)	6 (55%)	0 (0%)	11 (23%)
IV	8 (100%)	0 (0%)	0 (0%)	8 (17%)
Total n	16 (34%)	15 (32%)	16 (34%)	47 (100%)
Range	I - IV	I - III	I - II	
Mode	IV	II	I	

A total of 25 out of the 31 combined (CCBE and NCBE) clinic participants had SES levels of I or II. To determine the significance of the fact that all of the NCBE participants had an SES level of II or below, a binomial test was done. The probability score for this test was 0.032 which indicates that it is significant that all of the NCBE participants had an SES level of I or II. Six out of the 31 clinic participants (19.4%) had a SES level of III. To further test the probability that nine or fewer of the CCBE participants would be in the SES levels I or II, another binomial test was done. The resulting score was approximately 0.06 which, together with the previous result, indicates that it is significant that nine of the CCBE participants have lower socioeconomic status. While these results are limited because of the small sample size, they do indicate that women with lower SES are less likely to chose to take childbirth education class.

Broad generalizations from the total data are limited because no women were included in the study who were older, had more education or higher socioeconomic scores but had not taken classes. Women in these

categories do not attend the clinics for prenatal care, and participants were not sought in private physicians' offices.

In order to estimate the percentage of private physicians' clients who participate in childbirth education, I asked nurses in two different physicians' offices how many of their clients took childbirth classes. In both cases the nurses gave a similar rough estimate. They said that approximately 90 percent of all their clients took some form of childbirth classes, either Lamaze, Bradley, or Hospital based courses. Those who did not take the classes were predominately the very young teenagers, seventeen years or under, multiparas who had taken classes in previous pregnancies, single women who did not have support from family or the baby's father, and a few who worked full-time and were unable to schedule the time for the classes. While this information is not conclusive without more accurate and detailed investigation, it does appear to give some support to the hypothesis that women who are older, have more education, and higher socioeconomic status are more likely to take childbirth classes. Support from the family also appears to be a factor that affects decisions regarding childbirth education. This issue will be considered further in chapter VI.

Medical Coverage and WIC Participation

While medical coverage was used only for the purposes of determining the SES level of the participants, it may also be a factor that influences the childbirth education choice. Thirty-six percent of the study participants had private insurance; the rest were covered by Medicaid (Table 4.10). All but one of the Medicaid participants also received WIC. All of those who had private insurance attended the childbirth classes. Half of the participants who had Medicaid chose to

participate in the childbirth classes, while the other half declined the classes.

TABLE 4.10 - Childbirth Education Participation by Medical Coverage

MEDICAL COVERAGE	ECCBE	CCBE	NCBE	Total
Insurance	14 (30%)	3 (6%)	0 (0%)	17 (36%)
Medicaid	2 (4%)	14* (30%)	16 (34%)	32 (68%)*
Total	16 (34%)	17* (36%)	16 (34%)	49* (104%)*

* Note: two of these participants have both medicaid and Insurance

Women who have private insurance, or who can otherwise afford to cover the cost of childbirth education, have a broader choice of classes to choose from and are more likely to take them. Women who have Medicaid or no health care coverage are very limited in their choices for childbirth education, unless they have some other source to pay for their classes. The Education Center and Prenatal Clinic classes do accept the amount that Medicaid will pay for childbirth education, but other classes, such as Bradley or Lamaze, are more expensive and will not accept Medicaid payment (Childbirth Educator, personal interview, 12 December 1993). A woman who prefers to take classes outside of the hospital, but who cannot because of her medical coverage or lack of funds to pay required fees, may opt to take none at all. Some women may feel that the hospital classes are condescending when they accept Medicaid payments which are less than the amount other participants pay, and thus will not take them. Others may accept the fact that Medicaid will pay for classes and will attend. Although it was used specifically as one of the factors in determining the SES level for participants in

this study, medical coverage itself may influence a woman's childbirth education decision and should be considered in more detail in future studies of factors that influence childbirth education choice.

Ethnicity and Childbirth Education Decisions

Women from several ethnic groups participated in this study (Table 4.11). The age limitation for study participants (18 years or older) was a hindrance to the inclusion of several African American women. A few women from other ethnic groups were unable to participate in the study because they could not speak English. Though the majority of the participants are White Non-Hispanic, the small sample from other ethnic groups does provide some ethnic variation to the total participant group.

TABLE 4.11 - Ethnic Composition of Study Participants

Ethnic Identification	ECCBE	CCBE	NCBE	Total
White Non-Hispanic	14	10	9	33 (70%)
African American	1	0	4	5 (11%)
Hispanic	0	3	3	6 (13%)
Asian American	0	1	0	1 (2%)
Native American	1	1	0	2 (4%)
Total Respondents	16	15	16	47 (100%)

Marital Status and Childbirth Education Decisions

A total of 31 study participants took childbirth classes. Fifty-eight percent (18 out of 31) were married (Table 4.12). In the ECCBE group alone, more were married (12 out of 16 or 75%) than single (25%). However, in the CCBE group more single (9 out of 15 or 60%) than married (6 out of 15 or 40%) women participated in the classes.

The number of single women attending the clinics for prenatal care may be a factor in the higher number of single women in the CCBE group. Over a four-day sample period of observation, a total of 92 pregnant women were seen in the Prenatal Clinic. Of these, 26 were primigravidas and 66 were multiparas. Seventy-two (78%) of the women were single (21 primigravidas and 51 multiparas). With this percentage of single women participants in the prenatal clinic, it is not surprising that the number of single childbirth class participants is also higher than the married participants. However, when the CCBE and the NCBE are compared it is obvious that more married women (6 out of 8, or 75%) chose to take classes. More single women (14 out of 23 or 61%) chose not to take classes (Table 4.12).

TABLE 4.12 - Childbirth Education Participation by Marital Status

Marital Status	ECCBE		CCBE		NCBE		Total
Married	12	(75%)	6	(40%)	2	(12.5%)	20
Single	4	(25%)	9	(60%)	14	(87.5%)	27
Total Respondents	16	(34%)	15	(32%)	16	(34%)	47

Most childbirth education programs emphasize the participation of the woman and her coach in the labor and delivery experience. In the early childbirth courses such as those established by Grantly Dick Read (1944) and Bradley (1965) the expected relationship between the woman and her coach was that of husband and wife. Even in some of the current written childbirth information such as What To Expect When You're Expecting (Eisenberg 1991) the emphasis is still on the marital relationship. Some single women, or their partners, may feel threatened

by the emphasis on the husband and wife relationship, and thus decide against taking classes, even though the childbirth educators are perceptive and do not refer to the coaches as "husbands." This did not seem to be a problem, however, for the single women in my study who participated in childbirth classes.

None of the childbirth education studies that I reviewed specifically looked at marital status as an influencing factor in women's childbirth education choices. Leonard (1973) included only married women in his study. Huttel, et al. (1972) made no distinction between married and single women in their research. Watson (1977) also selected only married couples for her study and, though Davis and Morrone (1962) speak specifically of certain characteristics of "the mother and the father," they do not differentiate between married and single couples. McCraw and Abplanalp (1982) interviewed 77 primigravid volunteers from Lamaze classes. Of these, 72 (94%) were married. While it appears that the majority of women choosing those particular Lamaze classes were married, it is not stated as such in the study. It could have been that the married women attending were more willing to take part in the study, or the researchers may have been biased toward including more married than single women. Also, marriage itself was not looked at as a motivating or influencing factor in the participants' choice to take the classes.

Some of the studies on barriers to prenatal care give mixed information about differences between married and unmarried women. For instance, Taffel (1978) found that 16 percent of the single women who gave birth in 1975 initiated their prenatal care in the third trimester of their pregnancy, whereas only 4 percent of married women began their

care late in the pregnancy. In the Sable, et al. (1990) and Scupholme, et al. (1991) studies, more single than married women received inadequate prenatal care. However, Poland, et al. (1987) found no significant differences in the initiation of prenatal care according to marital status, but there was a trend for married women to receive better care.

Goldenberg, Patterson, and Freese (1992) and McCormick et al. (1989) suggest that it is the relationship between the man and the woman and not specifically the marital state that is the influencing factor in seeking early prenatal care. It may also be the case that women in strong relationships with the fathers of their babies are more likely to choose to take childbirth classes. If this is so, it could explain the high number of single women in the CCBE group. However, not all of the single women in my study had such relationships.

Among the thirteen single women who took the childbirth classes, six were not in stable relationships with the fathers of their babies. One had just finalized a divorce from her husband and had attended the classes with a girlfriend who was planning to be her labor coach. Two of the women had close relationships with their own mothers and attended childbirth classes with them. Kelli, one of the participants from the ECCBE classes, did not have a strong relationship with the baby's father but did have contact with him. He attended the classes with her, but she didn't think, "he would be around when she had to go into the hospital." Two women who attended the PC classes without partners had a minimal relationship with the fathers of their babies. The other single participants either lived with their baby's fathers or were planning to marry soon after their babies were born.

A close and supportive relationship with the father of the baby in either the married or single state may be an influencing factor in women's childbirth education choices. However, it may be that a strong, supportive relationship with anyone may be the factor. A larger study with more precise information concerning women's relationships and support systems and their choice in childbirth education needs to be done to confirm the trend seen in this study for single women in varying relationships to choose to take childbirth classes.

Chapter V

CHILDBIRTH CLASSES AND EDUCATORS

As a participant observer, I attended four Education Center (EC) and two Prenatal Clinic (PC) childbirth class series and interviewed the five childbirth educators who taught the classes. In each class I listened to the lectures, watched the films, got down on the floor with the participants and did the relaxation and breathing exercises. The women seemed to enjoy the fact that I was actually doing what they did, even though I was not pregnant and had no expectations of actually going through labor and delivery. We practiced together, laughed with each other, and complained about the cold hard floor and uncomfortable chairs. Actively taking part in the classes helped me establish rapport with the participants.

Education Center Childbirth Classes

The EC classes were held in small classrooms in a building across the street from City Hospital. One of the classrooms was decorated with pretty wall paper and had large windows covered with cream-colored curtains that were difficult to see through. The other classrooms had painted walls decorated with a few pictures. All of the classrooms were carpeted, and all had hard straight-backed stackable chairs for the participants to sit on. In each classroom the chairs were arranged in a

semicircle around the room. At the head of the circle in the front of the room there was a chalk board, a table, a chair, an overhead projector, and audio and video playback equipment. The rooms were cramped and crowded, especially when the participants were practicing together on the floor. Each of the educators acknowledged the less-than-comfortable conditions and explained that new classrooms were being built. Each of the participants brought several pillows with them and tried to make the most of the situation. When I interviewed the EC participants from the observed classes, six out of the sixteen (38%) stated that the only thing they would have changed in their class was to have larger rooms with more comfortable chairs and more padding on the floors.

In the foyer of the Education Center building the participants could pick up various handouts and samples. On one end of a large table near the entrance to one of the classrooms copies of Lamaze, Baby Talk, Parents, Baby on the way Basics, and Childbirth magazines, along with pamphlets on various aspects of pregnancy, labor and delivery, and copies of poster pictures used in the classes were stacked in neat rows, free for the taking. Samples of disposable diapers, baby shampoo, soap, and other items, as well as various advertisements and coupons, could be picked up as desired from the other end of the table. Each participating couple was also given a copy of the book To Have And To Hold (Kieffer 1992), which was used as the text for the course.

Each class session followed essentially the same format. In the first class session the educator introduced herself and then had each woman introduce herself and her partner. In succeeding classes the educator took roll at the beginning of the session. The classes I

observed were attended by six to nine married and unmarried couples. In one of the classes, one couple was composed of a pregnant woman and her girlfriend, the rest were male-female dyads. Although not specifically asked to do so, each woman introduced her partner as her husband, fiance, boyfriend, or, as in the one case mentioned, girlfriend. None of the women introduced her companion simply as her "partner" or "coach". The educators were sensitive to the fact that not all of the participants were married and consistently referred to the supporting person as partner or coach, and not as husband. It did appear, however, that all of the couples portrayed in the videos were married. Though this was not a big issue in the films and not specifically mentioned in the dialogue, each of the partners shown were male and female with obvious wedding rings on their fingers. The commentary in the films spoke of the support person as coach or partner and not specifically as husband.

The first hour of each class consisted predominately of lectures, demonstrations, and videos or slide presentations. Information given in previous classes was briefly reviewed and participants' questions or concerns were addressed. Occasionally the educator would review relaxation techniques in the first hour and have the participants practice, but, in general, this time was used for the presentation of new information.

During the second hour, after a short break, the educators concentrated mainly on the teaching and practice of relaxation techniques, comfort measures, and breathing patterns used during the different stages of labor. The educator discussed and demonstrated comfort measures such as back rubs, effleurage (soft, gentle stroking of

the abdomen), low back pressure, and application of hot or cold water bottles. In some of the classes soft music was played on the tape recorder while participants were taught general relaxation techniques. To complement their explanation and demonstration, the instructors drew diagrams of contractions and breathing patterns on the chalk board. One or two breathing patterns were taught each week for a total of five different patterns. By the last week of classes, the participants were practicing all five patterns. Moving to the floor with their pillows and their partners, the couples practiced the relaxation and breathing techniques while the educator directed, observed, and helped them. Occasionally other lecture material was presented during the second hour and videos were shown, but the major focus was on comfort measures and breathing and relaxation techniques.

In all of the EC class series a general content outline was followed. In the first session the course and its benefits were introduced and explained. Each educator discussed how fear and tension lead to and increase pain and how pain can be controlled through knowledge, confidence and relaxation. The main object of the course, according to the educators, was to help the women know what to expect and prepare them to cope with labor, delivery, and the care of themselves and their newborn after the birth.

The foundation having been laid in the first session, the rest of the course content followed a fairly logical progression. With the use of large picture posters, dolls with detachable cloth models of the umbilical cord and placenta, plastic models of the pelvis, knitted models of the uterus, and chalkboard drawings, the anatomy, physiology and medical care routines in the third trimester of pregnancy, labor,

and delivery were explained and demonstrated. In each class session, medical terms were clearly defined in common language that the participants could understand. Each of the educators I observed encouraged the class participants to ask questions and answered them using familiar words, uncomplicated pictures, or simple diagrams. If the participant still did not understand an explanation, the educator would try again or ask the person to talk with her after class. Effort was made to help participants understand the content that was being presented, but there were no tests or other measurements given to actually assess their learning. It could only be assumed that they understood if they did not look confused or did not ask questions. Of course, such an assumption is not valid. The educators tried to validate participants' understanding by asking them questions and giving them time to respond during review periods. At that time, the educators reinforced appropriate answers and tried to clarify and correct wrong or different answers or ideas.

The class content covered pregnancy (especially the third trimester), labor, delivery, and postpartum. Information was given on nutrition; safety, such as how to place a car seat belt in the last trimester of pregnancy; usual discomforts in pregnancy and measures for relief; danger signs and when to notify the physician; common tests in pregnancy; sex during pregnancy; movement, posture and exercises. In most of the classes, exercises were demonstrated by the educator and practiced by the participants.

The stages of labor and the physical changes that occur were discussed in detail. False labor (Braxton Hicks contractions), signs of impending labor, and signs of true labor were presented. Emotional and

psychological changes that occur in pregnancy and during labor and delivery were addressed. Participants were taught what to do and what not to do when labor begins, such as what to eat or drink, when to phone the physician, when to come to the hospital and what to do when they arrive. Coaches were given instruction in physical and emotional support of their partner including the use of items in their "goodie bag" (a bag prepared ahead of time that contains such items as candy suckers, water bottles, pillow, vaseline, tape recorder and relaxation music tapes, lotion and powder, reading material, camera and film, other comfort items they may want to bring, and lunch for the coach).

The delivery process was carefully explained, and videos portraying actual women in labor and delivery were shown. By the end of the course, the participants had witnessed several vaginal births depicted in the various videos. The hospital policies and medical management of labor and delivery were clearly delineated. Admission procedures and hospital routines were described. The need for and use of external and internal fetal monitors, intravenous fluids, oxygen, blood pressure monitoring, common tests and treatments that may be performed during labor, positions in labor and delivery, and episiotomies (a small perineal incision made to facilitate the delivery of the baby) were discussed and in some cases demonstrated (i.e., the instrument used for breaking the bag of waters, called an amnihook, and the electrodes used for internal fetal monitoring were demonstrated on a model and then passed around for each participant to see). The various types of analgesics and anesthetics available for use were also presented, including when they could be used, their action, safety, and possible

side effects to mother and baby, as well as things that could be done to minimize or counteract such problems should they occur.

The educators presented the facts without contention; however, some biases were inadvertently alluded to. For instance, analgesics and anesthetics were neither specifically encouraged or discouraged. They were presented simply as being available if needed and wanted. However, the issue of epidural anesthesia was more difficult. Some educators, through their own experience with epidural anesthesia, stressed the comfort benefits during labor and delivery. Others were more cautious about the procedure and more reserved in their presentation, focusing slightly more on the side effects for mother and baby that could occur during epidural administration. However, none of the educators overtly tried to influence any participant's decision to use or not use any of the available analgesics or anesthetics. All of the educators encouraged the participants to discuss the use of analgesics and anesthetics with their doctors before they went into labor to prevent confusion, disagreements, possible surprises, or disappointment during their labor and delivery experience.

Since a normal, uncomplicated delivery is the expected outcome for every pregnancy, the course content focused mainly on normal labor and delivery. However, not all births are normal, and this fact was not withheld. Induction of labor through the use of prostaglandins or intravenous oxytocin was briefly discussed, including indications for induction of labor, procedures involved during induction, differences in contractions and progress of labor with induction. Possible side effects from the induction of labor or debates concerning the advisability of labor stimulation were not specifically discussed. It

was, however, stressed that continuous electronic uterine and fetal monitoring and frequent checks of the mother's blood pressure would be done to assure that labor was progressing without complication for mother or baby. Interestingly, the participants seemed to accept this information and did not ask questions concerning its safety or potential side effects.

Complications leading to the need for Cesarean Section were also briefly presented. Problems such as malposition (breech, shoulder, brow, transverse positions), cephalopelvic disproportion (a pelvis that cannot accommodate the passage of the baby's head), cord prolapse (the cord drops into the birth canal before the baby's head leading to cord compression), abnormalities in the baby's heart beat indicating stress, or failure to progress in labor were mentioned as major indicators for surgical delivery. The preparation procedures and anesthetic administration for Cesarean Section was described, and either a video or slide presentation depicting an actual Cesarean Section birth was shown. Care, pain relief, and recuperation after surgery were also discussed.

During the last class session a small amount of time was allotted to care of the mother and infant after birth. Involution (the shrinking of the uterus back to its pre-pregnant size), changes in the color and amount of vaginal flow, care of the episiotomy, breast care and feeding were briefly discussed. Characteristics of the newborn and care at birth, such as suctioning, administration of oxygen, administration of eye drops and vitamin K (to assist the baby's blood clotting mechanism), first bath and feeding were explained. In some of the classes, breast feeding, holding, diapering and dressing the newborn were demonstrated

and practiced on newborn baby dolls. In other classes these were merely discussed or demonstrated by the educator.

In the last class session, following the postpartum maternal and infant care lesson, the total class was taken on a tour of the hospital and the obstetrical units. The participants were shown where to enter the hospital and how to get to the admission desk in the labor and delivery suite. They were taken into the triage room and shown the equipment that would be used to assess their labor status at the time of admission. They were allowed to explore a birthing room and to see where the equipment needed for the labor and delivery was kept. They were taken to the postpartum floor and shown the nursery and a typical postpartum room. Though not allowed to go in, they were also shown the surgical and recovery room suites. They were able to see the fetal monitor screens and meet some of the doctors and nurses working in the monitor stations. By the end of the tour they had a good idea of where to go and what to expect while in the labor, delivery, and postpartum units. At the completion of the tour, the educator allowed time for questions and comments, then wished them all "good luck," and the class was concluded.

Each EC educator followed the same content outline for her classes and used the same models, videos, and slide presentations, as well as the same diagrams, explanations, and demonstrations of the breathing and relaxation techniques. However, each educator had her own unique way of presenting the information. Some were very vivacious, walked about the classroom as they taught, told jokes, and encouraged a lot of class discussion. Others were more reserved and matter of fact in their presentation. One educator, who was very reserved and more controlling

of the class progression, sat on a chair at the head of the circle and carefully followed the teaching outline lying on her lap. However, as did the other educators, she walked around to monitor and help the couples during their breathing and relaxation practice. Another educator used a combination of sitting, standing, and walking about the classroom in her presentation, but she too was reserved. All of the educators encouraged the class participants to ask questions or raise issues of concern, and all were honest in the answers they gave. If they did not know the answer to a question, they found the answer during the week and presented it to the class at the next session.

Prenatal Clinic Childbirth Classes

I attended two Prenatal Clinic (PC) childbirth classes, each class consisting of three weekly sessions. Normally the classes were scheduled for four weekly sessions, but occasionally these were condensed into three sessions when conflicts for classroom use or other Clinic related demands on the educator occurred. The educator was very flexible and was able to cover all the information in three weeks; however fewer videos were shown, and time allowed for participants to practice the relaxation and breathing techniques was shortened considerably.

The classes were held in a small conference room adjacent to the Clinic waiting room. This area also served as the lunchroom for the Clinic staff. Near the entrance of the classroom was an adjoining staff locker and coat room. Occasionally during a class session a staff worker would come into the locker room, momentarily distracting some class participants.

At the end of the room opposite the entrance were a sink, counter top, storage cabinets, and a microwave oven. On the wall adjacent to the sink stood a large bookcase stocked with childbirth education materials, including pamphlets, magazines, pictures, video tapes, and sample items. Next to the bookcase was a large storage closet that contained the models, video tapes, posters, booklets, and other items the educator used for teaching. A television and video playback equipment sat on a movable stand that stood near the sink. On the wall opposite the sink near the entryway was a large chalk board. A long table stood in the middle of the room, around which stackable chairs were placed. The room was very cramped and crowded. The floor was tiled, and there was no room for the participants to stretch out and practice the relaxation and breathing techniques. When they did practice, they remained sitting around the table on their chairs.

The educator in the PC classes is one of the registered nurses who works in the City Hospital Prenatal Clinic. As a staff nurse in the PC she was able to encourage clients to take childbirth classes. Depending on convenience and schedules, some who chose to take the classes attended those offered by the PC, while others chose to take the EC classes. Women who had no partner or coach were more likely to take the PC classes. Coaches were invited and encouraged to come to the PC classes, but a woman was not disadvantaged if she attended without a partner.

The class size varied for each session and ranged from one couple to four couples and one or two lone women. As in the EC classes, some of the participants were married and some were not. And, unlike the EC classes, women participated without partners.

At the beginning of the first class, the educator told me that the class was not totally organized the same for each session. I wondered about such a seemingly lack of unified organization, but during the course of observing the class sessions I came to understand why she taught the classes as she did. Unlike the formal classes in the EC, the PC classes may or may not be attended consistently by the same participants each week, even though the classes were set up as a four-session unit. By being flexible in her presentations, the educator could meet the major teaching needs of each class participant each week. Thus, in each session, material presented in former sessions could be taught as review for returning participants while being taught as new material for new participants. New material for all of the participants could be added after the review. While this system did lead to repeated information from class to class, it also reinforced that information and the participants did not appear to object to the repetition. In fact, one couple attended five of the six classes that I observed. When I asked about it, they told me they enjoyed the classes so much they just wanted to come back and hear it all again. This couple already had one child by Cesarean Section and were planning to try a vaginal delivery for this birth. The educator made notes on the material covered in each session so that she would not overlook or forget important information. Over the course of the two class series that I observed, the educator covered the same material in the three weekly sessions that was covered in the EC classes, even though it was not in the same organized manner or taught in five weekly sessions.

Although the PC classes contained the same information as that taught in the EC classes, there were some differences. Since the PC

classes were small, there was a closer relationship between the educator and her students. She presented the information quickly, and sometimes in great detail. She used many visual aids in her teaching, including posters, pictures in books and magazines, diagrams that she drew on the chalk board, videos, and flip charts. She did not use a specific text for her teaching as did the EC educators but did use pictures and information from copies of magazines, such as Lamaze and Baby on the way Basics that the class participants had received. She also gave the participants individual copies of the poster pictures that she used in her presentation and printed handouts of easy-to-read information and directions for such things as items to put in the "goody bag," the signs of labor, when to call the doctor, and other helpful information.

The PC class educator spent less time on the relaxation and breathing demonstrations and practice than did the EC educators. She taught the class how to use a focal point, explained the relaxation techniques and gave them a few moments to practice. She diagrammed the five types of breathing on the chalk board, and, after a brief demonstration, had each woman and her partner, if present, practice a few times while sitting on their chairs. She acknowledged that this was not the ideal way to practice and encouraged them to practice several times a day at home. She also encouraged them to share with her any questions or problems they might be having with the techniques when they returned to class the next week or when they came for their normal clinic visit.

While less time was spent on breathing and relaxation techniques, considerably more time was spent on feeding and care of the infant. The educator discussed breast feeding and its advantages in great detail.

Using a newborn baby doll, she demonstrated the various ways to hold a baby while breast feeding and discussed techniques for inserting and removing the breast from the baby's mouth. She also demonstrated various methods for burping a baby after breast or bottle feeding.

For those women who were not specifically planning to breast feed, the PC class educator presented information about bottle feeding, including the proper way to clean bottles, nipples and caps, how to prepare various types of formula, and how to hold the baby while bottle feeding. She discussed the dangers of leaving the baby alone with a propped bottle and discouraged them from this practice. She also told them where formula could be most cheaply purchased.

Detailed baby care was also included in the PC classes. The educator explained what newborn babies look like and how they change over the first few days and weeks. She discussed eye, cord, and skin care, diapering, how many and what type of stools to expect according to the type of feeding, and how many times a baby should pass urine if he or she is taking enough breast milk or formula.

In the EC classes observed, the tour of the hospital was reserved for the last night of classes during the last hour. In the PC classes the tour was given during the second week of the class. The educator explained that she did this for two reasons: one, the participants often do not attend all four classes and she felt the tour was too important to leave to the last class; and two, touring the hospital would give the participants an even better understanding of the rest of the class content, especially when she discussed the hospital routines and the medical care during labor and delivery.

Most of the videos shown in the PC classes were the same as those shown in the EC classes, but some were different. One of the videos, entitled "Teens Having Babies," was not used in the Education Center classes. This film depicted teenage women attending classes and going through labor and delivery. These women, representing various ethnic groups, were portrayed with partners who were not obviously their husbands. Some of the couples shown were composed of two women while others were composed of a man and a woman. One couple was African American, another was a white woman and an African American man, another was Hispanic, while other couples were white. The emphasis of the film was on the physical mechanisms and the team work of the couple during the labor and delivery process. The gender or relationship between the team members was not an important factor. This film also used very common terms rather than medical jargon that needed to be explained. For instance, the term "pee" was used rather than urinate, and when describing the episiotomy, the term "cut" was used rather than "incision." The content of the film was very clear and easily understood. The films shown in the EC classes tended to use more medical jargon (though in most of them the terms were clearly explained), and all of the couples, also representing various ethnic groups, appeared to be older and were male-female dyads.

Since the PC classes were small, the educator was able to involve the participants more in the presentation of the material. She often questioned them to find out what they actually knew about the subject before she gave her explanations or showed a video. She also encouraged questions and discussion following videos and presentations. Individual learning styles and needs could be more easily identified and responded

to in these small classes. This educator also had the advantage of knowing the class participants from their visits to the prenatal clinic, which tended to promote good rapport.

The Childbirth Educators

Each of the EC educators were registered nurses. Two had Bachelor's degrees in nursing, one had a Diploma in nursing, and one had an Associate Degree in nursing. One had completed the teacher certification in the American Society for Psychoprophylaxis in Obstetrics (ASPO) childbirth education program. Another was an experienced lactation instructor, who also worked in the hospital as a consultant to help newly delivered mothers who were having problems with breast feeding.

All of the educators had worked in the labor, delivery, newborn, and postpartum areas in the hospital's obstetrical unit. All were married, had given birth, and had children of various ages in their homes. With the exception of the ASPO prepared educator, each had been taught how to teach the childbirth classes through apprenticeships and confirmation of teaching competency with an experienced childbirth educator in the EC. Some of the educators worked a few days a week in the Hospital obstetric unit, but for most, teaching was their only present occupation.

The EC educators were given a teaching outline that each must follow in their classes. The content of the outline was developed by the Director of the Education Center and a committee composed of supervisor nurses and physicians from the hospital obstetrical unit. The childbirth educators could occasionally make unified changes in the content, but, in general they structured their classes to meet the

established content outline. Each was free to use her own teaching methods as long as all of the content in the outline was covered. Each educator used the same videos, slides, overhead and chalk board illustrations, posters, charts, and textbook. If for some reason an educator had to miss a class session any of the other instructors could easily substitute-teach, even on very short notice. This system assured that all of the EC participants received the same information and that the information was factual and up-to-date with current hospital expectations and practices.

The registered nurse who taught the PC classes had a Master's degree in Health Education. She was also married and had several children. She had experience working in the hospital's obstetrical unit and had taught obstetrical nursing in the hospital's school of nursing diploma program before it closed. For her, teaching the childbirth classes was an added responsibility to her full-time work as a staff nurse in the Prenatal Clinic. This was an advantage for her because she got to know many of her class participants before they attended the classes. However, it was also a disadvantage because of the demand on her schedule that sometimes limited the number of class sessions that could be held and the amount of time that she could spend in preparation for the class. Her knowledge and teaching experience were an advantage for her preparation and teaching.

The content for the PC classes was determined by the two PC staff nurses who were the class educators. Both were in close contact with the staff and doctors who worked in the obstetrical unit, and they adjusted the class content when routines or procedures were added or changed. Consequently, the content of the PC classes was essentially

the same as that in the EC classes, even though there was no collaboration between them. The major differences between the two programs was the number of sessions per class, the timing of the hospital tour, the amount of demonstration and practice time given to the relaxation and breathing techniques, and the limited space for practicing in the Clinic classroom. There was also a greater emphasis on the postpartum and newborn care given in the PC classes. Other differences were the inclusion of women without partners, and less formal structure with more tailoring of content to meet participant needs, made possible by the smaller classes in the PC program.

Childbirth Educator Interview Responses

When asked what they thought women ought to know about childbirth, all five of the educators began their answer with essentially the same statement, "being as prepared as possible for the childbirth experience." They then explained that it included such things as knowing how the body works, the anatomy, physiology, and changes that occur during pregnancy, labor and delivery. Knowing what can be done to help make labor and delivery easier was another important part of being prepared, including relaxation and breathing techniques, medications, and comfort measures extended by the coach or support person. Tests, procedures, medical interventions, and hospital routines were also on the list of things women ought to know, as well as information about danger signs, possible complications, Cesarean section, and other possible emergency interventions. Postpartum concerns such as variations among newborns, newborn care and feeding, care of mother and contraception were mentioned. Before she listed specific things to know, one educator simply said "they need to know everything." Another

said, "women need to know that it's a natural process they need to be prepared for."

The educators were unanimous in their first response to the question, "Where can a woman get the information she needs about childbirth?" All answered, as one educator put it, "classes of course!" Other sources were also mentioned. Four educators included the doctor, family, friends, relatives, books and magazines. One mentioned high school family living courses, another suggested a midwife and movies as sources, and one stated that "If motivated, the library would be a good source."

They were not agreed as to which information source was the most important. One stated that "the classes are the most important because they are comprehensive, whereas the doctors don't spend enough time with the women to teach and answer questions." Two other educators stated that they thought the doctor is the most important source of information, but the classes are also important because they are best suited to answer questions that the women may have. Another educator thought that the classes are most important because "the women learn the most there and retain the most because they participate and practice together." Only one educator felt that the family was the most important source. She felt that the family focuses more on the values which ultimately lead to better care of the child.

The educators were more agreed when asked "What is the least important source of childbirth information. All but one said friends because "they give the wrong information," "are too emotionally laden" and "tell horror stories." Two of the educators included family with friends, and one said "anyone who tells horror stories" is the least

important. One educator thought that "the free stuff from doctors offices" was the least important because it was so fragmented. She was not sure that most people could sort through all of the information to get a full picture of what pregnancy and childbirth was really like. Another educator felt that the media, especially TV, was a poor source because it did not show the responsibility involved in childbearing and childrearing, which she felt were important aspects that should also be considered in preparation for childbirth.

When asked if there were any sources of childbirth information that might be harmful, especially for women who are pregnant for the first time, the educators gave varied answers. Friends and family were mentioned by three educators because "they can give the wrong information." One conceded that any non-medical people could be harmful because their experience "is cloudy" and not always correct. Another said that some books could be harmful because they give "conflicting information." Magazine articles "that are not legitimate, such as those in magazines that advocate home birth and other non-traditional practices that could be very harmful" was mentioned by one educator. In general, all were agreed that any wrong or conflicting information, as they defined it, could be harmful, especially for a woman experiencing her first pregnancy.

When asked to define childbirth education the educators unanimously agreed that it was education about pregnancy, labor, delivery, and postpartum. They went on to say that it was instruction and learning about all the aspects of the childbirth experience including, as one of the educators said, the "mental, physical, spiritual, and educational preparation of the whole person."

Preparation for a "typical delivery and the possibility of a Cesarean section and anything else that could be different" was stressed by another educator. She also said it prepared them for every thing they might have to know for labor and delivery, baby care, and breast feeding. Three educators mentioned "mom" as the focus of childbirth education, but one instructor stressed "couples" as being the focus. One educator summed up childbirth education as preparation for the "whole person so she can approach labor and delivery competently and confidently." None of the educators specifically mentioned teaching hospital policies or routines as the major focus of childbirth education, but they did imply that this was part of the focus when they talked about "preparing" the woman for the experience in the hospital and, as previously mentioned, this was part of the course content. The major concern expressed by each of the educators was the pregnant woman and the mental and physical changes that she would experience and how to best prepare her for that experience.

In general, all of the educators agreed that childbirth classes were necessary for women who were pregnant for the first time. One educator said classes were "absolutely important, especially for support." She went on to say, "I can't imagine it without classes." Another educator stated that it was "definitely important for first time moms because they don't know, and labor and delivery will be more easily handled by them and the staff if they are prepared." Only one educator was reserved in her answer. She said, "In general, yes, but for some, no, for instance, a registered nurse whose husband is an obstetrician." She also said, "For the first baby, the more prepared you are, the better equipped you are to handle everything."

The educators varied in their explanation of why some women chose not to take childbirth classes. Three stated that cost might be a factor. According to the City Hospital Family Education Class Registration Form, the Prepared Childbirth Classes cost $50.00, with non-refundable payment expected six weeks before the beginning of their scheduled class. Medicaid will pay for childbirth classes (EC Family Education Class Registration Form), and one instructor said "that no one would be refused if they could not pay." However, it is not widely advertised that Medicaid payment is accepted or that couples who cannot pay will still be admitted to the classes; therefore, unless they contact the Education Center or are told by their care giver, couples who cannot otherwise pay for the classes may not pursue taking them.

One educator thought that "culture might be a factor" that keeps women from attending childbirth classes. She said, "For instance, we don't see a lot of Blacks. They may feel they get enough information from their family." She also said that some may not attend because they read a lot and feel they know enough. Another educator said that for some transportation was a problem. Not valuing or seeing childbirth education as being important was mentioned by two of the educators. Schedule conflicts and not being able to commit to a certain number of classes was stressed by another educator. She said, "Everybody is over-scheduled now days." Two said that teens or very young and sometimes older women tend to "ignore" the classes. Not having a coach, was mentioned by another educator. One educator said that lack of education makes some women choose not to take classes, "They just don't know they should do it."

In general, all of the childbirth educators were agreed in their answers to the questions. Even though there was some disagreement as to which information source was the most important, they did agree that childbirth classes are an important source. In those areas where their answers were varied, the responses did not conflict, and in some cases were complementary to each other. From this information it appears that all of the educators have generally the same perception of childbirth education and the same paradigms and goals in their teaching to give women information about their bodies and the changes they will experience in pregnancy and childbirth, and to prepare them for a technologically managed hospital birth.

Though they have little to no influence in the development of the dominant childbirth ideology, the childbirth educators unconsciously acknowledge that they have assimilated it as their own. They use the language and tailor their behavior to express it. As role models and educators, they assist in the perpetuation and dissemination of the ideology's assumptions and practices. As childbirth education recipients incorporate these ideologies they will also mirror the language and behavior of their educators and accomplish their experience of childbirth as determined by the dominant ideology.

Chapter VI

CHILDBIRTH KNOWLEDGE PREFERENCE, PERCEPTION, AND INFLUENCING FACTORS

The knowledge that a woman has or thinks she ought to have regarding her childbirth experience may contribute to her childbirth education decision. Her expressions of knowledge and expectations for more knowledge reflect her own assumptions about childbirth and give insight into understanding her decision to take or not to take childbirth classes. Though not generally a part of one's conscious reasoning, the ideology to which a woman subscribes influences the way she thinks about her childbirth experience, the way in which she speaks of her experience, her perception of the knowledge she ought to have, and her decision to take or not to take childbirth education classes. This chapter is an exploration of the responses that the participants gave to what they thought women ought to know about childbirth, their perception of childbirth education, and who or what influenced their decision to take or not to take childbirth education classes.

What Women Ought to Know About Childbirth

I began my exploration of the influence of the dominant childbirth ideology in women's childbirth education decisions by asking, what do women think they ought to know about childbirth. First, I asked each participant what she thought women (in general) ought to know about

childbirth. Then, more specifically, I asked each participant what she wanted to know about childbirth. A few of the participants answered the first question by explaining what they had wanted to know or what they felt was important for them to know. Others said they did not know what women (in general) ought to know about childbirth but answered the second question by describing precisely what they thought was important for them to know. Some answered both questions without hesitation, though a few gave the same answer in both instances. None of the participants gave exhaustive lists of things they thought important for themselves or others to know. With a few exceptions, the answers given to both questions, though prioritized differently, were not dissimilar (Table 6.1 and Table 6.2). By combining the responses to the two questions, the participants' perceptions of what they thought women (including themselves) ought to know about childbirth was determined.

TABLE 6.1 - Response to "What Do You Think Women Ought to Know About Childbirth?"

Responses	ECCBE	CCBE	NCBE	Total
Health and physical changes in pregnancy	11 (69%)	10 (67%)	7 (44%)	28 (60%)
How to cope with labor and delivery	6 (38%)	6 (40%)	4 (25%)	16 (34%)
You can't know what to expect/ everyone is different	5 (31%)	0	3 (19%)	8 (17%)
Women learn on their own	1 (6%)	1 (7%)	5 (31%)	7 (15%)
Postnatal care of the baby	2 (13%)	1 (7%)	4 (25%)	7 (15%)
I don't know	1 (6%)	0	4 (25%)	5 (11%)
Prenatal growth of the baby	1 (6%)	1 (7%)	1 (6%)	3 (6%)
Number of Respondents	16	15	16	47

TABLE 6.2 - Response to "What Did You Want to Know About Childbirth?"

Responses	ECCBE	CCBE	NCBE	Total
How to cope with labor and delivery	9 (56%)	6 (40%)	6 (38%)	21 (45%)
Health and physical changes in pregnancy	6 (38%)	1 (7%)	4 (25%)	11 (23%)
Prenatal growth of the baby	3 (19%)	2 (13%)	3 (19%)	8 (17%)
I didn't know anything	2 (13%)	3 (20%)	3 (19%)	8 (17%)
I don't want to know anything	1 (6%)	2 (13%)	3 (19%)	6 (13%)
I know enough	1 (6%)	2 (13%)	3 (19%)	6 (13%)
Postnatal care of self and baby	2 (13%)	1 (7%)	0	3 (6%)
Number of Respondents	16	15	16	47

In their response to the question "what do you think women ought to know about childbirth," 60% (n 28 of 47) of the participants (Table 6.1) mentioned the "need" for information about the physical and psychological changes a woman experiences and what she can do to stay healthy throughout her pregnancy. This was the second most common response to the question "what did you want to know about childbirth," with 23% (n 11 of 47) of the participants (Table 6.2) mentioning this as information they wanted for themselves. In general, the women who gave this response included such things as diet or nutrition in pregnancy, and the use of alcohol, cigarettes, and drugs. They also mentioned physical and mental changes, signs and symptoms and how to know the difference between normal and abnormal changes, and general expectations for progress and care during pregnancy.

Loris (ECCBE), a talkative 29-year-old, married, White Non-Hispanic[1] participant, summarized the other responses when she said,

> "I think they need to know how you're gonna feel each month because there's so many different feelings, you know, physical and mental that you're not prepared for at all.

> Some of the different symptoms that you can have each month as far as the morning sickness, do you get it, don't you get it, you know, what's normal and what's not."

Meg (CCBE), an attractive, vivacious, 19-year-old, single, White Non-Hispanic participant from Block Clinic, complemented Loris' comments and gave her own advice for pregnant women. She thought women ought to know

> "How to take care of themselves, eat right, exercise, take time to relax, don't use drugs or anything, don't do anything that's too strenuous, and try not to get a bad attitude."

Though some of the respondents mentioned only one or two things women ought to know about changes and health, Loris's and Meg's comments were typical of those given.

The responses of the participants who mentioned changes and health during pregnancy as something they personally wanted to know were similar to those of Loris, Meg and others who thought this important for women in general to know. Lynnette (CCBE), a 25-year-old Asian American woman who had just finished her third year in college, summed up what many of the participants said they wanted to know. She and her husband had just completed the Prenatal Clinic childbirth classes when she said,

> "You know, like some kind of drug, you know, smokin', you know, does that really affect the baby, you know, kind of like, alcoholics, like if you drink a little beer does that affect the baby or, you know, not much sometimes. Take, we are not smokin' at all, but the place where I go to work right now, people smoke, so I wonder, you know, if I'm in that air is my baby affected at all? And why is my breasts so hurt?"

Seven (44% of 16) of the NCBE participants, all of whom were in the lower two SES levels, mentioned changes and health care in pregnancy as something they thought women ought to know (Table 6.1). Four of the seven also expressed this as something they personally wanted to know (Table 6.2). The concerns expressed by the participants who had not

taken classes were similar to those of the participants who had taken them, both in what they thought women ought to know and in what they wanted to know for themselves. For instance, Vakisha (NCBE), a very contemplative 25-year-old, single, African American woman, echoed Meg (CCBE) when she talked about what she thought women ought to know. She also included herself in her comments when she said,

> "As far as to, what to expect that, you know, it's someone new besides yourself, you know, to take care of someone else beside yourself now. Jus' have to eat healthy and you know, can't do some othe', can't live the life-style that you lived before.
>
> My think is also, pregnant women should always keep their self up, it's hard but, you jus' have to get up early and take that extra time to comb your hair and put your clothes on right and, you know, take care of your personal hygiene and stuff. Try to get as much exercise and walking in. Try to eat the right foods."

Eight of the total respondents (n 28) who mentioned physical and psychological changes and health in pregnancy as something women ought to know also mentioned them as things they wanted to know. The other 20 women who gave this response as something women ought to know, did not mention it as something they wanted to know for themselves. It is possible that they did not consider it important to repeat when discussing what they wanted to know.

Combining the total number of respondents who mentioned changes and health in pregnancy in their responses to what they thought women ought to know and what they wanted to know shows that 66% (n 31 of 47) of the participants considered this as an area about which women, including themselves, ought to have some knowledge. Comparison of the age, education, and SES among the 31 respondents who gave this response shows that more of the women who were older, had more education, and

higher SES, gave this response than did the youngest women, who had the least education and lowest socioeconomic status (Table 6.3).

TABLE 6.3 - Combined Responses Pertaining to Prenatal Changes and Health by Age, Education, and SES

Years of Age	Number Who Gave Response	Years of Education	Number Who Gave Response	SES Level	Number Who Gave Response
≤ 19 (n= 8)	4 (50%)	< 12 (n=10)	4 (40%)	I (n=13)	6 (46%)
20 - 24 (n=22)	14 (64%)	12 (n=15)	11 (73%)	II (n=15)	8 (53%)
25 - 29 (n=11)	7 (64%)	13 - 15 (n=14)	9 (64%)	III (n=11)	8 (73%)
30 - 39 (n= 6)	6 (100%)	≥ 16 (n= 8)	7 (88%)	IV (n= 8)	8 (100%)
Total (n=47)	31 (66%)	Total (n=47)	31 (66%)	Total (n=47)	31 (66%)

More (77% or 24 of 31) of the women who gave this response had attended childbirth classes. It is possible that they were more aware of the physical and psychological changes and things they could do to stay healthy because they had just finished their classes.

In her study of childbirth education, Maloney (1985) also explored expectant parents' expectations from childbirth education classes. Although she does not specifically rank their expectations according to importance, she does list well-being and nutrition during pregnancy as desired areas of information. It is significant that 66% of the total participants (n 31 of 47) in my study considered changes and health care in pregnancy as a major area of concern about which women ought to be informed. This finding is also consistent with Maloney's study results.

Knowing how to cope with labor and delivery was also seen by the study participants as an important facet in a woman's childbirth knowledge. When discussing what they thought women ought to know, coping with labor and delivery was the second most common response

mentioned by 34% (n 16 of 47) of the participants (Table 6.1). However, when the question was personalized, concentrating on what they wanted to know, aspects of coping with labor and delivery was identified by 45% (n 21 of 47) of the participants as the major concern (Table 6.2). This may reflect the fact that women in their last trimester, when considering their own needs or desires, begin to focus more earnestly on their anticipated labor and delivery experience as Jensen, Benson, and Bobak (1981) point out.

Various aspects of coping with labor and delivery were mentioned by the respondents. The more common things expressed included being prepared for labor, knowing hospital routines, and being able to breathe, relax, and cope with the pain of labor. Some participants talked about staying calm, knowing what to expect, and knowing hospital policies in order to make informed decisions while in labor. Knowing the medications and terminology pertaining to labor and delivery were also expressed as important considerations. The manner in which these concerns were expressed, however, differed between the two questions.

When addressing what they thought women ought to know, the respondents tended to list things in a rather detached manner. However, if something was a more personal concern or issue, respondents would often include their own feelings or thoughts in their comments. For example, Renae (CCBE), a 20-year-old, clinic participant was very matter of fact in her expression of what she thought women ought to know, until she began talking about medications. It was at that point that she became more animated and revealed her own concerns. She said,

> "I think they should know, um, they should know about what it's, what exactly the process is, you know, the transition stage, all the different stages of your contractions. Also, what kind of

> pain killer can be administered at what time, 'cause I'm debating that right now, if I wanna do that."

When asked "what did you want to know about childbirth," the respondents reflected more personal questions or desire for information. The physical signs and changes in labor, movement, descent and birth of the baby were commonly mentioned. Several participants wanted to know how they could tell they were in labor, what the labor stages were, what different kinds of labor could occur, how to know when to push, and what to expect in labor and delivery. Others wanted more information about electronic monitoring, episiotomies, and Cesarean Sections. A few mentioned wanting to know techniques for dealing with the pain of labor. They included such things as breathing, relaxation, and medications. And finally, some wanted to know who could go with them to the hospital and how many people could be in the room during labor and delivery.

Knowing how to tell when labor started and how it felt to deliver a baby were among the major concerns expressed. Rosalia (CCBE), a 24-year-old, married, Hispanic participant, summed up the comments of many of the respondents when she said she wanted to know, "All the mechanics of what my body is going to go through, 'cause this is my first child, so...." She then expressed another common concern,

> "I didn't know what to expect when they talk about contractions, it's just a word, I feel like any man off the street, you know contractions! So I wanted to know what to expect when the baby decides to come."

Knowing how to cope with the pain of labor was another concern often expressed. As Virginia (ECCBE), a 31-year-old, White, Non-Hispanic, married, registered nurse pointed out, she, like many of the respondents wanted to know,

> "Just techniques on how to make it easier, you know, the breathing techniques, the relaxing techniques, um, the exercises, what was best, you know, things to do to make it easier, anything to decrease the pain."

The respondents who had not taken classes mentioned some of the same fears and concerns as those who had taken the classes. Sonia (NCBE), for instance, a single, 20-year-old, White Non-Hispanic participant, expressed some of the same fears as Rosalia when she said,

> "But the most, I think, the question is, how is labor gonna feel. Is it really gonna hurt that bad or is people just makin' it up? Or contractions, like, how do you know if you're havin' a contraction when you don't even know what it feels like."

Knowing what labor was going to feel like and how one could tell when contractions had really begun was also a major concern mentioned by the respondents who had not taken classes. Several were also fearful of being out of control in labor and wanted information concerning how to "react" to contractions. Twenty-two-year-old Linnea (NCBE), a single, African American participant from the Block Clinic, put it this way,

> "Would I have my....hardening.....contractions....sort of (scary) you know, how to react, you know, don't be really wild and, you know...."

In her study of models of childbirth, Nelson (1983) found that "working class" women (whom she defines as those who have 12 or fewer years of education) tend to focus on the outcome of pregnancy, that is, the baby and being a mother, rather than the stages of the pregnancy itself. Several of the NCBE participants in my study, most of whom had 12 or fewer years of education (Table 4.4) and were in the lower 2 SES categories (Table 4.5), also mentioned being a mother and taking care of the child as their major areas of concern (Table 6.1). However, 50% (8 out of 16) commented on coping with labor and delivery in their responses to what women ought to know and what they wanted to know.

Though they mentioned contractions, pain, what labor felt like, and how to react in labor so they wouldn't be nervous or "wild," none commented on any of the technology used in labor and delivery such as electronic monitoring, episiotomy, or types of analgesic or anesthetic they might use. In other sections of the interview, however, a few did mention that they hoped they wouldn't have a Cesarean Section. The respondents who had taken classes did mention the use of technology; however, they may have done so because they had learned about it in their childbirth classes and it was fresh in their memory. Those who had not taken classes and had not been exposed to so many of the technological aspects might be more likely to focus on the personal experience of the birth.

Control of oneself and being informed about hospital policies and treatment routines in labor and delivery in order to make good decisions was a concern expressed by a few participants who had taken childbirth classes. When discussing what she thought women ought to know, Bonnie (ECCBE), a 25-year-old, married, sales manager said,

> "I think it's real important, as far as childbirth, that they know about the medications that are available and that you're educated on those, so that you're not making a rash decision, you know, as you're in labor, 'oh, I want that' and not know. And then the big, the episiotomy and all the lovely little names that they have for everything you don't want. You don't want your first experience with that to be in the hospital when you're pregnant, when you're in labor."

Celia (CCBE), a 21-year-old, married participant from the Prenatal Clinic, wanted to take classes to learn about hospital policy. In answering the question "what did you want to know about childbirth," she said,

> "The thing that I was really concerned about and wanted to take classes about, was, I was concerned about the hospital policy on certain things, like monitoring, if you have people there with

> you, the episiotomies and that kind of thing, I wanted to know what the hospital policy was."

Some of the women merely mentioned wanting to know routines and hospital policy so that they would know what to expect, while others expressed a desire for information in order to make decisions about medications or be in control of themselves during labor and delivery. However, none of the participants expressed a desire to be in control of what happened during the delivery or what kind of delivery they would have. Other than being able to make some decisions about the use of analgesics or anesthetics, power and control did not seem to be a specific issue for the women who mentioned coping with labor and delivery, either in what they thought women ought to know or what they wanted to know about childbirth.

Several of the women who talked about coping with labor and delivery were concerned about "the old wives' tales" and scary things they believed or had heard. Esther (ECCBE), a 29-year-old, White Non-Hispanic, factory worker who had taken classes with her fiance, spoke of many tales she had heard and things she had believed about labor and delivery. She began her response to the question "what did you want to know about childbirth," with the comment,

> "I don't know, I mean it's like I thought everybody just laid in bed and it was the foot in stirrups type thing, and I had no idea of what actually went on and stuff, I'd never had nobody really talk about their labor and delivery."

Clearing up such misconceptions was mentioned by several participants. Throughout their interviews they expressed doubt about what they had been told by friends and relatives and, although they didn't always know exactly what information they wanted, they knew they wanted information that could be taken as factual and up-to-date. They looked to their

physicians, nurses, and childbirth educators to give them that information. This was also true among several of the NCBE participants. Although they had not taken classes, some did say that they got information from their physicians or friends or relatives that were nurses. A few of the NCBE participants said they got information from public health nurses who visited their homes.

Five of the sixteen respondents who mentioned coping with labor and delivery as something they thought women ought to know, also mentioned it as something they wanted to know. Two of the five had not attended childbirth classes. The remaining 11 women who gave this response did not mention it as something they personally wanted to know. However, having already discussed it as something that women ought to know, they also may not have considered it important to repeat when discussing what they wanted to know for themselves.

A total of 24 (77% of 31) participants (21 who gave the response in one question only, and 3 who gave the response in both questions) who had taken classes mentioned various aspects of coping with labor and delivery as something they thought women in general or they themselves ought to know. Seven of the women who had taken classes made no mention of labor and delivery in their responses to either question. However, it is possible that they did not mention it because they felt they knew enough from their classes and therefore no longer saw it as an issue for them.

Combining the total number of respondents who mentioned coping with labor and delivery (11 who responded concerning women only, 16 who desired the information only for themselves, and 5 who responded in both questions) shows that 68% (32 out of 47) of the participants considered

coping with labor and delivery as a major area about which women (including themselves) ought to have some knowledge (Table 6.4).

Comparison of the age, education, and SES among the 32 respondents who mentioned coping with labor and delivery shows that those who were oldest (30 to 39 years), had the most education (16 years), and had the highest SES (level IV) were more likely to give this response than the youngest participants (≤ 19) who had the least education (< 12 years) and the lowest SES (level I) (Table 6.4). However, though the percentage of women giving this response does increase as education and SES increase, it does not consistently increase with age. In fact, the response was given by more of the women who were 20-24 years old than by those who were 24-29 years old (Table 6.4). This suggests that age is not a significant factor that increases a woman's concerns about labor and delivery.

TABLE 6.4 - Responses Pertaining to Coping With Labor and Delivery by Age, Education, and SES

Years of Age	Number Who Gave Response	Years of Education	Number Who Gave Response	SES Level	Number Who Gave Response
≤ 19 (n= 8)	5 (63%)	< 12 (n=10)	5 (50%)	I (n=13)	7 (54%)
20 - 24 (n=22)	15 (68%)	12 (n=15)	8 (53%)	II (n=15)	9 (60%)
25 - 29 (n=11)	7 (64%)	13 - 15 (n=14)	11 (79%)	III (n=11)	8 (73%)
30 - 39 (n= 6)	5 (83%)	16 (n= 8)	8 (100%)	IV (n= 8)	8 (100%)
Total (n=47)	32 (68%)	Total (n=47)	32 (68%)	Total (n=47)	32 (68%)

Attending or not attending childbirth classes may be a more significant factor influencing women's concern about coping in labor and delivery than are age, education, or socioeconomic status. The women who attended childbirth classes had fulfilled their goal to be prepared

for the delivery experience and therefore were more aware of their bodies and what to expect in labor and delivery. Their comments about coping with the experience may be as much a reflection of what they had just learned as it was of what they wanted to know or thought women ought to know about childbirth.

What is even more significant is the degree to which they appear to have accepted the tenets of the dominant childbirth ideology taught in the childbirth classes, which is revealed in the way they talked about the childbirth experience and the language they use. With few exceptions they used the same terms that were used in the childbirth classes, mentioned the technology that might be used, and without reservation appeared to abdicate total control of the childbirth experience to the physicians and nurses who would be in attendance at their birth experiences.

Growth and development of the baby before birth was the third most common concern expressed by 17% (n 8 of 47) of the participants as something they wanted to know (Table 6.2). However, it was mentioned by only 3 (6% of 47) participants as something they thought women ought to know (Table 6.1). Knowing what the baby looked like at various times throughout the pregnancy, knowing if the baby was healthy, and knowing how to care for oneself to insure a healthy baby were the most common comments concerning what women ought to know and what the respondents wanted to know about the developing baby.

In their response to what they thought women ought to know, the respondents were most concerned about what a woman does or does not do during her pregnancy that might affect the developing baby. Karen (NCBE), for instance, thought it was important for women to know how the

baby grows because she smoked before she knew she was pregnant and this was a concern for her. She said, "Usually your first few months, that's when the baby's immune system is growing and stuff so I quit smoking." Karen was an 18-year-old, single, Hispanic woman who had completed only eight years of education. She told me that she had read a few pamphlets and childbirth magazines but got most of her information from her mother or her aunt. She did not attend the childbirth classes.

Rosalia (CCBE) was also concerned about the prenatal development of the baby. After talking at length about diet changes in pregnancy, she said, "Your world revolves around the child already, I think, so that's one thing that I think they should teach, you know." Bonnie (ECCBE) was even more specific. She thought women ought to know exactly how the baby grows month by month so the mother would be aware of her diet and anything else that might affect any part of the baby's development.

Some of the respondents who expressed wanting to know about the unborn baby were concerned about the tests that were done and the health of their developing babies. Virginia (ECCBE), who was also a registered nurse, said,

> "I jus', you know, I wanted to know if everything was ok, knowing what problems there are out there, I wanted my ultrasound. I wanted the AFP done, you know, I just wanted to know that the baby was ok."

Virginia worked in a hospital medical specialty unit. When she volunteered for the study, she said she really knew very little about obstetrics. Even though she was part of the established medical community, she expressed the same concerns as did her less-educated pregnant peers.

Joan (ECCBE), a 26-year-old, married secretary, and Meg (CCBE), a 19-year-old, single sales clerk, expressed wanting to know if their babies were healthy. Joan was especially concerned about the normalcy of her unborn baby. Esther (ECCBE), who was also concerned about "old wives' tales," said it was important for her to "find out more on different things about what's good for the baby and what's not when you're pregnant." And 19-year-old Kerri (CCBE), who was just excited about being pregnant, said,

> "Most about the ultrasound, I like going to the ultrasounds, that was really cool, with the monitor you could see everything!"

Each respondent in her own way focused on her baby or the babies of other women, but it was clear that for this group of respondents knowing that the baby was healthy, how the baby grew, and the things the mother could do to keep the baby healthy as it grew were common concerns.

TABLE 6.5 - Responses Pertaining to Prenatal Growth and Development of the Baby by Age. Education, and SES

Years of Age	Number Who Gave Response	Years of Education	Number Who Gave Response	SES Level	Number Who Gave Response
≤ 19 (n= 8)	2 (25%)	< 12 (n=10)	2 (20%)	I (n=13)	3 (23%)
20 - 24 (n=22)	3 (14%)	12 (n=15)	4 (27%)	II (n=15)	3 (20%)
25 - 29 (n=11)	4 (36%)	13 - 15 (n=14)	3 (21%)	III (n=11)	3 (27%)
30 - 39 (n= 6)	1 (17%)	16 (n= 8)	1 (13%)	IV (n= 8)	1 (13%)
Total (n=47)	10 (21%)	Total (n=47)	10 (21%)	Total (n=47)	10 (21%)

Only one of the respondents who mentioned prenatal growth and development of the baby as something women ought to know also mentioned it as something she wanted to know. Comparison by age, education, and

SES of the total 10 respondents who gave this response does not reveal any distinct patterns (Table 6.5). Age, education and SES do not appear to be significant factors that influence the desire to know about the developing baby. Seventy percent (7 out of 10) of the participants who gave this response had attended the childbirth classes and that may have been more significant than age, education, or socioeconomic status. The classes may have contributed to the high interest in the tests that were done and what the results of the tests indicated. However, only 23% (7 out of 31) of the participants who attended classes gave this response. Eighteen percent (3 out of 16) of the participants who did not attend classes mentioned the developing baby. Therefore, though there is a slightly higher tendency for those who have taken classes to give this response, the difference between the two groups in the percent of respondents is not large enough to make generalizations.

It is interesting to note that, even though none of the women spoke of the "fetus" or "fetal development," they did mention specific medical tests such as "AFP" and uses of technology such as the ultrasound, and their subscription to certain medical routines such as specific diets, exercise routines, and elimination of substances such as sugar, cigarettes, alcohol, and drugs, all of which stem from the dominant childbirth ideology.

Postnatal care of the baby and self was the last thing that the participants mentioned in their responses to both what they thought women ought to know and what they themselves wanted to know. This response did not have high priority among the answers to either question. Fifteen percent (7 out of 47)) of the total participants expressed postnatal concerns about the infant as something they thought

women ought to know (Table 6.1). Only 6% (3 out of 47) of the participants mentioned maternal postnatal concerns as something they wanted to know (6.2).

Two of the women who commented on postnatal care as something women ought to know had taken the childbirth classes. Both commented on what women ought to know about their babies at birth. Amy (ECCBE), a 31-year-old, married, health and disabilities management specialist, mentioned a birth video that she had seen when she discussed what she thought women ought to know. For her, what a newborn baby looks like and what might be done for the baby at birth were important for women to know. She also personalized her answer when she said women ought to know

> "What the baby was going to look like, or you know, things that I just never even thought about and I probably would have thought, 'oh my god, why does my baby have that thing on his arm,' you know."

Andrea (ECCBE), a 25-year-old, married, registered nurse, agreed with Amy. Andrea had some experience working in obstetrics, and she said women ought to know

> "Exactly what happens in their room as far as what's going to be happening with baby, you know, 'cause a lot of times when they just delivered the mom is overwhelmed and I like to ahead of time tell 'em what we do with babies as far as assessment goes and things like that, just so there's nothing unexpected, you know, when it happens."

Those who had not taken classes did not express concern about the technological aspects of what would be done with the baby at birth or even what the baby would look like. They were all agreed that women ought to know how to take care of the baby and raise the child. Tanisha (NCBE), a 19-year-old, single, African American participant from the Block Clinic, said women ought to know "how to take care of him."

Coming from a home in which she was abused as a child, Tanisha thought women ought to know "how to control your temper" when caring for the child. Elena (NCBE), a 21-year-old, single, African American participant, thought women should know "how to handle a baby." And Jennifer (NCBE), a 22-year-old, married, White Non-Hispanic participant, thought women just ought to know "how to deal with the child." Jennifer (NCBE) and Karen (NCBE) also commented that women ought to know what kind of things or "stuff" the baby needs and should go out and get them to be ready when the baby comes. Rosalia (CCBE) thought women ought to look to the future of the child, "how to raise a child, what morals and foundations do you wanna instil in the children, not just have 'em, like run the streets."

Postnatal care of self and the baby was not a major issue among the things participants wanted to know about childbirth. Only three (6% of 47) participants mentioned this as something they wanted to know. All three of these respondents had attended the childbirth classes. Nan (ECCBE), a single, 21-year-old African American who was in her fourth year of college, expressed disappointment in her childbirth classes because they did not give her enough information about postnatal care. She said, "There wasn't much on after care, I kinda wanted to know, I guess that's more like, you learn it as you go along."

The other two respondents were more concerned about breastfeeding and care of the child. Risa (ECCBE), a 36-year-old, married, White Non-Hispanic participant, said, "My bigger concern than the delivery and labor is whether or not the baby's going to breast feed." And Lynnette (CCBE), the Vietnamese American who took the PC classes, said,

"Oh, how to raise the child. Actually it's the first one so it's very hard for me, now I don't know how, you know, to hold a baby, to care, that kind of stuff."

A total of 10 (21% of 47) participants mentioned postnatal care of self or baby either as something women ought to know or something they wanted to know. No one gave this response in answer to both questions. There are no distinct patterns by age or education among the combined respondents (n 10) who gave this answer. However, there is an increase in the percentage of responses as the SES increases (Table 6.6). The actual responses given by the participants as distinguished by their

TABLE 6.6 - Responses Pertaining to Postnatal Care of Self and Baby by Age, Education, and SES

Years of Age	Number Who Gave Response	Years of Education	Number Who Gave Response	SES Level	Number Who Gave Response
≤ 19 (n= 8)	2 (25%)	< 12 (n=10)	1 (5%)	I (n=13)	2 (15%)
20 - 24 (n=22)	4 (18%)	12 (n=15)	4 (27%)	II (n=15)	5 (33%)
25 - 29 (n=11)	2 (18%)	13 - 15 (n=14)	2 (14%)	III (n=11)	0
30 - 39 (n= 6)	2 (33%)	≥ 16 (n= 8)	3 (38%)	IV (n= 8)	3 (38%)
Total (n=47)	10 (21%)	Total (n=47)	10 (21%)	Total (n=47)	10 (21%)

SES may be more significant. The women who had higher SES tended to comment on what the infant would look like, what would be done for the infant at birth, and concern about breast feeding, whereas the women with lower SES made more comments pertaining to handling, caring for, and raising the child. Childbirth education did not seem to be a significant factor in these responses. The responses of the women with lower SES who had attended classes were similar to those of the women who had not attended classes. The responses of the women with lower SES concerning caring for and raising the child are similar to Nelson's

(1983) finding that "working class" women tend to focus on the baby and motherhood rather than other aspects of the pregnancy and birth.

The other responses to the questions "what do you think women ought to know about childbirth," and "what did you want to know about childbirth" were not similar and could not be evaluated together. However, these responses also gave insight into the way in which the participants thought and spoke about childbirth. First I will present the last three responses to the question "what do you think women ought to know about childbirth." Second, I will present the last three responses to the question "What did you want to know about childbirth."

The ideas that you can't know what to expect and everyone is different were expressed by 17% (n 8 of 47) of the participants (Table 6.1) in their responses to what they thought women ought to know. Johanna (ECCBE), a 29-year-old, married, school teacher spoke at length about what her mother and sisters told her concerning childbirth and then she said, "Nothing can prepare you for the reality of pregnancy, you just have to be ready to expect anything."

Similar responses were given about the experience of labor and delivery. Andrea (ECCBE), the RN who had some experience working in an obstetrical unit, said, "I guess you really don't know what to expect fully until you're there, I mean, as far as how intense that pain can be." Bonnie (ECCBE) agreed with Andrea and then added a new thought in her response, "You never know what to expect completely because everybody's different."

"Because everyone is different" was the premise upon which five other participants based their idea that "you can't know what to expect." Twenty-four-year-old Doris (ECCBE), a married design

consultant, had also asked her sisters about their experiences. She then came to the conclusion that, "I know they can't tell me exactly because every pregnancy and delivery is different." Those who had not taken classes had similar views as those who had. Two African-American participants, Vakisha (NCBE) from the Block Clinic and Elena (NCBE) from the Hospital prenatal clinic, agreed that each woman was different and had different needs for information. They both said that "it depended on the woman" as to what she ought to know about childbirth. Vakisha, however, thought she could expect some things. She said,

> "It all depends on the person, with me I know it's gonna hurt, you know, the pain's gonna be here so, you know, that's just something that you can expect."

Beth (NCBE), a 22-year-old, White Non-Hispanic, single, waitress, agreed with the others and then added a new dimension when she said, "I think all pregnancies are different and you have to go with your own, you have to learn on your own."

There were no distinct patterns by age or education among the participants who gave this response. However, 63% (5 out of 8) of the respondents were in the two highest SES categories. This same group of five had also completed the childbirth classes. While it is possible that SES affects women's thoughts concerning the way in which women experience childbirth, the childbirth classes may be the more common link. In the childbirth classes women are told that each woman is different, and they are taught to expect the possibility of various experiences. This may explain why this response was given by the participants who had completed the childbirth classes. The women who had not taken classes had obtained information from several different sources, including friends and families. It may also be logical for

them, having heard so many different stories, to conclude that "each woman is different."

Beth (NCBE), in her response to what women ought to know, mentioned that "you have to learn on your own." A total of seven participants (15% of 47) made reference to women learning on their own (Table 6.1). Though similar to the responses of being unable to know what to expect and every woman is different, the responses pertaining to learning on your (their) own reflected more the woman's own learning, i.e., how she learned or that she learned, and her responsibility for her own knowledge. The responses included such statements as, "most of it is in most of the books" (Sonia NCBE); "I've learned a lot since I've been pregnant" (Esther ECCBE and Jacoba CCBE); and "it just depends on the woman" (Elena NCBE). While these responses do not inform us as to what these participants think women ought to know, they do give insight into their thoughts on the process of learning about childbirth and who is responsible for that learning.

Two of the respondents who mentioned learning on your own, Esther (ECCBE) and Jacoba (CCBE), had attended the childbirth classes. Both said they "hadn't known anything" about childbirth before they became pregnant and they attended classes to help them sort out "the old wives' tales from fact." Both said they learned a lot from their childbirth classes and thought everyone should take them.

The other five participants who mentioned learning on one's own had not taken the classes. For them, what a woman ought to know depended upon the woman herself and could be gained through reading books or going through the experience of childbirth. They did not mention childbirth classes as an option for learning.

There were no distinct patterns by age, education, or SES among the women who gave responses pertaining to women learning on their own. What appears to be more significant is that five of the seven participants (71%) had not attended childbirth classes. This suggests that the idea of women learning on their own is more salient among women who do not attend childbirth classes. This idea may be a reflection of their childbirth ideology and influence their childbirth education decision.

When asked what they thought women ought to know about childbirth, five participants (11% of 47) said they did not know (Table 6.1). Even with further probing most declined to even speculate as to what women ought to know. Four of the respondents had not taken childbirth classes. Virginia (ECCBE), the registered nurse who worked in a medical unit, was the only one of the five respondents who had taken classes. She said "It's hard for me to say, being in nursing, you know a lot ahead of time." One might expect that a person who has gone through nursing education would have ideas concerning what women ought to know about childbirth; however, Virginia's response may be due to the fact that she works in a highly specialized area not related to obstetrics. In fact, even though she said she knew a lot, later in the interview she complained that her doctor and his staff neglected teaching her, she thought, because she was a nurse.

Melissa (NCBE), a 21-year-old, single, White Non-Hispanic participant who had worked as a nursing assistant, said she didn't know what women ought to know, because she "read a lot." Melissa was quite adamant that she did not "need childbirth classes." For her, reading and then "keeping a cool head" was all that was needed for the

childbirth experience. However, she would not elaborate on what she thought ought to be known, what she read, or how that reading helped prepare her for childbirth.

Carol (NCBE), a very shy and soft-spoken, single, 20-year-old participant from the Block Clinic, said, "I haven't really thought about that at all." Even with further probing she would not venture an idea of what she thought women ought to know. As will be shown later, Carol also said that she didn't want to know anything about childbirth because she didn't "want to be scared out of it."

Helen (NCBE), an 18-year-old, single, Hispanic participant from Block Clinic, said, "I don't know, I don't know anything myself." She went on to explain that she had read several books about childbirth and her grandmother, who had worked as a midwife, told her things. However, she did not identify anything that she thought women ought to know. Another Block Clinic participant, 27-year-old Yolanda (NCBE), implied that having problems with the pregnancy was the defining factor for what one ought to know. She said, "I don't know, it's kind of hard to say, I've never had any problems with this at all so far, so I don't know."

There were no distinct patterns by age, education, or SES among the respondents who gave this answer. With the exception of Virginia, the common link between the respondents was that they had not attended the childbirth classes. The fact that so few of the ECCBE and CCBE participants gave this response may be due to the fact that childbirth classes may give a different focus and heighten one's awareness of what to know and expect about childbirth. The NCBE respondents who said they did not know what women ought to know did not have the information from

the childbirth classes and may have had a different focus on the childbirth experience.

When asked what they wanted to know about childbirth, eight participants (17% of 47) stated they "didn't know enough" or "didn't know anything about pregnancy and childbirth" (Table 6.2). When asked what she wanted to know, Patricia (CCBE), a 22-year-old, single, White Non-Hispanic participant from the Prenatal Clinic, immediately responded, "I didn't know anything so I wanted to know everything!" Lynnette (CCBE), the 25-year-old Vietnamese American woman who took the PC classes with her husband, had a similar answer. She said,

> "Like to me, the first child, I don't have no idea what is it, what happenin', and now I know, ok, it will be like that, somethin', so I think this class is very helpful."

Another single, White Non-Hispanic participant from the prenatal clinic, 20-year-old Shelley (CCBE), talked at length about what women ought to know about childbirth; then when asked what she wanted to know, she said she was "scared" and "afraid of the pain." Then she went on to say that the classes had "eased" her mind because she had "a lot of questions or wonders."

Bonnie (ECCBE), the 25-year-old sales manager from the EC classes said she didn't know enough about the terminology used in labor and delivery and for that reason attended the classes. Karen (NCBE), the 18-year-old, single, Hispanic participant from the prenatal clinic, also said she didn't know enough about the terms used in childbirth. And Esther (ECCBE), the 29-year-old who was concerned about "old wives' tales," said, "I had no idea of what actually went on and stuff, I'd never had nobody really talk about their labor and delivery."

Twenty-five-year-old Vakisha (NCBE) from the Block Clinic took a took a slightly different approach when she said,

> "Because you don't know these things,like your body's changing, an' it's just a lot of different things that are happening to you and you don't know what's goin' on and you wanna know."

And when asked what she wanted to know, 19-year-old Janet (NCBE), a prenatal clinic participant, said, "Everything, I didn't know nothin', 'cause it was my first time, everything, I just wanted to know."

There were no distinct patterns by age, education, or SES among the participants who gave this answer. Sixty-three percent (5 of 8) had taken childbirth classes, but their responses concerning not knowing or not knowing enough were not distinctly different from those of the 3 (37% of 8) participants who had not taken classes. The respondents expressed similar concerns about the knowledge they felt they had and that which they needed, but the way they met their need for information differed. Some attended classes, some read for themselves, and some depended on friends or health care workers to provide information.

These expressions of not knowing anything or not knowing enough provide insight into what some women think about their own knowledge needs and what they do to get the information they want. Some women aggressively seek to gain the knowledge they think they need to accomplish childbirth successfully and use a variety of information sources including childbirth classes. Others are not so aggressive for childbirth information. As Lazarus (1994) points out, birth knowledge is not wanted to the same extent by all women. This fact is exemplified by the eight participants in this study. Five of the respondents took the childbirth classes and read various books and pamphlets. One respondent stated that she had wanted to go to class but did not have

transportation. She also said that she had not read any of the books or pamphlets that were available to her. One respondent who expressed no interest in taking classes stated that she got information from the nurse who visited her periodically. Another respondent who also did not want to take classes stated that she got most of her information from friends and sometimes from her doctor "if something is really bothering me."

In contrast to those who stated that they knew nothing or didn't know enough about childbirth, six participants (13% of 47) stated that they didn't have questions or didn't want to know anything (Table 6.2). Andrea (ECCBE), the 26-year-old registered nurse who had experience working in an obstetrical unit, said, "I just didn't have a lot of questions." This is a logical response due to her education and experience. But others also gave this response. On the other hand, Renae (CCBE), a 20-year-old, single participant who worked as a word processor, said "I didn't really wanna know anything." She then went on to explain that the classes upset her because she didn't want to know about the intensity of the pain. Twenty-year-old Carol (NCBE), a single, White Non-Hispanic participant from Block Clinic, said, "I really would rather not know, I don't want to be scared out of it!"

Twenty-seven-year-old Yolanda (NCBE), another White Non-Hispanic, single participant from Block Clinic, said, "Basically everyone's always told me everything so far so I haven't really had any questions at all really." On the other hand, 19-year-old Tanisha (NCBE), a single, African American participant from Block Clinic, simply said that she didn't want to know anything about childbirth because "really, there's

not that much to know about it." When specifically asked if there was anything she wanted to know about labor and delivery, she said,

> "I don' even think about that, I done heard so many stories, it's hard and it's gonna be hurtin', I don't think about it. I hears a lot of stories, I'm jus' waitin' for my time to come, I won't think about it when I get there then, I'll remember all those stories, but until then I don't think about labor or nuthin' like that, I jus' hope it don' be hard."

Yolanda (NCBE) and Tanisha (NCBE) felt they had enough information and knew enough to cope with their pregnancy, labor and delivery. Even though some doubt was expressed, especially by Tanisha, childbirth classes were not considered to be necessary for them to accomplish giving birth.

There were no distinct patterns by age, education, or SES among the participants who gave this response. Three of the respondents had taken childbirth classes and three had not (Table 6.2). There were no common links among the participants. It is interesting to note, however, that there are some women who do not want childbirth information, especially as it pertains to labor and delivery, because, for them, such information adds to their fears and increases their anxiety.

Another group of 6 participants (13% of 47) indicated that they knew enough about pregnancy and childbirth (Table 6.2). While these could have been included with the participants who said they didn't have any questions, I chose to place them separately because of the uniqueness of their answers. Esther (ECCBE), for instance, commented that she knew all about prenatal care, but in other areas she did have a lot of questions. As will be remembered, Esther was most concerned

about "old wives' tales" about labor and delivery, but she appeared to be comfortable with her knowledge about the pregnancy itself.

The responses of the other participants were a little different. Gloria (CCBE), a single, 20-year-old, White Non-Hispanic participant who worked as a fast food cook, angrily stated, "I already knew everything I needed to know, I took a parenting class in high school." Gloria was very disgruntled with her childbirth classes and saw them as "pointless" because "it was already stuff I already knew, and they didn't really, I don't know, didn't affect me any." Throughout her interview, Gloria expressed anger about her childbirth classes and was very insistent that she had learned all she needed to know in her high school class and had no need for more information.

Three (50% of 6) of the respondents stated they knew enough from their reading or from their friends and consequently did not need any more information. Twenty-one-year-old Milissa (NCBE), a single, White Non-Hispanic participant from the prenatal clinic, strongly expressed the fact that she knew enough. She said,

> "I don't know, I've got a really good book at home that shows and tells everything from beginning to end. I know enough to where I think if you keep a cool head you don't need to go to Lamaze and childbirth classes, you know."

Melissa was a self-assured young woman who exhibited a certain self-confidence in what she knew about pregnancy and childbirth and did not view childbirth classes as necessary in her preparation for labor and delivery. She gave more insight into her thought process and decision making in her responses to the question "who or what influenced you in your decision regarding childbirth classes," and I will return to her in that section.

It is interesting to note that none of the participants in the highest age, education, or SES categories responded that they knew enough. This may be significant in that it further contributes to the confirmation of the fact that older, more educated, and higher SES women are more likely to take childbirth classes. It may also be significant that younger, less educated, lower SES women did give these responses. This may indicate an ideological conflict in which the dominant childbirth ideology assumes that childbirth education is essential and some women assume that it is not essential. For some, as indicated in the question "who or what influenced your childbirth education decision," taking childbirth classes would lock them into doing things they didn't want to do. Thus, childbirth education itself becomes a power struggle issue that, though subtle, is present for some women.

What Do Women Learn in Childbirth Education Classes?

A woman's understanding of the nature of childbirth education may influence her decision to take or not to take childbirth classes. Frequently, women who have taken classes provide information about the class content for women who haven't taken them. Doris (ECCBE), who had also asked her sisters about their childbirth experience, pointed this out when she said, "My friends informed me, they talk about classes, I guess it's just my environment." Women who have not taken classes and have no friends or family who took them may have other ideas about the content given in childbirth classes and the relevance of that content to their own situation or needs.

To determine how the study participants perceived childbirth education, those who had taken the classes (CBE) were asked "If someone asked you what childbirth education (or childbirth classes) is, what

would you tell them?" Those who had not taken classes (NCBE) were asked, "What do you think women learn in childbirth classes?" The responses given to both questions were similar and were analyzed together under the question "What do women learn in childbirth education classes?" (Table 6.7).

Breathing and relaxation, preparation for labor and delivery, and what to expect in labor and delivery were most commonly mentioned as topics taught in childbirth classes (Table 6.7). However, for each of these topics there were distinct differences in the number of responses given by the non-childbirth educated (NCBE) and childbirth educated (CBE) participants.

Learning what to expect and how to be prepared for labor and delivery was the most mentioned response to the question "what do women learn in childbirth classes." A total of 34 participants (72% of 47) gave answers related to this topic (Table 6.7). Slightly more of the CBE (74% of 31) than NCBE (69% of 16) participants mentioned learning what to expect and how to be prepared.

TABLE 6.7 - What Do Women Learn in Childbirth Education Classes?

Responses	CBE	NCBE	Total
Preparation for labor	23 (74%)	11 (69%)	34 (72%)
Breathing and relaxation	12 (39%)	13 (81%)	25 (53%)
Anatomy/physiology changes	10 (32%)	1 (6%)	11 (23%)
Postnatal care of self and baby	7 (23%)	3 (19%)	10 (21%)
I don't know	0	3 (19%)	3 (6%)
Number of Respondents	31	16	47

In their response to the question, the CBE respondents spoke of being prepared for things that might happen during labor and delivery. Virginia (ECCBE), the nurse who had not had obstetrical experience, put it this way, "It's an education or guideline in what to expect and how to prepare for labor and delivery." Nineteen-year-old Meg (CCBE) said, "It's a way for you to get prepared for what's gonna happen." Another 19-year-old from the prenatal clinic, Rachel (CCBE), summed up all of the statements about expectations and preparation in her description of what is learned in childbirth classes,

> "Preparing you for birth, for labor and delivery, letting you know everything, all the possibilities, all the things that could go wrong, and explaining everything."

Some of the CBE respondents also commented on learning about the use of medications, knowing the options, and the possibility of having a Cesarean section.

The NCBE respondents' comments about learning what to expect and how to prepare for labor and delivery were similar to those of the women who had taken classes. For instance, Linnea (NCBE), the 22-year-old African American woman from the Block Clinic who was concerned about knowing how to react to contractions, said,

> "get you kinda prepared for, you know, when you have your, um, what do they call it, um, not cramps but... contractions."

Vakisha (NCBE), another African American participant from the Block Clinic, said that in childbirth classes women learned, "How to get from one thing to the next without, you know, panicking." Teaching "so you won't be nervous and will know how to react" and tours of the hospital were also mentioned by the NCBE respondents, but none mentioned learning

about the use of medications, things that might go wrong, or Cesarean sections.

Twenty-five of the total forty-seven study participants (53%) mentioned such things as relaxation, focusing or centering on yourself, keeping calm, and breathing as the main things that were taught in childbirth classes. Eighty-one percent (13 out of 16) of the NCBE participants gave these comments, whereas only 39 percent (12 out of 31) of the CBE participants did so (Table 6.7).

When speaking about breathing and relaxation, it was common for the CBE respondents to remark about the importance or worth of the techniques they had learned. The 21-year-old African American college student, Nan (ECCBE), put it succinctly with her comment,

> "The breathing methods, um, I didn't know how necessary that was but I think that's something that could be very helpful, especially since I am one to just kinda tense up."

A few NCBE respondents also agreed with Nan about the worth of learning breathing and relaxation techniques. When 27-year-old Yolanda (NCBE) was asked what she thought women learned in childbirth classes, she said,

> "Breathing, you know, and good stuff, I know they do it, they did tell me about that and I knew that. My Mom says it does help, so that's why I did it to begin with."

Yolanda was a single, White Non-Hispanic participant from the Block Clinic who had originally enrolled to take the classes. She was very positive in her statements concerning childbirth education, even though she was unable to attend.

In their response to the question of what women learn in childbirth classes, some of the CBE and NCBE respondents just mentioned, "breathing techniques" or "basically breathing" and did not elaborate.

A few of the NCBE respondents were not quite as sure or enthusiastic as some of the respondents when they talked about women learning breathing and relaxation techniques in childbirth classes. For instance, Janet (NCBE), the 19-year-old prenatal clinic participant who said that she didn't know anything about childbirth, said, "Breathing, maybe just how to tolerate the pain, I guess, I have never been there." Agreeing with Janet, another prenatal clinic participant, 21-year-old Amanda (NCBE) said,

> "I think, I'm not really sure, I think a lot of breathing and the comfortable positions, you know, to get into, how to cope with all the pain, I guess."

Even though some were less sure than others, it is probably not surprising that so many of the NCBE participants mentioned breathing and relaxation techniques because, when they first register for care in the prenatal clinics, the nurses tell them about childbirth classes. In their description of the classes the nurses stress that breathing and relaxation techniques are an essential part of what the participants learn. Several of the NCBE participants also mentioned that their sisters or friends had taken the classes, and it is likely that they shared the information they learned. What is more surprising is that so few CBE participants mentioned these things. It is possible that they merely forgot to mention them or they may have assumed that "everybody would know," since they are an integral part of the classes. Some may have also assumed that the techniques are part of the preparation for labor which they had already discussed and therefore saw no need to mention them separately.

Learning about anatomy and physical and mental changes that occur during pregnancy, labor, and delivery was mentioned by eleven

participants (23% of total 47) (Table 6.7). Ten CBE participants (32% of 31 total) and one NCBE participant (6% of 16 total) included these topics in their answers to the question "what do women learn in childbirth education classes." The respondents mentioned learning about "what's going on inside your body," "how the baby grows," "how your body looks and the changes you go through." Twenty-one-year-old Jacoba (CCBE), a single, White Non-Hispanic participant from Block clinic, included both the baby and the mother in her statement,

> "They inform you more about the baby and they let you know what changes your body's going to go through, not only how the baby grows but how you're going to grow too."

Several participants commented on learning about the positions of the baby in the uterus. Linda (ECCBE), a 33-year-old graphic artist, gave a good summary of these comments when she said,

> "Oh, just seeing the baby, like, pictures of the baby in different positions, to know what's going on inside your body and that was helpful."

Nutrition, use of medications, and general care were also mentioned in the statements pertaining to anatomy and changes in pregnancy. Loris (ECCBE), the talkative participant from the Educational Center, pointed these things out when she said,

> "To educate on, you know, the care of yourself, of course while you're pregnant, diet, use of any antibiotics or anything like that."

Elena (NCBE), one of the African American women from the Block clinic who thought women learned on their own, said, "How to, um, probably how to eat, how to... watch so you won't gain too much weight."

Some of the NCBE participants mentioned anatomy and physical and mental changes that occur in pregnancy, labor, and delivery when they were asked what they thought women ought to know about childbirth, but

none mentioned them as things that they thought women learned in childbirth education classes. It may be that they do not perceive these topics as being taught in the classes; however, since the question was open-ended and did not ask for specific information pertaining to various aspects of pregnancy and childbirth, it is more likely that the participants just didn't mention them. A more directed question or more probing might elicit additional ideas about the teaching of anatomy, physical and mental changes, and care in pregnancy, but since this was not the focus of the study this type of questioning was not pursued.

Ten participants (21% of 47 total) mentioned the postpartum period in their response to the question "what do women learn in childbirth education" (Table 6.7). With the exception of one response offered by Doris (ECCBE), that childbirth classes were "a general guideline to care for yourself and your baby," only infant care and feeding after delivery were suggested as things women learned about the postpartum period.

Seven CBE participants (23% of 31) and three NCBE participants (19% of 16) mentioned postpartum care as something that women learned about in childbirth classes (Table 6.7). This slightly higher percentage of responses by the CBE participants could be attributed to the fact that they had just finished their childbirth classes, which end with the postnatal care of mother and baby. Therefore, being more aware, they may have been more likely to mention this in their response. It may not be surprising that so few NCBE participants mentioned learning about the postpartum period because when the clinic nurses talk to them about the classes, the nurses tend to stress the relaxation and breathing techniques that are taught and only briefly mention things the participants will learn about the postpartum period. Therefore, it is

possible that NCBE women do not perceive childbirth classes as a place from which to gain information about care of themselves or their babies after the birth. It is also possible that the question itself, which asked about "childbirth" education, may have been misleading if childbirth was perceived as meaning only labor and delivery and not the period after the child is born.

Three NCBE participants (19% of 16) replied that they did not know what women learned in childbirth education classes. Twenty-one-year-old Debra (NCBE), a Hispanic farm worker, said, "Oh, I don't know what they do and everything, but I know that they have 'em here." Debra's comment was similar to those of an African American clerical worker, 19-year-old Tanisha (NCBE), and 25-year-old Danielle (NCBE), a White Non-Hispanic fast food worker, who also said they did not know what women learned in childbirth classes. With a little probing, each of these participants did venture a guess as to what was taught. Debra said, "The breathing, once you're inside the laboring room, 'cause I don't know that much about it." Danielle also mentioned breathing. She said, "Probably how to breathe, I have no idea." Tanisha paused a long time before she answered. Finally, very tentatively, she said,

> "How to prepare for the child, and, I don't know, learnin' techniques for when the child come an' how to be there for the child listening."

Though Debra, Tanisha, and Danielle guessed at what women learn in childbirth classes, none was confident that her response was correct and asked if that was the right answer. Even though I assured them that I was not looking for right or wrong answers but just wanted their ideas, they would offer no more information.

Debra, Danielle and Tanisha were 19 to 25 years of age, had 12 or fewer years education, and had level I or II socioeconomic status. While age does not appear to be a determining factor in their answers, their lower levels of education and lower SES may be.

Poorer, less educated women may not have enjoyed or progressed well in school and may feel threatened by childbirth classes if the classes are perceived as being like formal school classes. They may also have poor reading skills and therefore do not read the information they are given. Consequently, they may not know what childbirth classes are or see them as a source for the information they want. They may perceive childbirth classes as being for better educated women who have higher status.

It is also possible that less educated, working class women do not agree with or accept middle-class aspirations in the childbirth experience. If friends or family members, who share the same education and SES, have not taken classes, or provided information about them, it is not surprising that the content of childbirth education is not common knowledge. While there may be a correlation between a woman's general educational experience and her decision to take or not take childbirth classes, it must also be remembered that a woman's own childbirth ideology, supported by her social group, will probably influence her decision even more.

When asked the question "what do women learn in childbirth classes," some participants gave extraneous answers that did not pertain to what women actually learn but did give some insight into how they felt about the classes. In general, the women who had taken the classes were more positive in their answers. Esther (ECCBE), as did others,

expressed her satisfaction with the classes when she said, "It's a big help, a way of finding out fact from fiction." Others said they would encourage women to take the classes. Andrea (ECCBE) said, "I guess the biggest thing is I would encourage people to take a class." Thirty-two-year-old Kara (ECCBE), who was also a graphic artist, made an interesting statement. She said,

> "I think there are some people that wouldn't go just because they think, you know, well, they'll tell me in the hospital, why should I need to know that, you know, and I guess that's what I would, if somebody asked me, I'd tell them, you need to go because you need to know how to breathe and you need to know what your body's doing."

Three CBE participants also mentioned that classes were important for preparing the husband or coach so that he would know what to do and how to help during labor.

Three CBE participants expressed discontent when asked what they would tell someone what childbirth education is. Twenty-year-old Renae (CCBE), a single participant in the prenatal clinic, was distressed with the videos that were shown in class. She explained,

> "I get upset. When they made us sit there and watch those movies and stuff, I'd go in the bathroom and sit, because I can't watch 'em, I can't stand blood, I can't stand hearing....I know I'm in for it but, you know, I get, that makes me sick, I don't like it. That just scares me. You know, some people wanna anticipate, they wanna be prepared for the pain. I don't wanna be prepared for it, I will find out when I get there that's all there is to it, you know, I don't, 'cause it just makes me not look forward to it."

Risa (ECCBE), a married, 36-year-old college graduate, like Renae, was also frightened by the classes. She said, "I wasn't nervous about labor and delivery till I started those classes. Those classes scared me." She too expressed the fact that the videos were realistic and frightening, but she also said that it was good that she had gone to the

classes and, "I still do go in anticipating that it's not going to be that bad." On the other hand, Gloria (CCBE), a single, 20-year-old high school graduate, was not happy that she had taken the classes. When asked what she would tell other women, Gloria said,

> "That they're pointless. I thought they were, 'cause it was already stuff I already knew, and they didn't really, I don't know, didn't affect me any."

As mentioned previously, Gloria had taken a parenting class in high school and felt that she "knew all she needed to know" from that class. For her, childbirth classes were a waste of time and didn't help.

Five participants commented on the structure or composition of the classes. Twenty-two-year-old Jennifer (NCBE), a married participant, had not taken the classes, but she thought, "they [class participants] watched a lot of movies." Twenty-five-year-old Dora (CCBE), a married participant who had taken classes, confirmed Jennifer's assumption. She stated, "we saw a lot of movies." Some, like Jacoba (CCBE), a single participant from the Block clinic, said, "If you have fears or questions, you can ask." Twenty-four-year-old Rosalia (CCBE), one of the Hispanic participants from the Prenatal Clinic, was the only one to mention class members. She said, "I would tell them it's mostly couples in our class, but I guess it can be anyone who's going to be your coach."

Three other statements given in response to this question provide some insight into how some women view childbirth classes and how that view affects their childbirth education choices. Thirty-one-year-old Ardis (ECCBE), who worked as a marketing manager, said, "I went in not really knowing what to expect." Not knowing what to expect from the classes was also expressed by several women in other parts of the

interview. One, for instance, took the classes simply because she was curious, and several said they just wanted to see what the classes were like. The fact that some women take the classes just out of curiosity without knowing what to expect may be significant.

What influences one to take the classes when she does not know what to expect, whereas another may decline to take classes for the same reason? The data collected for this study may not be able to fully answer this question. Certainly ideology cannot be overlooked as an influencing factor. Based on Fairclough's (1989) theory that ideological assumptions are drawn upon without thought, it is probable that subconscious ideological assumptions of pregnant women influence their behavior, even though they may perceive the behavior as a mere response to curiosity or not knowing what to expect.

The final two responses pertained to the information gained in the classes. Bonnie (ECCBE) said, "I think you find out more than the general public knows," and Dolly (ECCBE), a 24-year-old, single participant who attended the classes with her mother, thought "they definitely provide information, whereas you don't receive it in the doctor's office." Getting information from the class that cannot be obtained easily during the doctor's visit was also mentioned by participants in other parts of the interview.

It appears that taking classes was a more satisfying and complete way of learning than just talking with doctors. Busy doctors often don't have or take time to answer all of their client's questions. Many physicians have nurses in the office who will teach the clients and answer questions, but in general, it is up to the woman herself to obtain the information she wants. Often, this must be done outside of

the doctor's office. The importance of, or need for, information in a woman's childbirth ideology, as well as her desire to learn and the availability of information, must be considered as factors that contribute to her childbirth education decision.

Who or What Influences Childbirth Education Decisions?

A woman's childbirth ideology affects not only the way she speaks of her childbirth experience but it also affects the decisions she makes in that experience. However, decisions may also be influenced by other contributing factors. To gain insight into both external and internal factors that affect women's childbirth education decisions, I explored the study participants' perceptions of who or what influenced their decision. Childbirth educated participants (CBE) were asked, "Who or what influenced you in your decision to take childbirth classes?" Non-childbirth educated participants (NCBE) were asked, "Are there any special reasons why you decided to not take childbirth classes?" The answers given by each group were too varied to be analyzed together and are therefore presented separately.

Women's Perception of Factors That Affect Their Decision to Take Childbirth Classes

When asked the question, "Who or what influenced you in your decision to take childbirth classes," some of the participants named only one person or factor, while others listed two or more determinants. Among the CBE respondents, the most mentioned influence was family. In the term "family," I include the respondent's mother, sisters, husband, fiance, or boyfriend. I also include in the "mother" and "sister" categories, the mother and sisters of the husband, fiance, or boyfriend who were mentioned as persons involved in the respondent's childbirth

education choice. Sixteen CBE respondents (55% of 31) mentioned various members of their families that encouraged or in some way influenced their decision to take the classes (Table 6.8).

TABLE 6.8 - CBE Participant Response: "Who or What Influenced Your Childbirth Education Decision?"

Responses	ECCBE	CCBE	Total CBE
Family Members:	8 (50%)	9 (60%)	17 (55%)
husband, boyfriend, fiance	5 (31%)	5 (33%)	10 (32%)
mother	1 (6%)	4 (27%)	5 (16%)
sister	2 (13%)	0	2 (6%)
Personal desire/decision	7 (44%)	8 (53%)	15 (48%)
It's expected, "the thing to do"	8 (50%)	3 (20%)	11 (35%)
Friends and other people	7 (44%)	2 (13%)	9 (29%)
Doctor, clinic, or nurse	5 (31%)	3 (20%)	8 (26%)
Number of Respondents	16	15	31

The woman's partner, spoken of by the respondents only as husband, fiance, or boyfriend, was the most mentioned family member (10 responses, 32% of 31) who influenced the decision to take childbirth classes (Table 6.8). Various things were mentioned about partners that influenced the decision to take the classes. Five respondents stated that their partners wanted to take the classes because this was their first child and they wanted to know what was going to happen. Such things as the father's being concerned and not knowing what to expect were commonly mentioned by these respondents. Renae's (CCBE) comment about her husband's influence echoed the other responses. She said,

> "The actual daddy, here, he wanted to take 'em. He's the one who signed up for 'em, 'cause he's the baby of the

> family and he's never been around babies and has no idea what the process is of pregnancy or anything."

Two respondents said they were worried that their partners wouldn't be able to deal with the labor without preparation and that influenced their decision to take the classes. Esther (ECCBE), for instance, told a long story about a fainting spell she had early in her pregnancy one hot day after bringing the laundry in from the line. When she fainted, she bumped her head and had to have some stitches. Her fiance became very upset with the situation and had such a hard time with what had gone on that she decided he would not be able to deal with labor and delivery at all if he were not prepared. He was willing to attend the classes and took part in them enthusiastically. At the time of the interview Esther said they both felt ready for the labor and delivery experience, but she still wasn't totally sure that her fiance would hold up under the stress. She was planning on being his support rather than having him as her support during labor.

For most of the CBE participants the husband, boyfriend, or fiance "went along with it" and took the classes, but in some cases it was the woman herself who did so in response to her partner's urging or decision to take the classes. One participant, 21-year-old, Jacoba (CCBE), stated that her partner thought it would be good for her to learn the relaxation techniques. She said,

> "Well, my fiance wanted us to take them because one of his friends, his wife's already had a baby, they took the classes, and for her they made her feel better, and I get so tired all the time, and he wanted me to learn to relax a little bit, he thought I was straining myself and if not myself I was straining the baby. I'm on the go too much, I had to learn to settle down. I went along with it."

The fact that husbands could be included and were encouraged to take part in the classes was an influencing factor for three of the women who mentioned husbands, fiances, or boyfriends. They felt that it was a good opportunity to include their partners in the experience of the pregnancy as well as having them learn how to be a support in labor. Bonnie (ECCBE), the 24-year-old, married, sales manager explained her decision this way,

> "I would most, I mean something that probably needed it, that I anticipated or that I looked forward to about it was that it was for both my husband and myself, whereas a lot of my appointments I make for my lunch hour or on my days off or things like that and my husband has only been able to attend a few of them, whereas this class was aimed at both a coach and the pregnant mom. So that appealed to me. I liked it that he was being involved in the pregnancy, so that certainly led me to take the class."

The fact that their partners wanted to know about childbirth, could be and were encouraged to be involved in the classes, and in some cases saw the classes as beneficial for themselves or their pregnant partners were strong influences for these respondents in their decision to take the childbirth classes.

The women who expressed the desire to include the father of the baby in the pregnancy and childbirth experience had stable relationships with their partners either through marriage, engagement, or living together. The need for a stable supportive relationship, though not identified as one of the influencing factors in the childbirth education decisions, was expressed by several of the participants. One of the CBE participants, who did not have a stable relationship with the father of her baby, repeatedly returned to the subject of the support person and how important it was to have someone to encourage and support you through pregnancy as well as labor and delivery. Several of the

participants who did not take classes also talked about the need for a supportive person. The presence of a supportive partner and the ability to include him or her in the childbirth experience may affect a woman's decision regarding childbirth classes, even when her own assumptions about childbirth do not otherwise include childbirth education.

The second most-mentioned family member was mother. Five respondents (16% of 31) mentioned their mothers or their fiances' mothers as the family member that influenced their decision to take the childbirth classes (Table 6.8). Three of the respondents said they had not planned on taking the classes but their mothers had a strong influence in changing their mind. Nan (ECCBE), the 21-year-old, African American college student, expressed it this way,

> "My mom pretty much pushed me, she told me that I would definitely, 'cause I wasn't gonna take one, I had figured, oh, I don't need it, I'll be ok, and then I took it and I'm like, oh my gosh!"

For some, mother was the goad that "pushed" the decision to take the classes, but for others, mother was the support person for the respondent's own decision to take classes. When asked who or what influenced her decision, Monique (CCBE), a 24-year-old, married, Native American participant from the Prenatal Clinic, pointed out that she thought the classes were important, but the support she got from both her husband and her mother helped her make the decision. She said,

> "My mom, myself, my husband. I jus' think it's important, just to know so you won't be as scared, you'll learn how to do those breathing techniques that helps you relax better and you can, you can use those for when you get your Braxton Hicks contractions."

Renae (CCBE), a 20-year-old, single participant, who earlier in the interview said she "didn't really wanna know anything," had a

different experience. When asked about the influences in her decision, she said, "I don't know, 'cause my Mom never took anything, so it wasn't her." She then went on to explain that her fiance's mother encouraged her. She also said that her fiance wanted to take the classes and he was the one who "signed up for them."

As in the previous examples of the influence that husbands, boyfriends, and fiances had in the childbirth education decision, here again, the influence of a supportive person is able to override the initial assumption that childbirth classes are not an important part of the childbirth experience. Whether as goads or encouragers, the mothers did influence their daughters' childbirth education decisions. It would be interesting to know what influenced the mothers in their decision to "push" or encourage their daughters to take childbirth classes, but that information was not sought in this study. The more important factor here is that the daughters responded and took the classes.

Although their sisters' childbirth experiences were recounted in other sections of the interview by eleven (35% of 31) of the CBE participants, only two (6% of 31) mentioned their sisters as persons who influenced their own childbirth education decisions (Table 6.8). Both mentioned that their sisters had taken the classes and that was an influencing factor in their own decision to take them, however; both participants stated that it was primarily the doctor, and not their sisters, who influenced their decisions to take the classes.

It was surprising that so few respondents mentioned their sisters as influencing their decisions. However, many of the respondents said they were the first "girl" in their family to be pregnant. Some had older brothers and a few had younger sisters who had children but these

siblings were not specifically identified as influencing persons. A few of the respondents said that "everybody" influenced them but did not identify who the "everybody" was. It could be that sisters were included in the "everybody" but this was not confirmed in the interview.

Personal desire and decision to take the classes was the second most mentioned influencing factor (Table 6.8). Fifteen of the CBE participants (48% of 31) stated that it was their own decision to take childbirth classes. That "they intended to take classes from the start," "just wanted the experience," or "just wanted to do it to learn as much as possible and be prepared for the experience" were common statements among the respondents. For instance, Andrea (ECCBE), one of the registered nurse participants, stated that she decided to take the classes "probably more just for the experience of it and for my husband." Gloria (CCBE), who had completed high school and worked as a fast food cook, said she took the classes, "'Cause I didn't really know what they were, thought maybe I might learn something."

Giving the reasons of just wanting to do it, to learn more, to experience it, to be prepared, to get to try things out, and just wanting to know, the respondents denied other primary influences on their own decision to take childbirth classes. However, some did mention secondary persons such as the doctor, a family member, or a friend that had encouraged or reinforced their own decision to take the classes.

Taking classes because "it's just something that you do" or "it's expected that you take them" was mentioned by eleven (35% of 31) CBE respondents (Table 6.8). Interestingly, none of these respondents said who expected them to take the classes or why they "had to do it."

Nonetheless, the unidentified "everybody," and "they" were compelling influences to take the classes. Comments such as, "But it's just something you always think, you gotta take them, it's the thing to do" (Risa ECCBE); "kind of just, that's what everybody does, you know" (Doris ECCBE); and, "I never thought about not taking it" (Amy ECCBE) were common responses.

Taking classes because it is the right thing to do was also mentioned. For example, Johanna (ECCBE), a married, school teacher, said that she and her husband just planned on taking the classes but then she stated, "You know, we just are more of the let's-do-things-right type people, and we try to make time for that." The perception of it's the thing to do, doing it right, and it's expected are the "ought to's" and "should's" of the dominant childbirth ideology that, having been accepted and internalized as a basic *common sense* assumption, not only reinforces other influencing factors but can in itself be a powerful influence in the decision to take childbirth classes.

Friends and other people outside of the family were also mentioned as influencing the decision to take childbirth classes (Table 6.8). Nine participants (29% of 31) said that their friends, women they worked with, or other people influenced them. Thirty-six-year-old Risa (ECCBE), a youth corrections officer, expressed a common comment when she told me "everybody's asking, have you started taking classes yet?" Twenty-nine-year-old Loris (ECCBE) who was an office worker in a local agency, said,

> "Basically everyone that I knew that had had babies took the classes and they recommended it, so I was kind of, it was on a recommendation, so I think I thought, well, it's just something that you do."

Several participants mentioned being pressured by people. Dolly (ECCBE), a 24-year-old sales clerk, pointed this pressure out when she was asked who or what influenced her decision,

> "I had a lot of pressure from a lot of people actually to take the birth classes, which was good. I had a lot of people at work asking me when I was going to take my Lamaze classes. Otherwise I don't know if I would've actually done it, I would probably have gone to the wayside."

Dolly's comment about going "to the wayside" further emphasizes the incredibly strong influence of the dominant childbirth ideology. Those who do not subscribe to the dominant assumptions and behaviors are seen as going astray or going by the wayside. As long as women (and their partners) stay in line, follow the prescriptions for childbirth education and childbirth itself, and do not "go by the wayside," the dominant ideology can continue to grow and exert its power. The women who fulfill the expectations set for them will then be, as Davis-Floyd (1988) puts it, transformed into new social roles, competent and accountable to society.

Influence exerted by medical caregivers is another external factor that affects childbirth education choices. Eight CBE participants (26% of 31) mentioned doctors, midwives, or nurses as persons who influenced their childbirth education decision (Table 6.8). Among the respondents, six identified the doctor, midwife, or nurse as the primary person who either suggested or encouraged class participation. One respondent stated that her doctor "demanded" that she take the classes. Doris (ECCBE), a 24 year old interior designer, had a similar experience. She thought that taking childbirth classes was expected of every pregnant couple. Her expectation was reinforced by her physician. She said,

> "Kind of just, that's what everybody does, you know, on my little sheet that I took home from one of my first doctor appointments it said, around three months make your appointment to go to these childbirth classes, so...."

Though never specifically told that she had to take the classes, she and her husband did so because they thought that was what "everybody" did and the doctor's information reinforced that thought. Accepting it as part of prenatal care expectations, she and her husband took the classes. They did not question the expectation nor their prerogative not to take the classes.

Another respondent, 31-year-old Ardis (ECCBE), interpreted her doctor's response as encouragement. She and her husband had already decided to take the classes before she went for her first prenatal visit. She explained it this way,

> "[We decided] Pretty much on our own, um, my doctor really encouraged it, and I mean right from my very first prenatal visit, you know, here's the book, here's the times of the classes, you know we really want you to go."

Although made before her first prenatal visit, Ardis's decision was strongly reinforced by her physician. Her physician's comments also indicate a certain expectation that childbirth classes would be attended.

Medical personnel encouraged and reinforced the decision to take childbirth classes, but for the majority of the respondents the care givers were not the primary influence in their childbirth education decision. In their study on the motivation to take childbirth education, McCraw and Abplanalp (1982) also found that, though mentioned, physicians were not identified as the most influential persons in their participants' decisions to take childbirth classes. While the number of participants in my study who listed medical

caregivers as influencing their decision is also small, the interview data indicate that medical personnel do influence women in their childbirth education decision, even though that influence is often not the primary source.

Women's Perception of Factors Influencing Their Decision Not to Take Childbirth Classes

The NCBE participants, like the CBE participants, gave a variety of answers when they were asked if there were any special reasons why they had chosen not to take the childbirth classes (Table 6.9). It is interesting to note that some of the influencing factors for choosing not to take the classes are the same as those given for choosing to take them. Many of the NCBE participants said that they wanted to take the classes. Their comments point out the strong influence exerted by the dominant childbirth ideology and the expectation to take the classes. For some, there is a struggle and frustration because they could not take the classes; for others a struggle is evident as they try to cope with the demands of the existing dominant childbirth ideology.

The majority of the NCBE participants expressed an interest in childbirth education classes. Ten participants (63% of 16) stated that they had either planned on taking the classes or had wanted to take them but for some reason could not (Table 6.9). A common comment was, "I wanted to [take the classes], but...." The reasons for not taking them are important factors to consider.

Three of the respondents said they wanted to take classes but did not have transportation. Earlier in the interview, one of the women, Karen (NCBE), a single, 18-year-old who had completed only 8 years of schooling, expressed interest in knowing about her pregnancy and wanted

more information about delivery. However, when asked if there was any special reason why she chose not to take the classes, she said that

TABLE 6.9 - NCBE Participant Response: "Who or What Influenced Your Childbirth Education Decision?"

Responses	NCBE
I wanted to go, but...	10 (63%)
I didn't want to go; I want to do it my way	4 (25%)
I just did not want to go; I'm too busy	3 (19%)
I know enough and don't need to go to classes	3 (19%)
Number of Respondents	16

transportation was the only thing that kept her from taking them. "I don't really have any transportation but my feet, so, gettin' around's kinda hard for me." Karen lived approximately 13 blocks from the hospital and walked in for each of her clinic appointments. She said there was no bus line close to her house, and even if there were, the bus schedules were not good because they ran so few times in the day and did not run at all after 6 in the evening. She went on to say,

> "Usually you take your classes in your seventh and eighth month, but I ain't got transportation except for my feet, once you get around your eighth or ninth month your feet start to blow up."

Consequently, not having ready transportation and believing that swelling in the eighth or ninth month was common and would hinder her walking, Karen did not enroll in either the PC or EC classes.

Two participants from the Block Clinic, Helen (NCBE), a 19-year-old, single, Hispanic woman, and Yolanda (NCBE), a 27-year-old, single, White Non-Hispanic woman, had similar stories about transportation problems. At first, both had decided not to take the classes because

they didn't think they needed them, but as they got further along in their pregnancies they changed their minds and decided to go. Both women had actually registered for the classes and had their class hours scheduled, but in the end, could not find transportation to get there. Helen did not say why she had no transportation, but Yolanda explained,

> "I don't know how I'm gonna get there, 'cause they're at night time and I don't have a car and most of my family works early in the morning so they won't be able to take me, they don't have time. If it was any other time it wouldn't be so hard with busses running and everything but it's eight to ten at night so, it's a different story."

For Helen and Yolanda, transportation, especially in the evening, was a problem. There are two morning classes given each week, one offered by the EC and the other given by the PC. The respondents did not mention the morning classes or problems that might be associated with attending them, i.e., their partner's or their own work schedules. Whatever their reason for not enrolling in the daytime classes, they reported lack of transportation as a barrier for them.

Another factor expressed as a hindrance to taking the desired classes was scheduling. Three respondents had conflicts between their schedules and the times that classes were offered. Twenty-one-year-old Amanda (NCBE), stated "We just were just having a hard time, between both of our schedules, trying to get there." Amanda's boyfriend, who was going to be her coach, worked in construction and often did not get off work until late in the evening. Amanda worked in a day care center in a small town just outside the city. She would wait for her boyfriend to come pick her up from work. Often he would be too late to drive the long distance to the hospital in time for the classes. Consequently, she did not register for them.

Another Hispanic participant, 21-year-old Debra (NCBE) had a similar story. Her husband worked every day until 7 p.m., but the EC had assigned them to a 6 p.m. class, "so I couldn't be able to come." There are classes that start at 8 p.m., which might have been better for Debra and her husband. But even the later class may have been difficult to get to. Debra was not asked why she didn't try to change to the 8 p.m. class. She may not have realized that she could request a time other than that assigned to her. Some women feel powerless when confronted by people involved in the medical profession and do not try to change things to their benefit. Also, classes do fill up early and she may not have been able to get into any other class. Regardless of the reason for not trying to change the class time, for this couple the scheduling conflict was an insurmountable barrier to their attending the classes.

The third respondent who mentioned scheduling problems was a full-time student in a local college and attended daytime classes. Her boyfriend, who was going to be her support person, worked afternoons and evenings. Though they both expressed an interest in attending the classes, no time was available when they could attend together. For this couple also, scheduling was a barrier.

The remaining participants who wanted to take classes had various reasons for not attending. Twenty-four-year-old Danielle (NCBE) didn't sign up in time to get into one of the evening classes; then she admitted, "None of the ones in the morning, I jus', dread, didn't feel like goin', I'm not a morning person." Danielle had completed only 10 years of education and she did not appear to be highly motivated to take the classes. Since she was very accommodating and was eager to please,

she may have said that she was interested in classes just to appease me.

Earlier in the interview, Danielle stated that she had put away all of the pamphlets and things she had received without reading any of them. She also said that she was not sure what was taught in the classes. When asked what she thought women learned in the childbirth classes she said, "Probably how to breathe, I have no idea."

Awareness of what is taught in childbirth classes may be a motivating factor in a woman's choice to take classes, but the time of day in which the classes are taught may also influence the decision. For some, morning classes may be difficult to get to if attending disrupts the normal daily schedule. Others may find it difficult to attend evening classes. Having to register for classes early in the pregnancy may also hinder some women, especially since at that time they tend to focus on the reality of being pregnant and are not yet thinking about the process of labor and delivery or how to prepare for it.

Twenty-two-year-old Beth (NCBE), a White-Non-Hispanic participant who worked as a waitress, had planned to attend the classes with her girlfriend who was also pregnant but, she said,

> "I lost the sheet, and it's like, well, maybe I should get another one, and it's like, it totally escaped my mind, though I had so much on my mind at the time, it was like, oh shoot, I missed those classes, you know, but....Anyway I have my mom here and everybody else so, I'm not too worried about it."

Beth also said that her friends had taken the classes but then told her "It was nothin' like the class, you forget everything." Beth went on to say, "One friend said it was a waste of time, she forgot everything, so that kinda stuck in my mind a little bit." Beth concluded that as long as her mom and "everybody else" were there, everything would be all

right. Though initially an interest for Beth, other problems crowding her thoughts and lack of encouragement from her family and friends made childbirth education classes an opportunity that could be missed.

Preexisting and overwhelming problems can be a dynamic factor in one's childbirth education decision. Like Beth, who said that she did not enroll for classes because she "had so much on her mind," 19-year-old Tanisha's response also demonstrated the barrier that life problems can place in one's decision and ability to take classes. When asked what influenced her decision, Tanisha replied, "Oh, I don't know, I guess it's jes' the problems that I have an' stuff that's keepin' me from goin'." When I had talked with Tanisha before the interview, she told me that she would like to go to the classes but she did not have a home base. She moved frequently from one home or shelter to another and never knew for sure where she would be next. Without question, this would be a hindering factor to the possibility of taking classes. For the same reason, Tanisha was not faithful in attending her prenatal clinic visits. The home and economic situation of a woman may influence her childbirth ideology and are factors that cannot be ignored in her decision to take or not to take childbirth classes.

For Sonia (NCBE), a 20-year-old, White Non-Hispanic participant who had 13 years of education, having time to attend classes was a problem. Sonia said she would have attended classes but,

> "I usually have to get up early and get my boyfriend or my fiance or whatever you want to call him, I gotta get him ready for work, laundry done, I mean, I don't have the time. I mean, right now I know I was going to be really tired after the baby so I'm trying to get everything to go before. And I found out way too late to start these classes."

Sonia actually gives two reasons for not attending the classes. It is interesting that her answer about being too busy is given for the present time, "right now...I'm trying to get everything to go." At the time of the interview, Sonia was in the thirty-seventh week of her pregnancy and naturally would be focusing on having things ready for herself and her new baby. However, she does not specifically mention if time was a factor early in the pregnancy. But her second statement provides more information. "I found out way too late to start these classes." Sonia said she began her prenatal care at 21 weeks and all of her care had been given by the Hospital Prenatal Clinic.

When each pregnant woman is enrolled in the Prenatal Clinic, she is interviewed by a registered nurse who takes a health history and gives information about the PC, making and keeping appointments, and whom to call in case of a problem. In each initial interview session the nurse also gives the woman a packet of information about pregnancy, childbirth, and childbirth classes. She emphasizes the classes and encourages each new client to consider taking either the PC or EC classes. The nurse also tells the client how to register for the classes and suggests that she do so as soon as possible because the classes fill up quickly. It is likely that Sonia was also given this information at her PC intake interview. Twenty-one weeks gestation (approximately 4 months) is later than the usual eight to ten weeks (2 to 2 1/2 months) when prenatal care is initiated; however, it is still early enough to register for childbirth classes. Nonetheless, Sonia did not recall knowing about the classes early enough to register. For Sonia the not knowing about the class was as much a hindering factor as was not having time.

In her book The Woman in the Body, Martin (1987) discusses many ways that women display subtle resistance to medically managed childbirth. Some of the women in her study admitted agreeing with everything the physician told them but in the end did exactly as they themselves wanted to do, thus in their own subtle way they were able to maintain control. For some of the women in my study, like Danielle, Beth, and Sonia, waiting too late or forgetting to register, giving an impression of lack of motivation, and unwillingness to adjust schedules in order to take the classes may also be subtle ways of resisting a childbirth ideology with which they were not in common agreement.

Not wanting to take classes because someone was already available to help or because of the desire to go through labor and delivery using one's own techniques or "doing it my way" was expressed by four (25% of 16) NCBE participants (Table 6.9). Three participants who expressed not needing or wanting childbirth education said they had their own help or their own way of doing things. For instance, twenty-year-old Carol (NCBE), a single participant from the Block Clinic, said, "I work better by myself and I don't want to rely on other people."

Twenty-two-year-old Jennifer (NCBE) was accompanied by her husband for her clinic visits. At each visit he appeared very over-protective and hesitant for anything that seemed out of his understanding to be done to or for his wife. At first, he even refused to let her take part in this study, but after a few weeks of talking with him he agreed, as long as it didn't take too much time. Carol was very shy and hesitant in the answers she gave to the questions, and when asked about her reasons for not taking the classes she quietly said,

> " 'Cause I already, I got my mother-in-law and my mom to help me pull through the labor and my husband's gonna be there."

The participants who mentioned having other support people perceived taking childbirth classes as a precursor to the displacement of the support persons they had chosen, which would then make them dependent on the medical personnel attending them in labor, and restrict their ability to be in control of their own childbirth experience.

During her interview, twenty-one-year-old Melissa (NCBE), a self-assured young woman who had worked as a nursing assistant, stated that she wanted to do things her own way during her labor and delivery. Earlier in the interview she said that she had "a really good book at home that shows and tells everything from beginning to end." She felt that learning the breathing was useless because "when it came right down to it you would forget anyway." When asked if there were any special reasons why she decided to not take the classes, she repeated her earlier statement, "I know enough to where I think if you keep a cool head you don't need to go to Lamaze and childbirth classes, you know." She then clarified,

> "I jus' didn't wanna go, because I think no matter what happens when it comes right down to it you're not gonna remember everything that was taught in that class, you're gonna try to do things your own way, you know, and I figured, I wanna do it my way, I wanna stay calm, I know how ta breathe, I know how ta push, you know, I jus', I didn't figure I needed the classes."

In fact, Melissa had some experience with labor and delivery. She had been present as the support person for her friend's childbirth experience. She said, "So I got to watch her delivery and everything, it was really neat, it was quite a bond." Melissa also said that when she had questions she asked her grandmother, a registered nurse who had

worked in a prenatal care clinic. So, in some ways, Melissa was quite prepared for her childbirth experience, even though she had not specifically taken the classes or learned the relaxation and breathing techniques. It is interesting that she emphasized "doing it my way." For her, taking the classes would rob or at least limit her own control of her labor and delivery. She was not willing to give up that control and was confident that she would be able to remain calm and stay in control no matter what happened.

Not having time and "just not wanting to" take childbirth classes was expressed by three (19% of 16) NCBE participants, some of whom had also expressed other reasons for not taking classes (Table 6.9). Sonia, mentioned previously, wanted to take classes but "did not have time." On the other hand, 19-year-old Janet (NCBE), who had a ninth grade education, gave no indication of wanting to take the classes. Without qualification, she said, "I just, I don't have time. I try to find time an' I'm busy." When asked if she were working or going to school she replied, "No, I'm just busy," and then would give no more information. Carol, who earlier had said that she worked better by herself and didn't "want to rely on other people," admitted openly that she just didn't want to take the classes. She knew they were available and that many women took them, but she had no desire to do so. Not having time, like forgetting to register, and not being willing to adjust schedules to take childbirth classes is another subtle way of showing resistance to the dominant childbirth ideology.

It is also interesting to look at the different approaches these three respondents took in obtaining information about pregnancy and childbirth. Sonia, who was interested in taking classes, had read some

books and had seen some videos, even though she had not pursued taking childbirth classes. Janet, on other hand, obtained information only when she talked with her doctor. And Carol, who also stated that she hadn't thought about what she or anyone ought to know about pregnancy, labor, and delivery said, "I really haven't had any questions." Sonia was motivated to learn and found sources that gave her information about pregnancy and childbirth, even though she could not go to the classes. Carol and Janet, on the other hand, did not seem to have the same motivation to learn and had no interest in the childbirth classes. It is possible that other internal or external factors which were not mentioned in the interview were affecting their decisions. Nonetheless, it appears that an interest in learning is also an important factor in childbirth education decisions.

Three NCBE participants (19% of 16) stated that they knew enough and didn't need the classes (Table 6.9). Melissa, mentioned earlier, thought she knew enough and did not need or want to take childbirth classes. But Elena (NCBE), a 22-year-old, African American participant, told a slightly different story. When the question was first asked, she said that she didn't know anything about the classes, but on further questioning she said that her sister had taken them. She was asked again if anything influenced or kept her from going to the classes and she responded,

> "No, not really, I jus', I thought I really didn't need 'em. I be tell, I figure well, um, the doctor tells me what I don't know."

Though she continued to deny knowing about the childbirth classes, when asked what she thought women learned in the classes, she listed how to eat, how to watch so you won't gain too much weight, the breathing, how

to deliver in the delivery room and how to be calm in labor. It appeared that, in fact, Elena did know more about childbirth education than she realized but nonetheless she did not think that the classes were necessary for her.

Elena did not identify her sister as an influence in her childbirth education decision, but she mentioned her sister's experience several times throughout the interview. Her sister had taken the classes and then delivered by Cesarean Section. Although Elena did not give this as an influencing factor, it may still have affected her decision not to take the childbirth classes.

Vakisha (NCBE), an African American participant from the Block Clinic, also said she didn't need the classes. When first asked who or what influenced her, she said, "The reason I didn't go is because I have nine nieces and nephews and I've helped raise 'em from birth on up." At first I thought Vakisha saw childbirth classes only as instruction for care of infants and children, but as I questioned her further, she explained,

> "I have two sisters and neither one of 'em, they have four kids apiece, neither one went to Lamaze classes or anything, they jus', went, so I said, if they can do it I can do it."

Since her sisters had not gone to classes, Vakisha felt that she did not need to go to classes. In the interviews with the childbirth educated participants, it was clear that contact with and encouragement from people that had good experiences and positive outlooks concerning childbirth classes had a strong influence in their choice to take them. Without positive influence from close family members or friends, the choice to take childbirth classes appears to be more difficult. The influence of one's personal network is strong as Vakisha pointed out,

> "I probably should have went to the Lamaze classes, but I was told either you're gonna have that baby or that baby's gonna have you, you'll learn as you go."

In the first part of her statement, the dominant childbirth ideology which incorporates childbirth education pulls at Vakisha. The perception of taking classes as the expected thing to do if you are pregnant is strong, but the influence of family and friends that have not taken the classes is stronger, and since her sisters did not take the classes and did not encourage her to take them, her decision not to not take the classes was made.

Vakisha also expressed the idea of learning by experience. "You learn as you go along." Vakisha defined childbirth classes as "basically just breathing." She also expected her own labor to be painful and she strongly emphasized painful. She mentioned breathing techniques that might help ease the pain of labor, but since her sisters had not taken the classes or used the breathing and just learned from experience, then she would do likewise.

Vakisha had fifteen years of education and was 25 years old. In general, the participants who were older and had more education were also more likely to take the childbirth classes (Tables 4.5 and 4.7). However, living in the inner-city and being strongly influenced by women who had not taken childbirth classes were stronger influencing factors for Vakisha than were her age and education.

Language, Patterns, and Behavior

Throughout the interviews the participants, with few exceptions, used a common language to discuss their perceptions of childbirth and childbirth education. The terminology used reflects the terminology of medical practitioners, the childbirth educators, and other proponents of

the dominant childbirth ideology. There are distinct patterns in the study participants' perceptions of what women ought to know about childbirth, what childbirth education is, and who or what influenced their childbirth education decisions. There are also distinct differences among the patterns. The influence of the dominant childbirth ideology is evident in the way the women talk of the childbirth experience, but for some participants who resist that ideology, a struggle is also evident as they try to hold their own childbirth ideologies while they work through the dominant system.

Through a complex of assumptions, perceptions, desires, goals, social influences, and childbirth ideology pressures, participants made their decisions to take or not take childbirth classes. For some, based on unquestioned assumptions that it is the good and right thing to do, the decision is easy. But for others, who either question the existing system of the dominant ideology, or who adhere to a different ideology, the decision is more difficult. In the next chapter I will further explore how the dominant childbirth ideology is reflected in the way women speak of the experience, how it affects the decisions they make, and how it is reflected in the behaviors they exhibit.

Notes

1. In giving the age, ethnicity, socioeconomic status, or other descriptive information about the participants, I do not mean to imply that these characteristics are the major determinants of behavior. I am simply describing, for the reader's information, the socially salient characteristics that describe and identify the participant with her particular participant group.

CHAPTER VII

THE CULTURAL CHARACTER OF CHILDBIRTH EDUCATION

The dominant American childbirth ideology influences many women in the development of their personal ideologies, values, and goals related to the birth event. Though women are not generally coerced into accepting the dominant ideology as their own, they are wooed and enticed into it. Fairclough (1989) points out that it is more common for the dominant bloc to draw people into the dominant ideology by making them "feel" a part of it, than it is to coerce or force them. Through education and pseudo-egalitarianism the dominant childbirth ideology draws in women of all classes, ages, education, SES, and ethnicity. Providing women with a common language to discuss their childbirth experiences with their caregivers, as well as with each other, and equipping them with the *common sense* assumptions and behaviors that comprise the ideology, the dominant childbirth ideology becomes the familiar and ordinary. Thus, taken for granted, the dominant childbirth ideology and the power differences within it are perpetuated.

According to Fairclough (1989:2-3), ideology is closely linked to language. This linkage occurs because the use of language is the most common form of social behavior. Language is also the form of social behavior in which we rely most on *common sense* assumptions. Though not

consciously realized, the way women talk about childbirth conveys their *common sense* assumptions: the childbirth ideology that they have incorporated, either totally, or in part, as their own. The language they use to describe the childbirth experience is learned as they are educated and drawn into the ideology.

Fairclough (1989:33) also points out that when practices appear to be universal and commonsensical they can often be shown to originate in the dominant bloc. This was evident in my study. The language the pregnant participants used to talk of their childbirth experience mirrored that of the dominant childbirth ideology, and indicated an infiltration of the *common sense* assumptions of that ideology, even into the common terms and common talk of the working class women who did not take the childbirth classes.

The Shared Ideology of What Women Ought to Know About Childbirth

The dominant childbirth ideology is invasive, reaching down to include even women's own ideas concerning what they ought to know. When asked what they thought women ought to know about childbirth, the participants' responses echoed those of the childbirth educators. The language and specific terminology used to express the things they thought women ought to know were similar among all of the women. While the language and use of the medical terminology might be expected among women who complete childbirth classes, their use among those who have not taken classes is surprising. However, since the dominant class controls the language production expressed in the dominant childbirth ideology, and since the dominant ideology supersedes that of the working class (figure 1.2), it should not be unexpected that the participants would use the same language and terminology, especially since they knew

they were talking with an interviewer who was familiar with that terminology.

When asked what they thought women ought to know about childbirth, both the pregnant women and the childbirth educators first discussed certain things that should be known about pregnancy itself. The women wanted knowledge about nutrition and weight gain, physical and mental changes that occur, how the baby grows, tests that are done, and common problems that may or may not need treatment. The childbirth educators' list was shorter. It included physical and mental changes, nutrition, tests that pertained to the readiness of labor, and danger signs that warn of impending complications. They did not include such things as how the baby grows, general prenatal tests or their meanings, or common problems, other than those that are more serious in the last weeks of pregnancy. It is possible that, since the focus of the classes is predominantly on labor and delivery, the childbirth educators may have inadvertently omitted those things that would be more of a concern earlier in pregnancy.

Browner and Press (1976) suggest that, although childbirth is a technological transaction, prenatal care is not. If, with the exception of some prenatal testing procedures, this is the case, then there is no need to prepare the women to comply with the technological model early in pregnancy, and it would be logical for the childbirth educators to omit this from their list of things women ought to know. The hospital offers classes which teach the women about the physiological and mental changes that occur, nutrition, prenatal care, and how to stay healthy during pregnancy. These are offered early in the pregnancy whereas the childbirth classes are offered in the last trimester of pregnancy. So

it is logical that the childbirth educators focused mainly on what women ought to know about labor and delivery.

The childbirth educators and the pregnant participants gave almost the same responses to what women ought to know about labor, delivery and the postpartum period. Both CBE and NCBE participants and the educators spoke of the different stages of labor, how the body "works" in labor, and techniques that help reduce the discomfort of labor and help the laboring woman stay calm and maintain self-control in her response to labor. Many of the women talked about breathing, relaxation and staying calm. Although postpartum care of the mother and the newborn, infant feeding, and contraception were mentioned by only a few of the pregnant women, their comments were similar to those of the childbirth educators.

Medications and technological interventions in labor and delivery were mentioned only by the childbirth educators and the participants who had attended the classes. Terms such as, "episiotomy," "induction," "monitoring," "epidural," and "Cesarean section," were used as naturally by the pregnant women as they were by the childbirth educators. And no one questioned either the use of the terms, or the use of the technology. They were taken for granted as usual procedures and techniques in the conduct of labor and delivery. It was also accepted that, though the laboring woman may have the opportunity to make some decisions regarding the use of this technology, ultimately, the physician would make the final decision. The childbirth educators and many of the participants agreed that women "should" be informed, not only to make decisions, but also to be able to understand and cooperate with the physician's decisions in the conduct of the labor and delivery. Thus, these taken for granted, unquestioned practices, as Fairclough

(1989) points out, strengthens the dominant childbirth ideology and perpetuates the power relationships within it.

The participants who had not attended classes focused more on the physical changes, how labor was going to feel, and how they could cope with the process. Though their focus did not include the technology, the language they used to express their concerns was the same or nearly the same as those who had taken the classes. For instance, in speaking of contractions, two of the NCBE participants started to use other terms; one started to speak of her "hardening," the other, her "cramps," but both quickly changed to the term "contractions," showing the influence of the language of the dominant childbirth ideology. Being able to use the dominant language contributes to the "feeling of belonging," and may provide a sense of security for women who, by nature of the hospital delivery alone, will be caught up into the practices of that dominant ideology. The problem is, however, that those who have not been fully educated into the system do not know all the terminology or the practices to which they will be subjected. For them, there will be few, if any, choices. And, through their medically controlled birth experience, the dominant childbirth ideology and its power relationships are further strengthened and perpetuated.

In her study of expectant parents' expectations in childbirth education classes, Maloney (1985) found that the women were more interested in gaining confidence in themselves and increasing their ability to cope with labor than they were with the "hard facts" of the labor process. The women in my study also expressed these concerns. While they did have an interest in the "hard facts" of the physical and mental changes that occur in pregnancy and labor, what they could do to

keep themselves and their babies healthy, tests that are done and what they mean, and the technology that might be used during the course of their pregnancy and childbirth, their main concern was how they were going to cope with the pain of labor and delivery. Many participants mentioned the importance of knowing how to relax and breathe during labor to help them cope.

In the interviews, the childbirth educators did stress the technological or "hard facts" of the birth experience as things the women ought to know about childbirth. As agents of the dominant childbirth ideology it is their responsibility to prepare their students to acquiesce within the technological management of birth. In the observed classes, the educators thoroughly explained the technological aspects of the birth experience and encouraged the class participants to work and cooperate with their physicians in the decisions made for their care in labor and delivery. However, they also responded to the women's need to gain confidence in themselves and their ability to cope with labor and delivery. They helped and encouraged the women in their practice of the relaxation and breathing techniques. They gave rational, and scientific explanations for the use of the technological interventions so the class participants could understand and cooperate with the procedures should they be used. They strongly encouraged the women to discuss these technological interventions with their physicians before they went into labor if they were concerned about, or did not want such interventions. They also suggested negotiable practices that are often medically accepted, such as requesting intermittent fetal monitoring, walking, warm baths, positions for labor, and frequent emptying of the bladder, that might be tried to prevent the need for

such interventions. Nonetheless, backed by the "authoritative knowledge" derived from the dominant childbirth ideology, the educators taught from their own experience and acceptance of the technological birth and prepared their students to expect and accept this type of birth experience for themselves.

Some of the participants echoed the idea that women ought to be prepared so that they could make informed decisions while they were in labor. Bonnie (ECCBE), for instance, talked at length about the importance of knowing what medications are available so that rash decisions would not be made during labor. Others mentioned knowing about procedures and policies so that they could make choices.

Certainly, being educated about the labor process and how it may be technologically managed does help women make informed decisions, and they do have the right to refuse technological interventions, if they so desire, but few would risk losing the help of their physician and other medical staff if they refused the suggested management regime. And therein lies the control. Medical practitioners control the technology, and through the controlling mechanism of childbirth education and informed consent they can manipulate the birth with the cooperation of the prepared woman who is in control of her own behavior. Uncontrolled "crazy" women who have not been educated into the technological system are perceived to be more difficult to "handle," and management of the birth can become an ideological struggle between the birthing woman and her physician. It is usually the woman and her infant that suffer the indignities of such a struggle, and though the end result may be a live mother and infant, the experience can be dissatisfying.

Many of the participants were concerned about how they would actually respond during labor and delivery. For instance, Shelly (CCBE), a 20-year-old, single participant, expressed this concern when she said, "For me, I'm actually scared, I have a feeling I'll be screaming or something." And Melissa (NCBE), who gained most of her information from her book, thought women ought to know what's going to happen in labor and delivery,

> "'cause if you don't, sorry, I can picture someone going in delivery just wild and crazy screamin', an' just when they need to stay calm. I'm really fixed on trying to stay calm, I don't wanna be a crazy lady."

Maloney (1985) points out that the technological birth, though effectively reducing many of the former hazards of childbirth, has nonetheless rendered women powerless in the childbirth experience. Maloney maintains that being able to effectively cope with labor and delivery, either with or without medication, is important to help the woman retain a positive self image and maintain some autonomy over the decisions made about herself and her infant. While this increased feeling of control of one's emotional reactions and ability to cope with labor, as Maloney suggests, does give a woman a certain amount of self-confidence that then allows her to mother her new infant, I contend that the perceived importance of being in control of one's responses during labor and delivery is also a tenet of the dominant childbirth ideology, and an example of the controlling mechanism of the cultural web of childbirth education.

Though the childbirth educators did not specifically mention that management of a laboring woman was easier if she was able to maintain

self-control, Andrea (ECCBE), the registered nurse who had experience working in an obstetrical unit, did talk about it. She said,

> "They're [labor patients] a lot easier to handle when they know what's going on. I said handle, but, you know, you jus', you do, you have patients that come in and they're out of control, and maybe they still would have been out of control, but I would think that most people, if they understand a little bit more of what to expect, it's less scary, you know, it is a scary experience no matter how you look at it, you know, whether you're fourteen or thirty, it's a scary experience, and I think the more they know about it, the more in control they could be."

Staying in control of herself was an important aspect for Dolly (ECCBE) also. Maintaining self-control had been impressed on her by other women who had given birth. When talking about their comments and her own fears about labor, she said,

> "I think about that, I'm like, oh no, I better try to be as quiet as possible when I come in. I know that's gotta be hard, but I just don't wanna get on anybody's nerves when I'm in there."

Andrea and Dolly both reflect the power of the dominant childbirth ideology to control the behavior of the laboring woman. In that ideology, it is expected that the laboring woman will cooperate with her caregivers and allow them to use technological interventions in the course of the labor and delivery. A woman who has been effectively prepared will know what to expect, and will be in control of her own emotions and responses. In being cooperative and giving consent for technological interventions, she sanctions the power inequalities within the system, and the dominant childbirth ideology is perpetuated.

Though not always in conscious awareness, there is a fear in going against this dominant system. Dolly's (ECCBE) comment about not wanting to "get on anyone's nerves," Shelly's (CCBE) fear of screaming, and the NCBE participants who expressed the fear of being "wild," "crazy,"

"nervous," and "panicking" in labor indicate a certain anxiety of possibly going against the expected childbirth behavior. Though the laboring woman perceives being in control of herself as important, her perception, and the way she speaks of it, is nonetheless ultimately influenced by the dominant childbirth ideology. In subtle ways it is conveyed to the woman through the instruction of her caregivers and her childbirth educator, and through the influence of women around her who have also incorporated the dominant ideology.

It has been demonstrated that women who are prepared for the birth experience through childbirth education classes do tend to have shorter, less medicated and less complicated deliveries (Hughey, McElin, and Young 1978). Certainly these outcomes are commendable and desirable, but the fact still remains that childbirth education acts as a mechanism that controls the behavior of the birthing woman, and makes her more compliant with whatever technological interventions that might be presented to her.

Almost unanimously, the childbirth educators in my study began their response to what women ought to know with "being as prepared as possible for the childbirth experience." One educator said "they need to know everything," and another said "they need to know it's a natural process they need to be prepared for." Likewise, many of the participants talked about the importance of knowing things about pregnancy and being prepared for the labor and delivery experience but none of the pregnant participants actually mentioned childbirth as being a natural process.

While it is true that birth is a natural process that takes place with or without preparation, the woman who has been educated for the

technologically managed childbirth will know how she is expected to respond to that management of the birth event. Consequently, when epidurals, episiotomies, electronic fetal monitoring, and other such technological interventions become commonplace, as they have in the American management and ideology of childbirth, they too can become accepted as the "natural" way. The woman and her partner who have been prepared for these possible eventualities will give little or no resistance to their use.

Three of the study participants had no suggestions of things women ought to know about childbirth. Yolanda (NCBE) and Carol (NCBE) both said, "I haven't really thought about it." Carol also said, "I don't want to know anything, I don't want to be scared out of it." Tanisha (NCBE) gave an interesting comment when asked what she wanted to know about childbirth. She said, "Oh nothin' really, there's not that much to know about." She went on to say that from the fourth grade on her parents taught her all she needed to know "about the facts of life." Tanisha also said,

> "I don' even think about delivery, It's hard and it's gonna be hurtin'. I'm jus' waitin' for my time to come...but until then I don't think about labor or nuthin' like that."

Responses such as these are difficult to order in my model of the dominant childbirth ideology. As it now stands, the model does not provide for inclusion of the non-planners who appear to wait and take life's events as they come. Women who hold to these beliefs are far on the periphery of the dominant ideology model but, nonetheless, they will be affected by the technological birth that stems from that ideology. They will then either acquiesce or be among the "crazy" women who lose control and struggle with the intricacies of the technological birth.

Either way, they become the unprepared, unknowing victims of the dominant childbirth ideology's technological birth.

The Perception of What Women Learn in Childbirth Classes

Although women may not be conscious of the cultural character of childbirth education that subscribes them to the dominant ideology of a technological birth, their perception of what childbirth classes are or what they can do for them may affect their childbirth education choice. Though the participants' list of things learned was more detailed than that of the educators, the terms they used and the way they spoke about the classes again mirrored many of the comments given by the childbirth educators. When asked what they thought women learned in childbirth classes, the participants carefully enumerated things that they thought were included. They mentioned more specific things than the childbirth educators mentioned. They thought the classes included information on such things as "how the baby grows," "how your body looks during the changes you go through," "what foods to eat," "how to center on yourself to be calm and relaxed in labor," "medications and side effects that may harm the baby," "the possibilities and things that can go wrong," "how to feel confident," "how to know when you are in labor," "breathing methods," "Cesarean Sections" and "how to care for yourself and your baby."

In their response to this question, the childbirth educators gave short, simple answers. They all agreed that childbirth education was an "education about pregnancy, labor, delivery, and postpartum." They emphasized that it was instruction and learning about all aspects of the childbirth experience, including the "mental, physical, spiritual, and educational preparation of the whole person." One educator said that it

was preparation for "a typical delivery and the possibility of a Cesarean section and anything else that could be different." She also pointed out that childbirth education prepares "them for everything they might have to know for labor and delivery, baby care, and breast feeding." Another educator summed up all of the comments when she described childbirth education as "preparation for the whole person so she can approach labor and delivery competently and confidently."

Although the educators in my study were addressing what women learn in the classes, their responses were consistent with the goals of childbirth education that were expressed by the educators in Sargent and Stark's (1989:40) study of childbirth education. In that study, the childbirth educators' goals were to:

1. provide a positive birth experience for the parents
2. educate women about their bodies and what to expect in labor
3. clarify the vocabulary

There was one difference, however. The educators in Sargent and Stark's (1989:40) study also mentioned the goal "to present a good public image for the hospital." The childbirth educators in my study made no mention of the hospital image. They did mention that class participants learned the hospital routines and what to expect after being admitted to the labor ward, but they did not express any desire or goal to present a good public image for the hospital or for the Education Center. This is not to suggest that this goal does not exist. In a city the size of Grand Rapids, where competition is high for pregnant women to take hospital based childbirth classes and deliver in the hospital's obstetrical suite, it only stands to reason that the educators would want to "present a good public image." They did not, however, give

this as one of their goals or as anything that was important for the class participants to assimilate.

It is clear, however, that from the childbirth educators' perspective, the major focus of the childbirth classes is the preparation of participants so that they will be confident and competent to cope with labor and delivery. They did not mention or question the fact that the labor and delivery would be medically controlled and technological. However, the technology was alluded to in a comment by one of the educators, that childbirth education is preparation for "a typical delivery and the possibility of a Cesarean section and anything else that could be different." That is, different from a normal, unmedicated, spontaneous, vaginal birth. The important thing, then, is the preparation of the class participants so that they will be able to understand, cooperate, and competently cope with the medically directed technological delivery.

The fact that the use, or sometimes overuse, of technology can interrupt the normal progression of labor, and can lead to further complications needing more technological intervention, was not mentioned. Nor was it mentioned that the laboring woman, even though well prepared for the experience, essentially loses all control of her birthing experience in such a technological childbirth. She may question, but ultimately she must abdicate her birth experience to the dictates of technology and the practitioners that control it.

The dominant ideology gains power as it is adhered to by members within the social structure. Likewise, as Fairclough (1989) points out, the practices of the dominant ideology become commonplace or "naturalized." This is evident in the dominant childbirth ideology in

which the use of technology is not questioned. This technology constitutes the "tools of birth" which Jordan (1993:87) says "are the visible, practical constraints on which the shape of the system rests." Consequently, because the technology is there, it is used, and both the practitioners and the recipients of the technology become its slaves and its victims, and some benefit and some suffer from its use. Nonetheless, technology is a major part of the American dominant childbirth ideology, an extension of sorts from the dominant technocratic ideology that governs American society. In order to maintain its dominance, members of society are socialized into the dominant ideology; thus it is important to socialize pregnant women into the ideology of a technological birth through childbirth education, which, like a web, draws and holds them within that ideology.

Davis-Floyd (1992) found that the women in her study were aware that knowledge would help them mature and take charge of their lives in order to be responsible for the care of another person. These women realized that factual and intellectual knowledge equipped them to function competently within our cultural system. They used the formal childbirth classes to gain the knowledge they felt they needed.

Most of the women in my study focused predominately on gaining accurate knowledge that would help them cope with the pain and stay calm and relaxed throughout labor and delivery. The ability to care for the baby after having successfully completed the birth experience was mentioned only by a few. In their definitions of what women learned, the respondents, as did the childbirth educators, identified childbirth education as a means by which they could get factual and scientific

information about birth as they prepared for the experience. As Esther (ECCBE) put it,

> "It's a big help, that'd be a way of finding out, you know, fact from fiction, I mean there's a lot of people who are out who tell you a lot of wives' tales and they, some of the wives' tales that people tell you are pretty scary."

Many of the participants expressed feeling that the information their family and friends gave was inferior and sometimes "scary." They wanted reliable information. In their responses to what women learned in childbirth classes they identified those things that they perceived to be factual and correct, stemming from what they perceived was a dependable and definitive knowledge base. In her comments, Bonnie (ECCBE) stressed the importance of having the appropriate knowledge about childbirth,

> "At least, I think if you have a little bit of knowledge, and just, you never know what it is that's actually going to happen, but at least if you're familiar, and I even think, you know, just terminology makes a big difference too because if you go in and you haven't heard the words and you don't know, and hospitals and any place is really outside your own environment, you go someplace else and they have their acronyms, you know, demerol, and they're throwing big words out and if you have no idea what any of those things mean it just makes you uncomfortable. So I think that's a real important thing so at least you understand what things they're talking about. So then I think the class helped with that."

Irwin and Jordan (1987), in their study of court ordered Cesarean sections, speak of "authoritative knowledge" which is perceived as being better and stronger than other types of knowledge because it explains the world better and comes from a stronger power base within the society. According to Jordan (1993:152), authoritative knowledge devalues other knowledge systems and through this devaluation, "hierarchial social structures are generated, maintained, and displayed." Jordan (1993) points out that authoritative knowledge is

not the knowledge of people in authoritative positions but is rather a collective knowledge on which decisions are made and justification for courses of action is given. Thus, authoritative knowledge is legitimized and accepted as "a fact of nature" that cannot be changed. In the dominant American childbirth ideology, the authoritative knowledge of biomedicine defines childbirth and sets the parameters for the care and management of the pregnancy and birth event.

Browner and Press (1996:144) argue that in prenatal care authoritative knowledge is shared with women not only to help them understand the changes they are going through but to also make them more likely to follow their caregiver's recommendations. They contend that this is a process of medical socialization in which women are taught the caregiver's interpretation of the signs and symptoms the women experience and the meaning they should attach to them. I maintain that the diffusion of authoritative knowledge through carefully crafted and controlled classes fortifies the medical socialization that begins with prenatal care and strengthens the hierarchical relationship between the laboring woman and her caregivers. Women who do not attend childbirth classes are at a disadvantage because their own knowledge systems are devalued, as they are expected to follow the recommendations for their care and respond in the socially accepted way as prescribed by the dominant ideology.

In my study, the authoritative knowledge that was shared in the childbirth classes was not questioned. Most of the participants who had taken the classes, and some who hadn't, described childbirth education as being important to give a woman the knowledge she would need to be confident and competent in her childbirth experience. The information

gained from the classes would help her know exactly what to expect and how to deal with any ensuing event. None of these respondents questioned the technological birth they would be experiencing. Many of the participants said they wanted to be in the hospital when they gave birth because all the technology was there should anything go wrong. Without their consciousness, the cultural webs of the dominant childbirth ideology and childbirth education had permeated their thoughts and fashioned their own childbirth beliefs. They accepted the dominant ideology and the authoritative knowledge that gave it birth and sought the information needed to behave properly within it.

It is interesting to note that most of the respondents who had not taken classes identified more of the things women learn to do for themselves to stay calm and cope with the pain in labor such as comfortable positions to get into, breathing and relaxation, and knowing what to do "when the doctor says to push" [the baby out]. Tours of the hospital were also mentioned, but no one mentioned medications, things that might go wrong, or Cesarean sections. Not having attended classes, these participants were not directly exposed to the technological aspects of the birth that they would ultimately have to deal with. Though several mentioned further in the interview that they hoped they would not have to have a Cesarean section, none mentioned that or any other of the technological birth interventions as part of what women learned in the childbirth classes. The knowledge these participants had about the classes came from more informal sources; they had not been fully indoctrinated by the authoritative knowledge given in the classes.

Participants who had taken classes also mentioned learning relaxation and breathing techniques and staying calm in labor, but more

spoke of the technological aspects of the experience. They also included touring the hospital, knowing what to expect so there wouldn't be any surprises, being prepared in order to make "informed decisions," "danger signs," and "Cesarean sections." As Rachel (CCBE) put it,

> "Preparing you for birth, for labor and delivery, letting you know everything, all the possibilities, all the things that could go wrong, and explaining everything."

It was clear from these statements that the dominant ideology of a technological birth had reached these class participants and molded their ideas and beliefs so that they would acquiesce when they entered the sacred space of the obstetrical unit. Bonnie (ECCBE) summed up what many of the CBE participants expressed. She said,

> "You can never completely know what you're expecting or be completely prepared because you really don't know what it is that you're individually going to be facing, but I think that if you have a broad knowledge of the possibilities, of the things that can go wrong, of the medications that you can have, of the breathing techniques, of the different options, then I think it gives you a little bit more of a serenity about it."

Many reasoned that the lessons learned from the childbirth classes would help them cope during their labor and delivery experience. And, according to some respondents, the ultimate result from the experience would be a mother who was ready to care for her child. As Johanna (ECCBE) put it,

> "Well, I would say it's finding out how to be prepared to give birth so that it can be the most enjoyable and healthy experience for the mother, the father, and the baby and so you can get started on the right foot, you know, when you're actually, if things go better with delivery and whatever, it helps when you bring the baby home and get started, so that you can get the healthiest baby with the best care, and as the mother that I would be receiving the best care so that I will be able to be the best mom."

For Johanna, the lesson was well learned. She was now prepared for the technological birth: the "rite of passage" that would transform her into

that "best mom" and make her acceptable to the society in which she lives.

Factors That Influence Childbirth Education Choices

What a woman thinks she ought to know about childbirth and what she perceives to be the benefit of childbirth education certainly influence her decision to take or not to take childbirth classes. Also, as discussed in chapter four, age, education, and socioeconomic status tend to influence women's choices. In general, women who are older, have more education, and higher SES are more likely to take classes than are women who are younger, less educated, and have lower SES. Relationship with the father of the baby also appears to influence women's choices. Those who are married, or in otherwise stable relationships, are more likely to take classes than those who are single in unstable or non-existent relationships. But these are not the only influences in women's childbirth decisions. Other external and internal factors also play a part. In this section, I will further examine those factors that the women themselves identified as influences in their childbirth education choice.

The Influence of Social Support

Social support has been identified as a major factor that affects a woman's participation in prenatal care (Sable, et al. 1990; Giblin, et. al. 1990 and Boone (1988). Those who have the positive support of the father of the baby (husbands, boyfriends, or fiances), other family members, or friends, are more likely to obtain prenatal care than those who have no social support. Social support is also an important factor that influences a woman's childbirth education choice.

In their study on the motivation to take childbirth classes, McCraw and Abplanalp (1982) found that friends were the most influential in women's decisions to take childbirth classes. Husbands were mentioned secondly and other family members the third most influential persons in the childbirth education choice. In my study, family members were mentioned the most as influencing the decision to take childbirth classes. Among the family members, the partner (husband, boyfriend, or fiance) was identified as the most influential. Several respondents said it was actually their partner who wanted to take the classes, but others said they took the classes to ensure that their partner would be prepared for the experience and would be able to give support during labor and delivery. A few said they took the classes because of the opportunity it gave for the father of the baby to be involved in the pregnancy as well as in the birth. In each of these cases, the partner provided the social support needed for the woman to make the decision to take the classes and then to follow through with that decision.

Most of the NCBE participants gave no indication that their partners had shown interest in or support for childbirth education classes. In most cases, the respondents made no mention of the partner's involvement in the pregnancy or plans for the delivery. However, three of the NCBE respondents who had wanted to take classes stated that they could not because their partners were unable to attend due to conflicts between work and class schedules. The fact that these women had even wanted to take classes may be reflective of the social support they received from their partners, even though the circumstances did not permit class participation.

The need for male support was stressed by Tanisha (NCBE), who had reported that she did not have a "home base" and moved frequently from house to house. When asked what she thought women ought to know she said, "Jus' get a man that's faithful, that's all I can say." Tanisha did not have "a man" to give her support, nor did she have any other firm social support, and, like many others in her situation, she did not take childbirth classes. However, Tanisha did not specifically mention the lack of male support as her reason for not taking classes. The major thing that hindered her from taking classes was her "problems and stuff." As a result of her weak social support system, Tanisha, like the women in Lazarus' (1990) study, "fell through the cracks" in both prenatal care and childbirth education.

Women in the family were also important in influencing my study participants to take the childbirth classes. While only six percent of the CBE participants mentioned their sisters, sixteen percent mentioned their mother or their fiance's mother as the person who most influenced their decision. In some cases mothers were so influential that they changed the minds of their daughters who had originally decided not to take the classes. As Nan (ECCBE) said, "My mom pretty much pushed me, she told me that I would definitely, 'cause I wasn't gonna take one." A few, like Kerri's mother, insisted on it. Kerri (CCBE) had gone on a trip, and when she returned, she kept telling her mother that she would call [the Education Center]. Kerri said,

> "I said I'll call, I'll call and find out and she said, <u>call now</u> and find out now, and she says, 'cause it's really going to help you a lot."

Other mothers merely supported their daughter's decision to take the classes.

Yolanda's mother had taken classes with her second, third and fourth pregnancies and encouraged Yolanda to also take them. Yolanda (NCBE) said,

> "I listen to her, I know what she's talking about, she's tellin' the truth. I wouldn't know anything my Mom says about stuff like that."

However, Yolanda (NCBE) did not have enough social support to follow through with her decision to take the classes. Though she had enrolled in the classes which were to start the Monday following the interview, she reflected sadly,

> "That's the thing, the thing is I really can't. I can't really say about Monday, 'cause of the fact that I don't know how I'm gonna get there. 'Cause they're at night time and I don't have a car and most of my family works early in the morning so they won't be able to take me."

As it turned out, Yolanda was not able to attend the classes. Lack of social support can and often does devastate the best intentioned plan or decision to take childbirth classes. Yolanda did receive childbirth information from her mother, "I had my Mom tell me, you know, my Mom talks to me about everything." But such non-formal information is not considered to be "authoritative" and is therefore devalued by those who hold to the veracity and authority of formal childbirth education. Women like Yolanda are labeled by those who adhere to the dominant childbirth ideology as being unprepared and irresponsible in their pregnancy and childbirth.

Although several participants talked about their sisters' experiences with childbirth classes and birth, only two actually identified them as an influence in their decision to take childbirth classes. Even in these two cases sisters were mentioned only has having taken the classes, which merely reinforced the respondent's decision to

take them. Many of the participants in my study were the oldest daughter in their family, and although they had younger sisters, few had given birth. This may account for the lack of influence sisters had in my study participants' choice to take classes.

Two participants who did not take classes talked about the influence of their sisters. It was on her sisters' experiences that Vakisha (NCBE) based her decision not to take classes. She said,

> "I have two sisters and neither one of 'em, they have four kids apiece, neither one went to Lamaze classes or anything, they jus' went, so I said, if they can do it, I can do it!"

Elena (NCBE) was also influenced by her sisters' experiences. She had several sisters who had talked to her about their birth events. Only her younger sister had taken the childbirth classes; then after a long labor with no progress, she had a Cesarean section. Elena said,

> "My sister went to 'em [but] I jus', I thought I really didn' need 'em. I be tell, I figure well, um, the doctor tells me what I don't know."

In the course of the interview Elena insinuated that the classes did not help her sister very much, and her other sisters delivered without classes, so she didn't think she needed them either.

Sisters' experiences with classes and childbirth can be very influential in a woman's childbirth education decision. Vakisha had thought about attending classes but her sisters told her "either you're gonna have that baby or that baby's gonna have you, so you'll learn as you go." Without their positive support, Vakisha decided childbirth classes were not that important. On the other hand, Elena's sister had taken the classes, and although her sisters had not discouraged her, the final outcome of the Cesarean section dissuaded her from taking them.

Lazarus (1994) points out that choices and control are limited for working class women. The conditions and circumstances that surround their pregnancies also affect their ability to obtain information about childbirth and their ability to act when they do have the information. Elena's sister had information about childbirth, but it did not prevent her from having a surgical delivery; therefore, from Elena's perspective, classes were of no specific value, and without a strong support system to encourage her, she opted not to go. For Vakisha, the baby would come regardless of what she did. She had no power and no choices, and childbirth classes were of no value. Without a positive role model, positive social support, and the ability to make choices, the decision to take childbirth classes is less likely.

Friends compose another part of the social network that influences the childbirth decision. The participants in the McCraw and Abplanalp (1982) study listed friends as the most influential in their childbirth education decision, but friends were listed as the fourth influencing factor by the women in my study. In fact, only 29% percent of the CBE participants mentioned friends as influencing their decision to take the classes. Although this is not appreciably lower than those who listed partners (32%) as the most influential, it is well above the influence of sisters (6%) and mothers (16%).

Friends influence in interesting ways. Some merely ask, as Risa (ECCBE) pointed out, "have you started taking classes yet?" Others, as Dolly (ECBE) put it, "pressure" pregnant women to take the classes. And still others, like Loris's (ECCBE) friends, share their childbirth education experiences and recommend the classes. Loris said, "Basically

everyone that I knew that had had babies took the classes and they recommended it." Amy's (ECCBE) response was similar, she said,

> "My friends informed me, they talk about classes, I guess it's just my environment, I mean, that's a natural question, well, what classes are you going to do, when do they start, so it's your, it's a matter of, um, not habit but it's just an expectation."

However they do it, friends, especially those who have successfully completed formal classes and a technological birth, act as agents of the dominant ideology that entices pregnant women and their partners into taking childbirth classes. Many of the participants also mentioned that their extended family did not live near. As Oakley and Rajan (1991) found, when no consistent supportive family member is near to talk to or get advice from, the influence of friends can be very significant. When those friends give positive support, the decision to take the childbirth classes becomes, as Loris (ECBE) put it, "just something that you do."

Friends can also discourage a woman's decision to take childbirth classes. Beth (NCBE) had planned on going to the classes with a girlfriend who was also pregnant, but she lost the information sheet. She said,

> "it's like, well, maybe I should get another one [information sheet], and it's like, it totally escaped my mind, though I had so much on my mind at the time. It was like, oh shoot, I missed those classes, you know, but....
>
> From what my friends told me, they went through the childbirthing classes and they just, it just totally blew their mind, it was nothin' like the class, they said you forget everything and, you know, all pregnancies are different, all labors are different, all births are different, so they just said, you know, it's kinda, it's not a waste of time not to go to 'em, you should go to prepare your mind and your body to know what it's gonna go through, but, you know, you kinda do forget about that kinda stuff when you get in there....

> One friend said it was a waste of time, she forgot everything, so that kinda stuck in my mind a little bit though."

The fact that Beth received no encouragement to take the classes cannot be overlooked. Encouragement, or lack of it, can be a powerful factor that influences the childbirth education decision. Without positive reinforcement from her friends to take the classes, Beth, like the women in Martin's (1987) study, appears to resist in her own clandestine way when she fails to get another instruction sheet that would give her the information needed to enroll for the childbirth classes. In her actions, Beth appears to be trying to maintain her own integrity while she hangs on to her own childbirth ideologies.

On the other hand, Kerri (CCBE), who had put off making arrangements to begin classes, was encouraged by her mother until she enrolled. The response of any member in the social group can encourage, discourage, or change a woman's childbirth education choice and in doing so perpetuate the childbirth ideology of that member.

Some of the childbirth education decisions that participants in my study made were specifically influenced by some member or members of their social group. The members who had positive experiences, or who accepted the technological birth, tended to encourage attendance in the childbirth classes and then gave support when the decision to do so was made. Those who had less than satisfying experiences, or who had managed to cope in a technological birth without having taken the classes, tended to dissuade from taking classes but also supported when that decision was made.

In their study of social class and social support, Oakley and Rajan (1991) found that middle-class women, who tended to have better

support systems, were more likely to obtain appropriate and adequate care throughout their pregnancy experience. The working class women, who tended to have weaker and in some cases no social support, had less adequate care even, when they were classified as high risk. In my study, the available support systems mentioned by both middle-class and working class participants were supportive, once the childbirth education decision was made. However, the decision itself depended upon the information and encouragement the woman received from her support system, not just the fact that she had that support system. Yolanda was the only respondent whose support system let her down. Though she was encouraged in her decision, she was not supported or helped after she made the decision to take the classes. The response of the support system, then, has a strong influence on a woman's decision and ability to take the childbirth classes.

Ideological Influences

Some women make their decision to take or not to take childbirth classes without any perceived influence from other sources. However, although not in their conscious awareness, their own childbirth ideology affects the decisions they make. McCraw and Abplanalp (1982) mention that in their study 27% of the respondents stated that "nobody" influenced their decision, and another 6% gave "vague" responses such as "various people" and "everybody." In my study, 48% of the participants who took the classes also denied the influence of other people. They stated that it was their own decision to take the classes. Common among the responses were statements of "wanting to know," and, "wanting to be prepared" for the childbirth experience. Several respondents, like Meg (CCBE), said, "I just wanna be prepared. I pretty much decided on my

own, I don't know what's gonna happen to me." For others, like Johanna (ECCBE), the decision had always been there, decided perhaps, before the pregnancy even occurred. Johanna said,

> "I don't know, it wasn't a big decision, it's just something that we just sort of planned on doing. It wasn't like, ok are we going to do this or not, it was just something we intended to do from the start so we could be prepared and have some clue on."

Some of the respondents who said they had decided on their own to take the classes also mentioned the encouragement and influence of others. Ardis (ECCBE) pointed this out when she said,

> "We decided pretty much on our own, and it was something that even my doctor encouraged, and let alone family and friends that had done the same thing, so it's really important."

For these respondents, the encouragement and example from their social support systems reinforced and solidified their decision to take the classes. However, they denied that this social support had actually influenced their decision.

In my study, like that of McCraw and Abplanalp (1982), there were also those who mentioned the influence of "everybody." Many of these also said it was "the thing to do." Thirty-five percent of the participants who had taken the classes said they did so because it was expected or the thing to do. For some it was not only something "everybody does" but it was also something that "should" be done. Doris (ECCBE), for example, gave this response, "kind of just, that's what everybody does, you know. And I do feel like that's something I should do just to be as prepared as possible."

If looked at from the perspective of the cultural ideology influence (that a woman decides on her own to take classes or makes the decision because "it is the expected thing to do" or "everybody does

it") it does not appear as "vague," as McCraw and Abplanalp suggest. As mentioned earlier in this chapter, as the dominant ideology takes hold, members from all SES, education, and ethnic backgrounds incorporate it and eventually see and experience reality through the ideals of the dominant bloc who espouse the ideology. In taking the childbirth classes the woman establishes herself as part of the dominant bloc and affirms the dominant childbirth ideology. Childbirth education, as a *common sense* assumption of the dominant ideology, then, becomes a "should" or "ought to" or "it's expected" or "everybody does it" behavior that links pregnant women with the consistent and integrated society and defines the manner by which they experience childbirth. Whether defined as a contributing part to the childbirth "rite of passage" (Davis-Floyd 1992) or as merely the external source of information that provides the link between what humans can and do become (Geertz 1973), it is clear that the cultural web of childbirth education has so permeated women's ideas about the childbirth experience that many candidly take the classes without forethought or plan.

Lazarus (1994) suggests that there is a link between the desire for knowledge and control in childbirth. She also points out that the extent of desired information about childbirth differs among women. In my study, also, there were those who were excited about their childbirth classes and could not get enough information about pregnancy and childbirth, while others expressed little or no interest in classes and were satisfied with a minimum, if any, written information. A few who had not taken classes also said that even though they were given booklets and pamphlets, they merely put them away without looking at them. Unfortunately, no one, including myself, tried to establish the

reading ability of these respondents. Though much of the written material about childbirth is aimed at the fourth-grade reading level, if a woman cannot read, none of the booklets or pamphlets will be of use to her.

Reading ability may be an, as yet, unexplored barrier that affects women's childbirth education choices. A woman who can't read will be limited in her ability to discern the types of classes and schedules available to her, and she will not be able to read the materials used in the classes themselves. The inability to read could limit a woman's interaction and participation in a childbirth class and threaten her own self-image. The woman who can't read, then, is more likely not to take childbirth classes and may discard booklets, pamphlets, or other written material she receives. However, the ability to read was not explored with my study participants, nor was it mentioned as a reason for choosing not to take the childbirth classes.

The question remains, then, why do women opt out of childbirth education? Surprisingly, 63% of the participants who did not take classes said that they had wanted to take them. Though the cultural ideology was strong enough to pull them in and shape their own ideas about their pregnancy experience, other problems and pressures in their lives kept them from behaving as they "ought" within that ideology. Lack of transportation, conflicts in schedules for themselves and their partners, and preexisting and overwhelming problems, including homelessness, were given as reasons for not following through with their desires to take classes. While it is true that some of the behaviors observed seemed to indicate a certain amount of resistance to the dominant ideology, it is also true that all of these reasons are

symptomatic of a lack of social support which, as mentioned earlier, can be devastating to the best intentioned desire or plan to attend the classes.

The issue of control cannot be overlooked in any discussion pertaining to women's childbirth education choices. It has already been pointed out that in the dominant childbirth ideology the technology belongs to the medical practitioners, and as controllers of the birth process, it is their prerogative to use the technology as they deem necessary. While some women reject the passive role they are expected to play in a physician-controlled technological birth and strive to take charge of their birth experience, others accept the technological birth, provided that they can be awake, alert, in control of themselves, and able to make informed decisions. For women who accept the technological birth with these provisions, the important thing is knowing what to expect, being awake and being able to cooperatively decide with the physician what medications and technological interventions to use and when to use them. Still others who favor technological intervention are willing to be the passive recipients of the caregiver's technology because they believe it will alleviate the pain, reduce embarrassment, and in general, help them survive the birth (Shapiro, et al. 1983; Sargent and Stark 1989; Davis-Floyd 1992; M. Nelson 1983).

As Jordan (1993), Sargent and Stark (1989), and Davis-Floyd (1992) point out, the technological birth has been generally accepted among American women, and childbirth education effectively socializes them to cooperate with their physicians during the birth. In order to cooperate, the woman needs to be informed about the technology available to her, and she needs to be in control of herself to effectively take

part in the experience. In childbirth classes, she not only learns techniques by which to control her reactions and behavior, she learns about the technology that may be used during her parturition, and she learns how she is to behave in and respond to the event.

None of the women in my study questioned the technology that might be used during their parturition. Some hoped they would not need to have a Cesarean section or an episiotomy, but they did not rule these options out of the possibilities in their birth experience. A few said they wanted to try to "do it" without the use of medication but would accept it if things "got too hard to handle." And others said they were going to ask for the epidural as soon as they walked through the doors of the obstetrical unit.

As pointed out previously, many of my study participants, both CBE and NCBE, stressed the importance of being able to relax, stay calm, and breathe through contractions. Though not specifically said, being able to relax, stay calm, and breathe through contractions implies a certain amount of self-control in the labor process. Without realizing it, the respondents had incorporated one of the major tenets of the dominant childbirth ideology, which proposes that a woman who is in control of herself during labor and delivery doesn't disrupt things, is easier to "handle," and is more likely to cooperate with the decisions the physician makes for her.

Three participants in my study said they chose to take childbirth classes in order to be informed and able to make educated decisions during labor, but none of the participants who had taken classes mentioned the desire to control their parturition events. Without reservation, the CBE respondents in my study were deferring the major

portion of their childbirth experience to the control of the physician. As in Sargent and Stark's (1989) study, which found that women desired more to be alert and pain free than to have control of decision-making and limited technological intervention, the majority of my study participants wanted to be calm, relaxed, and ready to allow the use of the technology with an informed perspective.

While the women in Davis-Floyd's (1992) study who wanted to make their own childbirth decisions took classes, such as those offered by the Bradley Method, the two women in my study who wanted "to do it" their way felt that classes were not necessary. The first, Melissa (NCBE), said,

> "I know enough to where I think if you keep a cool head you don't need to go to Lamaze and childbirth classes, you know. I jus' didn't wanna go, because I think no matter what happens when it comes right down to it you're not gonna remember everything that was taught in that class, you're gonna try to do things your own way, you know, and I figured, I wanna do it my way, I wanna stay calm, I know how ta breathe, I know how ta push, you know, I jus', I didn't figure I needed the classes."

As mentioned earlier, Melissa had said "I'm really fixed on trying to stay calm, I don't wanna be a crazy lady." Melissa had attended one childbirth class with a friend of hers who was pregnant, but she did not complete the series of classes. Melissa's grandmother, who was a registered nurse in a nearby town's prenatal clinic, had given gave her some childbirth information. Melissa also said that she had read several books and pamphlets and she felt she "knew enough." She did not feel that the classes could give her more than she already knew. Melissa did have some knowledge of what to expect and how to handle herself in labor, but she had not completed the formal "authoritative"

childbirth classes, and the clinic staff who referred her to me for the study considered her as "unprepared" for her childbirth experience.

At no time during the interview did Melissa mention the use of medications or technology; however, she did mention that she definitely wanted to deliver in the hospital "because that was the safest place if anything would happen." As Davis-Floyd (1992) points out, the belief that technology can make safe what is believed to be an inherently unsafe birth links the dominant childbirth ideology and the desires of women's hearts with such a strong bond that even those who would prefer to deliver at home will still go to the hospital believing that "it is the safest place if anything would happen."

Melissa was adamant about doing things her way in labor and delivery, but she too was bound by the technological ideology that says the hospital and the technology used there is safer. In fact, four days after the interview Melissa had an ultrasound and stress test which indicated that her infant was in distress. She was hospitalized immediately. A pitocin induction was initiated followed by a long technologically controlled labor and delivery. While it is true that the technology used probably saved the life of her infant, in reality, Melissa, like many other women with lower SES, had few choices. She thought she could choose to "do it her way," but a combination of circumstances and technology took away her choice. Had the baby not been in distress, it is doubtful that Melissa would have had many more choices, for when technology is available it is most often used, superseding the preconceived choices of an "unprepared" woman.

Carol (NCBE), like Melissa, also chose not to attend classes, but she did so because she did not want a coached labor and delivery. When

asked what influenced her childbirth education choice, Carol said, "I just didn't want to. I work better by myself and don't want to rely on other people." For Carol, taking the childbirth classes would be paramount to accepting the type of controlled and coached labor that she did not want. Farther in the interview she indicated that she had "her own answers," and then she said, "I pretty much know what I need to know."

Carol was very reserved and soft-spoken throughout the interview and answered each question with a short deliberate response. Even when probed, she would give no more information. She made no mention of any aspect of technology that might be used for her birth experience. When asked what she thought women ought to know, she said she "hadn't thought about it," and when asked what she had wanted to know, she said, "I really would rather not know, I don't want to be scared out of it." Nelson (1983) found that when working class women didn't make choices it was most often because they had not thought about the issues. Though Carol said she had not thought about what she or other women ought to know about childbirth, she had made a choice. That choice was not to take childbirth classes.

In another study, Nelson (1982) found that middle class women who had not taken classes were interested in having their babies by "natural childbirth," but working class women did not share this goal. This may explain Carol's comment about not wanting to be "scared out of it." If Carol planned to play the passive role and allow the physician to make all the decisions and use unlimited technology, and if she perceived childbirth classes as preparation for a "natural childbirth" which she did not want, the classes themselves would be interpreted as a threat

that would frustrate her plan. Thus, by not taking the classes she would be free to go through labor as she wished. If she had planned on a medically controlled, technological delivery she would most likely not be disappointed, even though she was not "prepared" to understand and cope with it.

Misconception of what childbirth classes are or what benefit one may gain from attending them can affect women's childbirth education choices. While Carol mentioned that she had not taken classes because she didn't want to rely on anyone during her labor, Jennifer (NCBE) gave just the opposite answer. She said that she didn't take classes, " 'Cause I already, I got my mother-in-law and my mom to help me pull through the labor and my husband's gonna be there." Jennifer was slow to answer during the interview, sometimes appearing not to comprehend the questions. When asked what she thought women learned in childbirth classes, she said,

> "How to breathe, an when the doctor tells you to push, and other times when the doctor tells ya, or the Lamaze classes shows ya, and they probably watch movies at best, probably childbirth movies."

Though she did have some understanding of what was taught in the classes, Jennifer was fearful that if she took the classes her own chosen support system would be taken away from her. If the childbirth classes are perceived as part of the dominant childbirth ideology that will change a woman's support system or force her into a type of delivery that she does not want, she will be less likely to choose to take them.

The Obstetrical Caregiver's Influence

The influence of the medical caregiver in women's childbirth education choices appears to have diminished over the past few decades. When childbirth education was first introduced in the United States by Grantly Dick-Reed, it was not accepted by the medical community. Even in the early days of Bradley's *Husband Coached Childbirth, the concept* was not broadly accepted. However, as the Lamaze method took hold, physicians began to accept the concept, add their own "authoritative knowledge," and encourage women to take the classes. In a 1973 study of childbirth classes in Rhode Island, Watson (1977) found that physicians' and "word of mouth" referrals were the most common influence in women's decisions to take the classes. Another study of childbirth education in Indianapolis conducted between 1973 and 1976 (Zwirn, et al. 1979) also found physicians to be the most influential. Forty-nine percent of the childbirth class participants in that study reported being referred by their physicians.

In McCraw and Abplanalp's (1982) study, 3 out of 59 participants (5%) stated that an obstetrician or nurse influenced their decision. In my study also only 8 out of the 31 who took classes (26%) mentioned a caregiver (physician, nurse midwife, or registered nurse) as influencing their decision, and of these, only 6 (19%) identified the caregiver as the primary influence in the decision.

When asked what influenced her choice to take the childbirth classes, Linda (ECCBE) said,

> "I think my doctor pretty much, almost demanded it. He was, he didn't, well he had the book with the classes listed and circled the ones I should go to, so, he did feel pretty strongly about it."

While some of the other participants also said their doctors strongly encouraged it, none said their doctor "demanded" it. When husbands and later significant others were first allowed in the delivery room, childbirth classes were required, but this is no longer the case. Therefore, it is a rare case in which a physician would "demand" that the woman and her partner take classes. They may, however, "strongly encourage," which could be interpreted as a "demand."

Nevertheless, for most of the women in my study, friends and family were more influential than any of the medical personnel involved in their care. The dominant childbirth ideology and its socializing web of childbirth education has become so integrated into the ideologies of American childbearing women that the caregivers need only to provide information pertaining to class schedules and enrollment procedures. This is not to say that the caregivers are not influential in the decision to take classes, for they still encourage women to take them, but they do not have to convince them or demand it. The information and encouragement from a woman's own social support system, and her own desires to take the classes, often appear to be in force even before the caregiver's influence. For many American women, the "should" or "ought to" or "must do" childbirth classes has become fully incorporated into their own childbirth ideology from the dominant childbirth ideology.

The decision to take or not to take childbirth classes emanates from a complex accumulation of influences, of which the physician's suggestion or encouragement is only a part. A woman's own beliefs are affected by either the dominant childbirth ideology or a subordinate ideology. Her convictions, strengthened by the influences of her social support group, intertwine with other factors such as her age, education,

SES, relationship with the father of the baby, and the type and amount of knowledge she desires, and direct the childbirth education decision she makes.

Chapter VIII

CONCLUSIONS

Although childbirth is one of life's events that affects most women in the course of their lives, the manner in which they experience the event is shaped and controlled by their social and cultural environment. Based on a marxist perspective of ideology, as shown in chapter one, the dominant American childbirth ideology can be seen as superseding other childbirth ideologies. As the dominant ideology, it not only prescribes the management of the pregnancy and parturition, it also provides the language with which women talk about childbirth, and defines the behavior expected of them during that experience.

As an extending web of the dominant ideology, childbirth education draws women in, and, as Jordan (1993) and Davis-Floyd (1992) contend, socializes them into the dominant childbirth ideology. Although the childbirth class is the ultimate means of socialization, childbirth information is also disseminated by written materials, movies and videos, and verbal information from medical caregivers. Several participants in my study attested to the fact that written childbirth material is freely distributed to pregnant women. When speaking of her sources of information, Bonnie (ECCBE) confirmed the comments of other participants:

> "And I laugh because you really just get lambasted with, I mean, brochures and pamphlets and this and that and everything else, I laugh, and I said, you know, your incubation period should be closer to three years so that you can actually read all this stuff!"

This visual and verbal deluge of information, accented by childbirth classes, provide the "authoritative knowledge" that prepares women for a childbirth event in which they are expected to be in control of themselves while they are being controlled in a technological birth experience.

Language Use and Behavior Expectations in the Childbirth Experience

It was evident from the way the participants in my study spoke of their own childbirth experience that, without their awareness, the webs of the dominant childbirth culture had drawn them in. They shared a common interest in what they thought women ought to know about the childbirth experience. It could be argued that this interest would be the same merely due to their shared physical experience of pregnancy; however, the fact that they spoke specifically about staying calm, using relaxation and breathing techniques, and "delivering" in the hospital with a physician conducting the delivery, links them to the dominant American childbirth ideology. It is true that the women who had taken the classes focused more on the technology used in the birth experience, and the women who did not take classes tended to focus more on the things they could do to stay calm and relaxed during labor, but both of these issues are part of the *common sense* assumptions of the dominant childbirth ideology. It is logical that those who had attended the classes would be more aware of the technology used in the parturition processes, while those who had not attended would focus more on

breathing and relaxation because these were stressed more by the prenatal clinic staff who encouraged them to take the classes.

Another aspect of the participants' *common sense* assumptions about their childbirth experience was revealed in the reasons they gave for taking the childbirth classes. Though some participants stated that they had been influenced by family or friends, others said that it was the "expected thing," or "everybody did it," or, it was "what everyone should do." Even some of the NCBE participants who had not expressed wanting to take classes said, they probably should have taken them.

These statements about the "expected" behavior, the thing "everyone" does, and the "I should have done," exemplify Fairclough's (1989:91) assertion that

> "if a discourse type so dominates an institution that dominated types are more or less entirely suppressed or contained, then it will cease to be seen as arbitrary (in the sense of being one among several possible ways of 'seeing' things) and will come to be seen as *natural*, and legitimate because it is *the* way of conducting oneself."

Childbirth education has become *naturalized* and is an important part of the technological, medically controlled childbirth, which, as Sargent and Stark (1989) and Davis-Floyd (1992) point out, has also become the *natural* way of birthing. Many women no longer see childbirth classes as being an arbitrary thing to do: it is the expected and "natural" thing that "everybody" does, or at least, "should" do. As a component of the childbirth ideology web, childbirth education has become fully entrenched as part of the dominant childbirth ideology, hidden in the perceived logical reason for taking classes and incorporated by many as the *normal* and expected thing to do.

If, as Fairclough (1989) suggests, the *common sense* assumptions of ideology are expressed in common language and social practices, then it could be assumed that women who use the language of the dominant childbirth ideology would also fulfill the expectations of that ideology, which includes attending the childbirth classes. However, this was not the case for the participants in my study. Although the participants had common thoughts about what women ought to know about pregnancy and childbirth, and what women learn in childbirth classes, and, though they spoke of the childbirth experience using a common language and common terms that reflected the dominant childbirth ideology, not all of them ascribed to taking the childbirth classes or using the techniques taught in those classes. Some said they knew enough and therefore did not "need" to take the classes. Others said they just didn't want to go, and two expressed the desire to "do things their own way." However, all of the women stated that they wanted to be in the hospital for their delivery because "that is the safest place to be." The webs of the childbirth ideology had touched these women but had not drawn them in completely. They remained on the periphery of the dominant ideology.

Being able to use the language of the dominant childbirth ideology contributes to a woman's feeling of belonging, which, as Fairclough (1989) points out, is an important factor in drawing people into the dominant ideology. Therefore, by using the language and terms of the dominant childbirth ideology even women who do not take classes can still have the "feeling" of belonging. Being able to use the terminology gives a woman a certain edge in being able to navigate the childbirth system, at least through prenatal care; but without the

complete indoctrination of the childbirth classes, she is labeled and limited, and conflict and struggle are likely to occur.

Use of the language also gives the person a sense of power and equality, even though that power and equality are only superficial and likely to crumble when the birth technology is used. Though childbirth education does not provide significantly more power and equality, it does solidify the *common sense* assumptions of the dominant childbirth ideology and socializes women into the unquestioned acceptance of the technological, physician controlled, hospital birth. Without conscious knowledge, women's use of the language and unquestioned consent for the use of technology and physician control in childbirth legitimizes and perpetuates the unequal power relationships and control in the dominant childbirth ideology.

Fairclough (1989:86) points out that even though those in power try to force the common sense assumptions of the dominant ideology, there will always be some people who will not respond. Thus, there will always be some degree of ideological diversity, conflict, and struggle. Only a few of the participants in my study reflected this potential conflict and struggle, but conflict and struggle were evident in their decisions not to take the classes and to try to respond to labor and delivery in their own way. Their comments and their actions confirm Fairclough's supposition that ideological diversity, conflict, and struggle will always be present. And some gave evidence of subtle ways of resistance to the dominant ideology, just as the women in Martin's (1987) study gave resistance to physician controlled, technological births.

There are many factors that affect a woman's decision to take or not to take childbirth classes. Although the women in my study expressed similar desires for childbirth information, not all chose to gain that information by attending classes. The women who were older, better educated, and had higher SES were more likely to attend. All of the women who did not attend the classes had lower SES, most were younger than those who did attend, and most were single. In general, these findings corresponded to the studies of Davis and Morrone (1962), Leonard (1973), Watson (1977), and Huttel, et al. (1972), which also indicated a higher class participation among women who were older, and had higher education, and higher socioeconomic status.

The studies of childbirth class participation have not focused on the influence of social relationships in the decision to take or not to take classes. Goldenberg, et al. (1992) and McCormick et al. (1989) suggest that the relationship between a man and a woman can affect the seeking of early prenatal care. It is possible that similar relationships may also affect attendance or nonattendance in childbirth classes. In my study, the influence of boyfriends, husbands, fiances, and other family members and friends was very important in the participants' decisions to take or not to take the classes. For them, the overall social support, and not just the relationship between the women and the men, was the predominant defining factor in their childbirth education decisions. Women who took the classes tended to have strong and positive social support. Those who had negative or minimal social support did not take the classes, even though several said they had wanted to take them, and some had signed up for them. Even when the dominant childbirth ideology has been incorporated as

one's personal ideology, the lack of social support can hinder the response to the tenets of that ideology.

Poland, et al. (1997) Boone (1988), Lazarus (1990), Giblin, et al. (1990), Kalmuss and Fennelly (1990), Sable, et al. (1990), and Scupholme, et al. (1991) identified many barriers that keep women from adequate prenatal care. Included in these barriers are such factors as lack of motivation, miscommunication or lack of understanding, lack of information about the system, expectation differences, feeling a lack of control and a lack of social support which includes lack of encouragement and lack of transportation. It was clear from the interviews with some of the women in my study that these same, or at least similar, barriers also kept them from taking the childbirth classes. Even when they were interested and motivated to take the classes, barriers such as lack of transportation and lack of social support prevented them.

Unfortunately, the barriers are not considered when assessing a woman's preparation for childbirth. Even though she may have sought extensive information for herself through reading, and video tapes, and talking with knowledgeable relatives or friends, a woman is not considered to be fully prepared if she has not attended classes. When she enters the labor room a woman's knowledge is seldom assessed, her knowledge is assumed on the basis of her attendance or non-attendance in formal childbirth classes. Without classes, she is labeled as unprepared and is often expected to be uncooperative and out of control. While it is true that some women are not prepared for labor and struggle with the experience and technologies used to accomplish the birth, it cannot be assumed that this will be the case for all women who have not

attended childbirth classes. Negative labels and their accompanying assumptions and expectations that contribute to conflicts and dissatisfaction might be prevented if a woman's knowledge and expectations for her childbirth experience, rather than just her childbirth class attendance, was fully assessed during her admission to the labor room. The barriers that prevented her participation in childbirth classes should not also be barriers in her childbirth experience.

Is Childbirth Education Appropriate for All American Women?

Although childbirth education has become one of the dominant childbirth ideology's *common sense* assumptions among many American women, the question still remains: are childbirth education classes appropriate for all women who give birth in the United States? To be appropriate, childbirth education needs to begin with what women themselves think they ought to know about childbirth. It depends on how women learn and what the expectations are after learning takes place. And ultimately it depends on the woman's own perception and beliefs about her childbirth and how she wants to experience it.

With few exceptions, the women in my study wanted information about pregnancy and childbirth. They sought that information in various formal and informal ways. Only a few said they didn't want to know anything, either because it would make them fearful of the birth experience or it would hold them to behaviors and a type of delivery that they did not want.

The information wanted was similar among the respondents for all ages, levels of education, and socioeconomic status. There was a tendency for participants with less education and lower SES to want more

information concerning themselves and how they could cope with labor, whereas participants with more education and higher SES were slightly more interested in the technological aspects of birth. However, the over-all desired knowledge was similar among the majority of the women. A general desire to know what to expect, especially for labor and delivery, was commonly expressed.

Although the childbirth classes explored in this study provide women with limited information concerning the prenatal period, the classes do give detailed pertinent education for the birth experience. The educators carefully explain the anatomy and physiology of labor and delivery and prepare the women for what labor feels like, how long it can last, and what they can do for themselves to help reduce the pain and cope with the process. They also describe the medications and other technological interventions that are available and might be used during labor, delivery, or postpartum. In short, the childbirth classes answer questions and provide the birth information my study participants said they wanted.

Formal childbirth classes, such as those I observed and participated in, present information in a well ordered and intellectual manner. They assume that all of the participants can read and assimilate knowledge presented in a semi-theoretical framework. As the educational and socializing arm of the dominant childbirth ideology, they present "authoritative knowledge" and devalue most knowledge gained from more traditional sources, i.e., family and friends. And, though not specifically intended, they appear to promote a family unit of husband and wife who are giving birth to a much wanted and valued child. While some of these characteristics of childbirth education may be

commendable, they can also be threatening for women who do not fit the expectations and may act as barriers that prevent women from getting the childbirth information they want.

Though it may or may not be esteemed, the dominant childbirth ideology of a hospital, physician-controlled, technological birth is the standard in most American hospitals. Even when birth is conducted in a birthing center or home setting using nontechnological methods, the technology remains, waiting in the background should "something go wrong." There is virtually no way to completely escape technology in childbirth, nor would most women want to, for the appropriate use of technology has contributed to safer deliveries and a reduction in maternal morbidity and mortality (Koonin and Hani 1993).

Unfortunately, when technology is available, it is used, even in low-risk cases. This inappropriate use of technology results in an increase in maternal morbidity and mortality (Michaelson and Alvin 1988). Women who are less knowledgeable and unprepared to cope with a technologically managed childbirth are at a distinct disadvantage and are even more likely to undergo technological interventions than those who have completed childbirth classes (Nelson 1983).

Even though childbirth education is the socializing arm of the dominant childbirth ideology, it does have value for the parturient woman. Childbirth education itself can be beneficial in decreasing the need for technological interventions in the birth process. A woman who knows about her pregnancy and childbirth and is supported and equipped to cope with labor through the use of non-invasive, nontechnological methods, such as breathing and relaxation techniques, is more likely to

have a positive birth outcome without succumbing to extensive technological interventions (Michaelson 1988).

And so I ask, is childbirth education appropriate for all American women? And in general, my answer is, yes, but with some qualifications. First of all, childbirth classes as they are now - taught in a formal classroom setting with lectures, reading assignments, and partner interaction in breathing and relaxation techniques - are not appropriate for all childbearing women. These classes are set-up for and appeal to women who are educated, middle to upper class, and in stable, supportive relationships. Such women are accustomed to formal class settings and work and learn well within them. The attendance in these classes by higher numbers of older, better educated, married women with higher SES is indicative of this fact. Such classes are appropriate for women with these characteristics, abilities, and expectations.

However, the nature and format of these formal classes tend to cut off discourse and interaction among the participants. The content of the classes is established by the owners of the "authoritative knowledge", who provide only that information deemed pertinent for the expectant woman and her partner to know. Though a certain amount of time is allowed for questions, there is little time available for discussing individual fears, sharing informal information, or clearing up "old wives' tales."

The assumption that all class participants can read and assimilate information given in a lecture, video, or textbook can promote anxiety and hinder the woman who did not do well in school or cannot read well. The emphasis put on the shared practice and experience of relaxation and breathing techniques between the woman and her coach can also hinder the

participation of women who do not have a good relationship with the father of the baby and who feel uncomfortable with another support person. And, for those women who have difficulty with transportation, the sparsity of daytime classes can prevent class attendance.

In order to provide childbirth education for all women, some adjustments in the educational system need to be made. A combination of various types of classes that would be appealing to various women should be established. The established formal classes for women and their partners would not have to be changed. These classes do benefit those who are accustomed to formal classroom learning.

Less formal, more interactive classes should be established for women who learn better through sharing and discussion. In this type of class women could identify for themselves the information they want. Through the informal teaching of a health care facilitator, and participant sharing of individual knowledge and experience, anxieties could decrease and confidence increase. The informal knowledge of the woman would not be devalued. Correct information could be strengthened and, if necessary, incorrect information, or "old wives' tales," could be corrected in a non-threatening manner. Stretching and exercises, as well as relaxation and breathing techniques for labor and delivery, could also be taught, thus giving the woman confidence in her own ability to cope, even though she may not have a supportive partner to accompany her through labor.

Classes such as these would have to be small so that interaction and discussion could take place. The health care professional facilitating the classes would have to be culturally sensitive and willing to be supportive of women with varied childbirth information and

ideologies. Started early, and given over a longer period of time, these classes could give a woman the information she wants and needs to cope with pregnancy and birth. They could also provide a support system that would encourage participation and help the woman through difficulties she may encounter during her pregnancy. The classes could be arranged for women alone or for women and their partners.

Class times should be arranged so that transportation would not be a problem. Morning and afternoon classes could be made available for women attending the clinic for their prenatal care. Classes could also be made accessible by holding them in neighborhood clinics or churches. Evening classes could still be held for those who prefer them. Women could have the choice of attending either the formal childbirth classes, the informal discussion classes, or both the formal and informal classes. If classes are tailored more to the needs and learning styles of the women, they are more likely to choose to take them.

The expectations for the woman after having attended the classes also need to be established. If she thinks she will have to give birth "naturally" without medication or technological support when she does not want this type of birth, she is likely to reject any sort of class made available to her. On the other hand, if she thinks she will have to have an unwanted technological, physician-managed birth because she has gone through the classes, she is also likely to reject them. Childbirth classes should be established to give the woman knowledge and skills to deal with the type of birth she desires to have.

As seen in my study and corroborated in other studies (Sargent and Stark 1989; Davis-Floyd 1992) many women desire the use of technology, especially epidural anesthesia, which keeps them awake and alert but

takes away the sensation of pain and discomfort. Perhaps this desire in itself is the outcome of childbirth education which socializes the woman into a technological model of childbirth. Childbirth classes should not promote either a "natural" or a technological birth, but the decision should be left to the woman, and that decision should be supported inasmuch as possible by her caregivers and support persons.

While childbirth education is beneficial and appropriate for all American women, if presented without bias, and according to their perceived needs and learning styles, there will always be a certain number of women who will choose not to take childbirth classes. Desire, motivation, and circumstances cannot be controlled, and in themselves may pose barriers to childbirth education. Social support will still play a part in women's childbirth education decisions. Artificial support systems such as moms' groups, a scheduled visiting friend, a social worker, or a nurse could help a woman in her decision to take childbirth classes, but ultimately the choice is hers. And some women will choose not to take childbirth classes.

Other means of education can be supplied for women who do not take classes. Appropriate reading material (depending on their reading ability), video tapes, and individual teaching during prenatal visits can also be used to provide childbirth education.

Cultural differences must also be considered in childbirth education. The value, experience, and meaning of childbirth vary among cultures, and these cultural differences will affect the response to pregnancy, childbirth, and childbirth education. The limitations of this study, which prevented the inclusion of women under eighteen years of age, hindered the gathering of information concerning cultural

differences, especially among African American women who tend to begin childbearing early in their teen years. Future studies need to look at this group of women to determine cultural differences, if any, and then modify childbirth education to meet their needs.

If it is true, as some studies have shown (Doering and Entwisle 1975; Hughey, et al. 1978), that women who have completed childbirth education courses are better able to cope with labor and delivery and tend to have more satisfying birth experiences, then all women should receive childbirth education. However, classes that demand shared participation between the woman and her coach, devalue her informal knowledge, and fail to consider her varying learning styles and needs, do not help her gain the knowledge, confidence, and competence she needs to cope with labor and delivery.

Modification of the present system of childbirth education, so that women can make decisions for their own learning and share their informal knowledge with each other as well as being given formal "authoritative" knowledge, would give childbirth education a broader interpretation, and would make it more acceptable for women who are anxious about formal classes because of their limited reading skills, discomfort with formal class settings, or lack of social support or coach to encourage participation. Broader childbirth education that provides women with more than strict "authoritative knowledge" that focuses on a technological birth; good prenatal care, regardless of a woman's ability to pay; and positive support in labor, could make the use of technological interventions less relevant, and lead to birth outcomes that are more positive. This kind of childbirth education

would change not only the cultural ideology of childbirth but also the cultural character of childbirth education.

APPENDIX

APPENDIX

Interview Schedule for Childbirth Educators

General Background Information:

1. When were you born?
2. Where were you born?
3. Who did you live with during your childhood years?
*4. What grade in school did your mother complete? Did (or does) your mother work outside of the home? What sort of work did (or does) she do?
*5. What grade in school did your father complete? What sort of work did or does) your father do?
6. How many years of schooling have you completed? What is the highest degree that you presently hold?
7. What preparation did you have to teach the childbirth education classes?
8. Is teaching childbirth education your only occupation? Do you work in other professional or non-professional positions?
9. Are you single, married, separated, divorced, widowed, living with someone?
**10. How many years of schooling has your husband (or significant other) completed? What is your husband's (or significant other's) occupation?
11. Do you speak any languages other than English? How or where did you learn the language?
12. What is your ethnic background?
13. Do you consider yourself to be White non-Hispanic, Black non-Hispanic, Hispanic, Asian American, Native American, or Other? (If other, what is the other?)

*This question will not be asked if mother or father is reported as being absent during the childhood years.

**This question will not be asked if the participant reports that she is single, divorced, separated or widowed.

APPENDIX

Interview Schedule for Childbirth Educators

Questions Regarding Childbirth Education:

1. What do you think a woman needs to know about childbirth?
2. How can a woman get the information she needs about childbirth?
3. What do you think are the most important sources of childbirth information? Why are they important?
4. What do you think are the least important sources of childbirth information? Why are they less important?
5. Are there any sources of childbirth information that you think might be harmful, especially for a woman who is expecting her first baby?
6. How would you define and describe childbirth education?
7. If a couple (or woman) could attend only one of the classes in your series, which do you think would be the most important class for them to attend? Why would you chose this class?
8. If a couple (or woman) could attend all but one class in your series, which of the classes would you suggest as the one for them to miss. Why would you chose this class?
9. Who decides what content will be included and how the childbirth classes you teach, will be structured?
10. If it were possible for you to do so, how would you change your childbirth education program or classes?
11. Do you think that it is necessary for every woman to attend formal childbirth classes to be prepared for childbirth?
12. Why do you think some women chose to not attend childbirth education classes?
13. How would you describe the ideal birth?
14. Are most births like your ideal model?

APPENDIX

Interview Schedule for Participants in Childbirth Education Classes

General Background Information:

1. When were you born?

2. Where were you born?

3. Who did you live with when you were growing up?

*4. Do you know what grade in school your mother completed? Did (or does) your mother work outside of the home? What sort of work did (or does) she do?

*5. Do you know what grade in school your father completed? What sort of work did (or does) your father do?

6. What grade in school did you complete? (If more than high school) What is the highest degree, technological training, certification that you presently hold?

7. Do you work outside of the home?
(If yes) What kind of work do you do? Do you work full or part-time? What other jobs have you had?
(If no) Have you ever had a job? (If she did work) What kind of work did you do?

8. Are you single, married, separated, divorced, widowed, living with someone?

9. Who lives with you?

**10. What grade in school did your husband (or significant other) complete? What kind of work does your husband (or significant other) do?

11. Do you have insurance, medicaid, or Mich-care? (If on medicaid or Mich-care) Are you registered in WIC? (If no insurance or medicaid) Who will pay for your care?

12. Do you speak any languages other than English? How or where did you learn the language?

13. What is your ethnic background?

14. Do you consider yourself to be White non-Hispanic, Black non-Hispanic, Hispanic, Asian American, Native American, or Other? (If other, what is the other?)

*This question will not be asked if mother or father is reported as being absent during the childhood years.

**This question will not be asked if a husband or significant other is not reported as presently living in the household.

APPENDIX

Interview Schedule for Participants in Childbirth Education Classes

Questions Regarding Childbirth Education:

1. When did you first go to the doctor for your prenatal care?

2. What do you think a woman needs to know about childbirth?

3. How can a woman get the information she needs she needs to know about childbirth? (If several sources given,) Which one of these do you think is best?

4. When you have questions about your pregnancy, labor, or delivery, who or where do you go to first for information and advice?

5. Do you get information from any other person(s) or place(s)? (If yes) Who or what are they?

6. If someone asked you what childbirth education is, what would you tell them?

7. Do you think childbirth classes are for everybody? Can you give me some reasons why you think this?

8. Who or what influenced you the most in your decision to take childbirth classes?

9. Do you know if there are any other kinds of childbirth education classes or programs? (If yes) Which ones? Would you have preferred to take one of these? (If yes) Why did you chose to take this program?

10. If you had a friend who was pregnant for the first time, and she could go to only one class, out of all the classes that you went to, which class do you think would be the most important for her to go to? Why would you chose this class?

11. If your friend had to miss one class out of the group of classes that you went to, which class would you suggest she could miss? Why would you chose this class?

12. If you could change anything in the childbirth classes that you went to, what would you change? Why would you make this change?

13. Have you ever been with a woman during her labor and delivery?

14. What do you think your labor and delivery is going to be like?

15. If you could have your baby anywhere that you wanted, where would you most like to have your labor and delivery take place?

16. If you could have anyone you wanted, who would you like to have with you during your labor and delivery?

17. What would you want each of these people to do for you during and after your labor and delivery?

APPENDIX

Interview Schedule for Non-Participants of Childbirth Education

General Background Information:

1. When were you born?

2. Where were you born?

3. Who did you live with when you were growing up?

*4. Do you know what grade in school your mother completed? Did (or does) your mother work outside of the home? What sort of work did (or does) she do?

*5. Do you know what grade in school your father completed? What sort of work did (or does) your father do?

6. What grade in school did you complete? (If more than high school) What is the highest degree, technological training, certification that you presently hold?

7. Do you work outside of the home?
(If yes) What kind of work do you do? Do you work full or part-time? What other jobs have you had?
(If no) Have you ever had a job? (If she did work) What kind of work did you do?

8. Are you single, married, separated, divorced, widowed, living with someone?

9. Who lives with you?

**10. What grade in school did your husband (or significant other) complete? What kind of work does your husband (or significant other) do?

11. Do you have insurance, medicaid, or Mich-care? (If on medicaid or Mich-care) Are you registered in WIC? (If no insurance or medicaid) Who will pay for your care?

12. Do you speak any languages other than English? How or where did you learn the language?

13. What is your ethnic background?

14. Do you consider yourself to be White non-Hispanic, Black non-Hispanic, Hispanic, Asian American, Native American, or Other? (If other, what is the other?)

*This question will not be asked if mother or father is reported as being absent during the childhood years.

**This question will not be asked if a husband or significant other is not reported as presently living in the household.

APPENDIX

Interview Schedule for Non-Participants of Childbirth Education

Questions Regarding Childbirth Education:

1. When did you first go to the doctor for your prenatal care?
2. What do you think a woman needs to know about childbirth?
3. How can a woman get the information she needs she needs to know about childbirth? (If several sources given,) Which one of these do you think is best?
4. When you have questions about your pregnancy, labor, or delivery, who or where do you go to first for information and advice?
5. Do you get information from any other person(s) or place(s)? (If yes) Who or what are they?
6. Do you know there are childbirth classes for pregnant women?
7. What do you think women learn in childbirth classes?
8. Do you think childbirth classes are for everybody? Can you give me some reasons why you think this?
9. Are there any special reasons why you decided to not take childbirth classes? (If she answers only that she does not have transportation also ask) Are there any other reasons why you decided not take the classes?
10. If you would decide to go to a childbirth class, what is the most important thing you would like to learn?
11. Have you ever been with a woman during her labor and delivery?
12. What do you think your labor and delivery is going to be like?
13. If you could have your baby anywhere that you wanted, where would you most like to have your labor and delivery take place?
14. If you could have anyone you wanted, who would you like to have with you during your labor and delivery?
15. What would you expect each of these people to do for you during and after your labor and delivery?

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