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THE LIVED EXPERIENCE OF THE AFRICAN AMERICAN PREGNANCY
THAT ENDS IN PRETERM BIRTH

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Clarise Hairston Ottley

December 2009

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Clarise Hairston Ottley

2009

THE LIVED EXPERIENCE OF THE AFRICAN AMERICAN
PREGNANCY THAT ENDS IN PRETERM BIRTH

By

Clarise Hairston Ottley

Approved November 20, 2009

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ABSTRACT

THE LIVED EXPERIENCE OF THE AFRICAN AMERICAN PREGNANCY THAT ENDS IN PRETERM BIRTH

By

Clarise Hairston Ottley

December 2009

Dissertation supervised by Dr. Mary Ann Thurkettle

The research study was undertaken to help fill the gap in understanding the disparity between the current preterm birth rates of African American women and White women. A phenomenological methodology was used with a sample of seven African American women who had experienced preterm birth. The findings provide insight into experience of a pregnancy that ends in preterm birth.

An in-depth understanding of the contextual factors associated with preterm birth in African American women was provided through a description of experiences as voiced by the participants themselves. Their stories provided rich, detailed data and insight into their lived experiences, revealing new insights and perspectives on the phenomenon of the African American pregnancy ending in preterm birth. Two Themes emerged: "Strong Black Woman Ideal" and "Feeling Trapped."

Awareness regarding the need to “peel back” layers of generational factors which influence stress on and the types of stressors specific to African American women were noted. While it is safe to say that stressors, stress, and stress responses are experienced by all pregnant women, it may be that African American women are unique in their cumulative experiences of and response to stress.

Reflection on and review of extant knowledge in the literature on the extracted themes revealed some concepts that may be related to the extracted themes "Strong Black Woman Image" and "Feeling Trapped." Permeating both themes was the experience of stress these women felt in having to live up to self- and other-imposed expectations of strength resulting from the image of a strong Black woman and feeling trapped by the expectations of the image, along with other responsibilities and obligations. The end result is feelings of being trapped by the expectations of that image and a pregnancy that is affected by the cumulative effects of the two.

Knowledge gained from this study will contribute to future knowledge development regarding factors that may be associated with preterm birth among African American women.

DEDICATION

I dedicate this research to the hundreds of thousands of women who have lost their babies as a result of prematurity, and to the thousands who may lose their babies in the future. May God comfort you where you hurt, and may He instill the wisdom and knowledge in those who desire to find ways to reduce the pain associated with premature births.

I also dedicate this research to other African American women who are nurses, those who aspire to become nurses, and those who did not believe they could ever become a nurse. You are a gift to this great nation! You can become leaders and giants by tapping into your rich heritage, ordained steps, and destiny prepared in advance for you by God. I pray for your strength, perseverance, and faith to trust Him to use you to make a difference!

To my grandchildren, who are yet to be born, please know that you are precious, you are royal, you are chosen kings and queens, and you are loved! May you follow my footsteps, no matter your chosen profession, and go wherever God leads you. Serve Him and others with the gifts He has placed within you.

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I first express my gratitude and acknowledgement to God, my Father, for loving me so much that He would give me the strength, wisdom, knowledge, perseverance, and faith to accomplish this task. To Him I give all glory and honor for my success! He is truly a keeper of His promises (Jeremiah 29:11-13).

To Jesus Christ, the lover of my soul! My Jehovah Jireh, Jehovah Rapha, Jehovah Shalom, Jehovah Rohi, and Jehovah Shammah, thank you for giving your life in exchange for mine, and for choosing me to be your favorite!

To the Spirit of God, who has kept me, comforted me, encouraged me, and empowered me to “step out on waters, when they said it could not be done.” Thank you for your power which gave me the strength to speak to this mountain!

To my husband Al, my mentor, my confidant, my supporter, and my friend! Thank you for your obedience to God 30 years ago! Thank you for your innumerable sacrifices! Thank you for the life lessons in stepping out in faith. Thank you for the verbal visual that stayed before me, whenever I felt “choked” by the enormity of the task: “How do you eat an elephant? One bit at a time!” Your love and encouragement helped me stay the course. Now that you have reached your summit, you can sit down from your labor and rest!

To my four sons, Jason, Jonathan, Jordan and Joel, a mother’s most cherished treasure and gift! Thank you for your love and forgiveness for those days when I was not able to be there for you! I still hear your voices echoing in my head: “Are you almost done???”

To mama (Vinnie Nellie Bell Moyer [Hairston] Pinnix), mom (Vera Anita [Ottley] Smith) daddy (Tommy Clarence Hairston), and “Stuff” (Carl Clayden Pinnix), thank you for your never ending, never ceasing, countless acts of unconditional love and support.

To my family, the Hairstons, the Moyers, and the Pinnix, you represent generations of faith walkers. Thank you for lighting the way for me!

To Marlene Gray, thank you for believing in me, seeing my worth, and giving me a chance eighteen years ago, as a new nurse on the Maternity Unit. The seed you deposited into my life will continue to grow and positively impact the lives of people we may never know.

To Kathleen Gaberson, my friend, thank you for your example of courage, strength, and perseverance. Thank you for believing in me and showing me the way. Thank you for laboring with me as I stepped out in tumultuous waters of indecision and apprehension. It was your example, nurture and faith in me that rekindled my passion to pursue this degree.

To all my sisters in Christ, especially the women who are a part of WWWGOD & WCW, thank you for your prayers, words of encouragement, and countless shoulders to cry on. Thank you for your confidence in me and your sacrificial love. Thank you for allowing me the opportunity to teach, serve and be served by you! Because of you, I have grown personally, professionally, and spiritually!

To my church family (Covenant), thank you for your endless prayer, and for keeping a vigil for me when I was too exhausted to pray!

To Dr. James Brown and staff, thank you for your assistance and the opportunity to serve the OB community! Our partnership will assist in providing ongoing research that will help reduce and/or eliminate preterm birth for all women in general, but especially for African American women who currently have the highest preterm birth rate of all races.

To my colleagues at Shepherd University and my co-workers at City Hospital, thank you for stepping in and covering for me during times of family crisis and sheer exhaustion.

To each of the participants of this research study, please know that I will be forever grateful for your story! As a result of your unselfish sacrifices, the preterm birth rate for African American women will decrease!

Last, but certainly in no ways least, I thank you Dr. Mary Ann Thurkettle (dissertation chair), Dr. Carolyn Nickerson and Dr. Cynthia Persily (committee members) for your sacrificial guidance and support. Your expertise in your respective areas is evident throughout this manuscript, and will reach further than the words on the following pages could ever go!

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Chapter 1: Introduction

It is well recognized that preterm birth is one of the most persistent health disparities in the United States, with the highest rates occurring in African American women. To reduce the rates of preterm birth, and thereby reduce the cost to individuals and society, a better understanding is needed of the factors that lead to preterm birth. This understanding is especially needed for assessing factors particular to African American women, given the higher rates of preterm births in this population.

The current study examines factors that may contribute to the high rates of preterm birth among African American women by looking at how African American women describe their own lived experiences of pregnancies that ends in preterm birth. This chapter includes background on issues of African American preterm birth, the disparity among African American women and White women in preterm birth rates, the current understanding of the reasons for this disparity, and the need to better understand the lived experiences of African American women to reduce this disparity. Following the background, the chapter includes the (a) study purpose, (b) assumptions underlying the study, (c) definitions of terms used in the study, (d) significance of the study to nursing, and (e) delineation of the researcher's background as a first step in bracketing.

Background: Preterm Birth

Preterm birth is one of the leading causes of infant mortality and the leading cause of infant morbidity in the United States, affecting more than 500,000 babies each year. Since 1981, the preterm birth rate has increased from 9% to 12%, with an estimated cost to the United States that exceeds \$26.2 billion in medical care and lost household and labor market productivity (Green, et al., 2005).

Preterm birth constitutes a public health concern for three primary reasons: (a) a troubling increase in the rates of preterm birth in the past decade, (b) the emotional and economic cost of a preterm infant on families and communities, and (c) the notable disparities in the rates of preterm births across populations in the United States, with the greatest disparity among African American women. For these reasons alone, the prevention of preterm birth is crucial to improving pregnancy outcomes (Institute of Medicine, 2007).

Despite advances in medical technologies, therapeutic perinatal and neonatal care, proposed management methods, interventions, and access to prenatal care, plus a decrease in smoking during pregnancy, the preterm birth rate continues to climb. In 2003, the preterm birth rate for the United States rose to 12.3%, representing a 16% increase since 1990 and a 30% increase since 1981. In 2004, the preterm birth rate reached 12.5% (Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005). As of 2007, the rate was 12% (Institute of Medicine, 2007).

The high proportion of this increase is attributed to babies born at 32 to 36 weeks gestation. Compared with infants born at term, preterm infants have a greater risk of death and disability. Approximately 75% of perinatal deaths occur among preterm infants. One-fifth of infants born at less than 32 weeks gestation do not survive the first year of life (Slattery & Morrison, 2002).

Preterm infants comprise about 70% of the cases of neonatal mortality and almost 50% of long-term birth-related neurological morbidity, and their care constitutes 35% of all U.S. health care spending (Goldenberg, 2002; Goldenberg & Rouse, 1998; Lewit, Baker, Corman, & Shiono, 1995; Martin, et al., 2002; McCormick, 1985). In 2002, the

preterm mortality rate was 15 times that of those infants who were born at full term (Martin, et al., 2005). Those babies who survive often suffer lifelong consequences, such as cerebral palsy, mental retardation, chronic lung disease, blindness, and hearing loss. Preterm birth is associated with many familial, social, and economic costs related to the intensive care and developmental deficits of those babies who survive (Schempf, Brenum, Lukacs, & Schoendorf, 2007).

In 2001, 384,200 of 4.6 million (8%) infant stays in the hospital nationwide were for babies diagnosed as preterm (less than 38 weeks gestation) or low-birth-weight (LBW). The cost of hospitalization for these babies totaled \$5.8 billion, representing 47% of the costs for all infant hospitalizations and 27% for all pediatric stays. The average cost per day for preterm infants was \$15,100, with a mean length of stay of 12.9 days, compared to \$600 and 1.9 days for uncomplicated newborns. Costs for extremely preterm infants (<28 weeks gestation) averaged \$65,600 per day. In 2005, the annual societal economic cost associated with preterm birth was \$26.2 billion. Preventing preterm birth would result in major infant cost savings (Institute of Medicine, 2007; R. B. Russell, et al., 2007).

Background: Poor Reproductive Outcomes of African American Women

African American women fare worse in birth outcomes compared with White women at every social, biological, economic, and educational level (Mullings, et al., 2001). Disparities continue to persist in this population despite improvements in overall national health. Medical insights have not led to significant improvement in many of the health issues African American women face, mainly due to the lack of understanding of factors that contribute to these disparities.

After two decades of health care initiatives and remarkable progress in medical advancement, disparities continue in the burden of illness and mortality experienced by African American women when compared to the general population of the United States. Nationally, mortality rates for nearly all causes of death remain higher for African American women than White women. Although they may experience many of the same health problems as White women, African American women are generally in poorer health, use fewer health services, and continue to suffer disproportionately from premature death, disease, and disability (Webb, 2004). Reproductive health is among the top concerns for African American women. Reproductive health studies indicate that African American women are less likely to receive adequate reproductive health care (U.S. Department Health and Human Services, 2001 ; Webb, 2004). Poor reproductive outcomes in this population include a higher incidence of preterm birth. Health research continues to focus on factors that may explain the differences between African American women and White women with regard to preterm birth and LBW (Hogue & Yip, 1989; Jackson, Phillips, Hogue, & Curry-Owens, 2001; Krieger, 2000; Mustillo, et al., 2004; Rowley, 2001).

The disparity between the two races regarding preterm birth has widened for the past several years and has persisted for over 70 years (Hogue, Buehler, Strauss, & Smith, 1987; Institute of Medicine, 2007; Moore, 2003; Rowley, 1994). Epidemiologists continue to be puzzled by this widening disparity in the number of preterm births by African American women compared to White women. Current knowledge reveals that births to African American women make up 17.8% of the preterm birth rate, the highest of any race. African American women are 3 times more likely than White women to

deliver prematurely, nearly 4 times more likely to deliver extremely prematurely, and 5 times more likely to have a second or third child born prematurely (Kistka, et al., 2007; Rich-Edwards, et al., 2001). Extremely preterm birth (between 20-28 weeks gestation) accounts for more than one-half of the infant mortality gap that has existed for the past 50 years (J. W. Collins, et al., 2000; Institute of Medicine, 1985, 2007; Rowley, 2001).

Currently, a large disparity exists between the percentages of preterm births for African American women compared to preterm births for White women (17.8% compared to 11.5%). Rowley (2001) described this excess rate of preterm delivery among African American women relative to White women as a gap. The tremendous advances in medicine and a growing body of research on risk factors for adverse pregnancy outcomes have not closed the gap that exists between Whites and African Americans in pregnancy outcomes, mainly because the understanding of potential causes of racial and ethnic disparities in preterm birth in the African American population is not well developed. Although much work has been done in the public health and medical arenas to publicize the gaps between African American women and White women in health and overall quality of life, more work is needed to close this gap.

In West Virginia, where the purposive sample for the current study was taken, this gap persisted. Of the 51.4 % of females who resided in West Virginia, 3.2% were African American. Even with such a small proportion, African American women represented the population at greatest risk for poor reproductive health, with the highest rate of preterm birth of any ethnic group (West Virginia Prenatal Wellness Study, 2006).

West Virginia has little racial diversity compared to other states, with fewer than 5% of all births to women of non-White races. For many decades, West Virginians

ignored this minority health disparity because of the small numbers. However, a closer look at the disparity revealed an infant mortality rate of 15.1% for African American women compared to 7.4% for White women and a low birth weight rate of 14.2% for African American women compared to 9.2% for White women. Infant deaths attributed mainly to preterm birth were 17.7 per 1,000 live births for African American babies compared to 7.5 per 1,000 for White babies. These disparities exist not only in West Virginia but also nationally, suggesting an urgent need to address possible contributing factors (West Virginia Prenatal Wellness Study, 2006).

During the 2006 Perinatal Wellness Summit in Charleston, West Virginia, health professionals addressed the health crisis among pregnant African American women, reporting that racial and ethnic disparities in birth outcomes were the result of disadvantages and inequalities, such as poor health and health care, unemployment, inadequate housing, high crime and violence in their neighborhoods, and stress (West Virginia Prenatal Wellness Study, 2006). However, when researched, such factors did not account for the continued disparity gap in preterm births between African American women and White women (Rich-Edwards, et al., 2001).

The need to close this gap is of great concern, as this problem is expected to worsen as the minority population continues to experience exponential growth:

The demographic changes that are anticipated over the next few years elevate the importance of addressing disparities in the reproductive health status of women of color. The ethnic and racial groups currently experiencing poorer health status continue to significantly grow in proportion to the total U.S. population. Therefore, the future health of America will be increasingly influenced by the success or failure of improving the health of African American, Hispanic, Asian, Pacific Islander, American Indian and Alaskan Native women of color (Drew, 2001, p. 5).

Of the 281.4 million persons living in the United States in 2002, 143.4 million (50.9 %) were female. Of the 143.4 million females, 42.1 million females (29.3%) were members of racial and ethnic minority groups. In 2000, slightly more than 18 million (18,193,005) or 12.7 % of all females living the United States were African American, not of Hispanic origin. This information signifies that African American women are a relevant group to explore, as they are more likely than White women to experience negative reproductive health outcomes (National Women's Health Center, 2009).

Preterm Birth: Persistent Health Disparity in the United States

African American women have the highest infant mortality rate of all races, attributable to a twofold increase in LBW and preterm births and the near threefold increase in very low birth weight (VLBW) and very preterm births (birth before 32 weeks gestation) among African American infants (Lu & Halfon, 2003). A significant disparity exists between rates of preterm birth for African American women (17.8%) compared to White women (11.5%). This disparity remains a mystery to researchers.

Traditional explanatory models have focused on biological, physiological, and sociological factors as explanations for this disparity. This is consistent with studies suggesting that factors such as the environment, genetics, economic resources, socioeconomic status, behavior, access to and availability of health care services, and quality of health care contribute to disparities in adverse perinatal outcomes between African American women and White women (Hogan, Njoroge, Durant, & Ferre, 2001). However, research supported by organizations such as the United States Department of Health and Human Services, through the *Healthy People 2010* initiative (US Department Health Human Services, 2002), and the March of Dimes (March of Dimes, 2009) and

efforts by other researchers examining the interplay among various risk factors and preterm births show that socioeconomic (Jackson, et al., 2001; Mathews, MacDorman, & Menacker, 2003; Mullings, et al., 2001; Schoendorf, Hogue, Kleinman, & Rowley, 1992), biological (Culhane, McCullum, Hogan, & Wadhwa, 2001; Kramer, Seguin, Lydon, & Goulet, 2000; Wadhwa, et al., 2001), and environmental (J. W. Chambers, et al., 1998) risk factors do not explain the adverse birth outcome disparity between African American women and White women.

A woman's experience of pregnancy is affected by many factors, including age, health, socioeconomic resources, work, availability of social support, obstetric history, pregnancy status (planned/unplanned, desired/undesired), and race (Lobel, 1998).

Although the literature is full of research investigating the role of such factors regarding complications of reproduction and poor outcomes of pregnancy, very little research exists on life experiences of pregnancy for any cultural heritage group (Mann, Abercrombie, DeJoseph, Norbeck, & Smith, 1999).

Need for Studies Focusing on Lived Experiences of African American Women

Research that relies on and acknowledges the authoritative voices of African American women to understand their lives and the conditions that imperil their health and well-being may provide answers to causes of disparity in reproductive outcomes among these women (Jackson & Phillips, 2003). Any research that expects to uncover significant factors contributing to disparate reproductive health outcomes for African American women needs to focus on the lived experiences of these women and the deliberate articulation of the identities they assume as well as those imposed on them.

African American women have a long history of articulating their health-related experiences through storytelling. Through their own voices, these women have explained their experiences with breast cancer (Lackey, Gates, & Brown, 2001; E. Thomas, 2006), menopause (Palmer, Rosenberg, Wise, Horton, & Adams-Campbell, 2003), perinatal loss (Kavanaugh & Hershberger, 2005), abortion (Palmer, Wise, Adams-Campbell, & Rosenberg, 2004), racial discrimination as it relates to preterm birth (Mustillo, et al., 2004; Rich-Edwards, et al., 2001), exposure to racial discrimination and infant birth weight (J. W. Collins, et al., 2000), pregnancy (Barbee, 1992; George, 1995; Norbeck & Anderson, 1989b; Warren, 1997), and general health (White, 1994). To date, however, qualitative research examining the lived experience of the African American pregnancy that ends in preterm birth is lacking. Many studies have described pregnancy from a medical perspective, and a few studies have used qualitative methodology to examine and describe the personal experiences of pregnancy (Mann, et al., 1999). Unfortunately, the lived experience of the African American pregnancy that ends in preterm birth is not well documented in the research literature.

Several researchers have emphasized the importance of understanding the actual experiences of people to obtain insight into phenomena (Colaizzi, 1978; van Kaam, 1996; van Manen, 1990). These researchers indicated that the best place to start is through exploring lived experiences rather than through attempting to derive meaning through the eyes of those who carry out the research and those who have formulated theoretical constructs.

Purpose of the Study

The purpose of this study is to examine the lived experience of African American pregnancy that ended in preterm birth, and to uncover possible factors related to the etiologies of preterm birth for African American women for future investigation. This research provides an in-depth understanding of the contextual factors associated with preterm birth in African American women through a description of their experiences as voiced by the women themselves. Knowledge gained from this study will contribute to future knowledge development regarding preterm birth among African American women.

Assumptions Underlying the Study

According to P. H. Collins (2000), the everyday lived experiences of Black women, as only they can describe them, are central to understanding their needs, desires, and place in society. Based on this belief, a qualitative research method was chosen for this study. Background and tenets of phenomenology are described in Chapter 2. This section describes the paradigm used in this research study and the assumptions underlying this paradigm.

This research study used a naturalistic paradigm for its inquiry. The fundamental assumptions of this paradigm are epistemological and methodological. Epistemologically, the naturalistic paradigm assumes that knowledge is maximized when the distance between the inquirer and those participating in the research study is minimized. Additionally, the voices and interpretation of the participants are crucial to understanding the phenomenon of interest. Findings from this type of inquiry are the product of the interaction between the inquirer and the participants (Polit & Beck, 2004). Methodologically, knowledge is obtained through an inductive process, integrating

information to develop a description that elucidates processes under observation.

Emphasis is on understanding the human experience as it is lived, through the collection and analysis of qualitative materials that are narrative and subjective (Polit & Beck, 2004).

One fundamental assumption of this naturalistic research study takes the epistemological positions of Edmund Husserl and Patricia Collins. Husserl (1913, 1982) emphasized epistemological questions of knowing and concentrated on the subject of the lived experience. Collins (2000) believed that there was a Black woman's standpoint known as Black Feminist Thought. Black Feminist Thought demonstrated the significance of Black women's positions as agents of knowledge.

A number of epistemological assumptions underlie the current research study: (a) Data on the phenomenon of preterm birth are contained within the perspectives of African American women, (b) African American women will honestly communicate their experiences of preterm birth and verbalize a truthful recollection of the experience, (c) African American women's recall of preterm birth will reflect their perceived pregnancy experience leading up to the preterm birth of their babies, (d) African American women's perceptions of their experiences of preterm birth are unique to their personal situations, and (e) the phenomenological research method is appropriate for this study.

The methodological assumption underlying this study is that, in order to understand the context of the lived experience of preterm birth for African American women, it is necessary to be aware of factors that may have precipitated the phenomenon. This is achieved through an inductive process that captures aspects of human experience in their entirety, within the context of those who experienced them. Through this

naturalistic phenomenological study, the researcher integrates information to develop a description of the phenomenon to elucidate processes under observation.

Limitations

One limitation of this study, similar to all qualitative studies, is reliance on the ability of the participants to communicate their experiences concisely and intelligibly. Although qualitative approaches such as phenomenology ensure rich, contextualized data, the ability to produce findings that can be generalized across populations is limited. The described experiences of human beings can only be generalized to the specific type of situation researched (Ashworth, 1996; Weller & Romney, 1988).

Another limitation is the non-probability purposive sampling technique used in the study. This type of sampling technique “focuses on selecting information-rich cases whose study will illuminate the questions under study” (Patton, 2002 p. 230) and lacks generalizability to larger populations but can be transferred to similar populations (Patton, 2002). It is, therefore, important to note that the findings of the study are limited to persons who met the inclusion criteria.

Definition of Terms

Preterm birth. An accurate definition of *preterm birth* is necessary for comparing and interpreting studies that have assessed its etiologies. Earlier efforts in defining *preterm birth* relied solely on birth weight. The use of birth weight as a proxy for prematurity posed a problem because it only identified a group of infants homogeneous for one parameter of fetal development and overlooked other babies, such as those large for gestational age who were preterm but who may be classified as term

because of their weight. Birth weight is now known to be an inconclusive determinant for gestational age when assessing for prematurity (Institute of Medicine, 2007).

In the past, obstetricians and epidemiologists classified all births occurring between 20 and 37 weeks of gestation as preterm. These births were combined for statistical purposes and resulted in obscured findings, which led to uniform, experimental, and unsuccessful treatment strategies for babies born preterm. The number of acute complications and long-term health and neurological developmental consequences that have occurred as a result of preterm birth makes the need for accurate assessment of fetal maturity urgent. Gestational age alone is not a sufficient indicator of the level of maturity or immaturity of a newborn (Institute of Medicine, 2007).

Insight into the complex interplay of factors contributing to preterm birth, such as the duration of pregnancy, fetal size, and fetal maturity, is necessary to provide interventions that prevent or reduce the number of preterm births among African American women. Careful attention to a workable definition of *preterm birth*, distinguished from other varied definitions, is necessary to achieve an understanding of prior, ongoing, and current research on this phenomenon (Institute of Medicine, 2007).

For the purpose of this research, *full-term birth* is defined as the birth of a baby between 38 and 41 weeks gestation, and *preterm birth* is defined as the birth of a baby between 20 weeks and 37 completed weeks gestation (Institute of Medicine, 2007).

Centers for Disease Control and Prevention, (2007) adopted the following subgroups of preterm birth to further assist in understanding the breakdown of weeks gestation as it relates to preterm birth:

- *Ultra preterm*: Birth of a baby between 17 and 19 weeks gestation

- *Extremely preterm*: Birth of a baby between 20 and 28 weeks gestation
- *Very preterm*: Birth of a baby between 29 and 32 weeks gestation
- *Moderately preterm*: Birth of a baby between 33 and 37 weeks gestation.

African American. The term *African American* is not easily defined. It is used in research and literature synonymously with the terms *Black*, *Afro American*, and *Negro*. However, there is no consensus on which term is considered the most appropriate (Fairchild, 1985 ; Jewell, 1985; Lacayo, 1989). “The need to find an agreed upon definition is paramount,” according to Kennedy (2005, p. 92). However, determining a single term to define African Americans is quite complex; there does not appear to be one agreed upon term that can describe such a diverse group of people in American society.

Since 1977, the United States officially has categorized an African American person (revised to *Black* or simply *African American*) as a person with origins in any of the Black racial groups of Africa (Mustillo, et al., 2004). In this research study, the term *African American* is used to define the population of women who are, by self-report, American-born descendants of African slaves, as distinguished from more recent immigrants from Africa. This study is limited to only self-described African American women who are descendants of African women and who are American-born. The term *Black* is used synonymously with *African American* in this study, which is consistent with other researchers studying the phenomenon of preterm birth who use the term *Black* to refer to African Americans (Mustillo, et al., 2004; Schempf, et al., 2007; Schoendorf, et al., 1992).

Significance to Nursing

To provide outstanding nursing service, reflect professional caring, and promote culturally sensitive care, nurse researchers must identify disparities and gaps in the care provided to all people. Culturally appropriate health care can best be realized through a deeper understanding and generation of knowledge of the etiology of preterm birth in the African American population.

This research is expected to contribute insight into factors that might explain the high rate of preterm birth for African American women. A phenomenological research method was chosen to examine factors related to the lived experiences of these women. Spiegelberg (1975) noted that phenomenology, with its humanistic and indefinable qualities, is accepted as the research of choice in nursing because it helps to provide a better understanding of the lived experiences of people. This type of research has a powerful effect on policy change and, most importantly, humanistic practice because of the knowledge gained (Morse & Field, 1996). Moos (2004) stated that knowledge is power. Consequently, nurses are in a position of power, “through education of themselves, their patients and the public, through research and through support of the national campaign to prevent prematurity, to impact the knowledge necessary to overcome the threat of prematurity in the near future” (Moos, 2004, p. 37). This study will add to the knowledge of preterm birth in the African American population by seeking to describe the pregnancy experiences as lived by African American women who delivered preterm babies. Research that incorporates lived experiences can be a catalyst for identifying factors that increase the probability of preterm birth in this population (C. A. Blackmore, et al., 1993).

According to Rowley (2001), research that captures the experiences and ideas shared by African American women provides a unique angle of insight into their lives and the communities in which they live. Self-definition, self-evaluation, and self-identification through voice have been themes for the African American community since the 1890s. The voices of this community provide insight into the interrelatedness of their health, education, social opportunities, moral character, cultural values, and general social betterment (Hogue, Hoffman, & Hatch, 2001). Until recently, the literature did not contain basic descriptive information about the self-defined experiences of pregnancy among African American women and their families (Rowley, 2001).

Patricia Collins (2000) noted that by placing African American women, their voices, and their thoughts in the center of research, researchers are able to move beyond the traditional epidemiologic reductionist framework and take on a Black feminist approach. Black Feminist Thought provides African American women the opportunity to have a voice originating from their own personal experiences, rather than a voice from those who can provide only an opinion of the experiences (P.H. Collins, 1986).

Research focused on what originates from within is not interested in adjusting African American women to look like White women but is interested in capturing those experiences and ideas shared by African American women to provide distinctive insight into who they are. This type of research offers an interpretation by the study participants of their own lived experiences rather than an interpretation of that experience by the researchers (P.H. Collins, 1990). Research relying on the authoritative voices of African American women as a way to understand their lives and those conditions that imperil

health and well-being may shed light on causes of disparities in reproductive outcomes (Jackson & Phillips, 2003).

Nurses can use knowledge gained from the personal perspectives of African American women as context for interpreting future research seeking to narrow or close the disparity in the preterm birth rate between these women and White women. This knowledge is vital in achieving the health promotion and disease-prevention objectives for this population described in *Healthy People 2010 (U.S. Department Health and Human Services, 2001)* and the knowledge gained may contribute to decreasing the number of preterm births occurring in this population.

Aspects of Personal Biography of Researcher

When using a phenomenological methodology, it is important that the researcher set aside personal assumptions and avoid any judgment that might interfere with the participants' descriptions of an experience (Drew, 2001). This process of identifying and holding in abeyance any preconceived beliefs and an opinion about the phenomenon of study is referred to as *bracketing*.

To assist in bracketing, personal biases and assumptions that might influence the researcher when presenting the participants' lived experiences were set aside. As a first step in the process of bracketing, it was necessary to provide aspects of the researcher's life that may need to be held in abeyance to assist in remaining as unbiased as possible, such as previous experiences, knowledge, and opinions. Various aspects of the researcher's life were revealed to help the researcher become aware of possible prejudices, viewpoints, or assumptions, as noted in Chapter 3. The following personal experiences were reviewed and acknowledged: The researcher is an American-born

African American with firsthand experience of preterm birth, possesses clinical experience working with women who experienced preterm birth, and has a personal interest in the voices of African American women as contributors to knowledge regarding preterm birth.

Chapter 2: Review of the Literature

Introduction

This chapter first provides a literature review of previously published qualitative research on African American women's perspectives of pregnancy and, second, provides an overview of the phenomenological and Black Feminist Thought philosophical underpinnings for this study. This literature review of previous work from the woman's perspective was done to determine whether the research question had been previously addressed. A more extensive literature review was postponed until after data analysis of the current study, as is characteristic of qualitative research approaches in general and phenomenology in particular. This postponement helped the researcher avoid leading participants to what had already been discovered, allowing for a pure description of their experiences (Speziale & Carpenter, 2003; Streubert & Carpenter, 1995). The more extensive literature review is presented and discussed in relation to findings in Chapter 5.

Qualitative Studies Pertaining to Preterm Birth for African American Women

This preliminary literature review is based on an extensive search of the literature to determine whether there had been previous research of the lived pregnancy experience ending in a preterm birth from the perspective of African American women. Databases searched used included Academic Search Premier, CINAHL, MEDLINE, Pre-CINAHL, Dissertation Abstracts, Cochrane Database of Systematic Reviews, and Health Source: Nursing/Academic Edition. To narrow the search, key words and phrases used to search terms included the following: *pregnancy (racial or ethnic) and dispari**, *perinatal outcomes, preterm, premature and/or preterm birth* or deliver**, *maternity or pregnant, environ* (reduce* and elimin*)*, *lived experiences, phenomenology, minority, African*

American, and Black. The electronic search was limited to English language studies with abstracts or full text. Useful articles and abstracts were retrieved for future examination. Eligibility for review was based on whether the study used qualitative methodology related to preterm delivery experiences among African American women. Systematic review was based on whether the article was able to provide information on the topic. Selected articles were distributed into subcategories according to the main idea discussed in the article.

The preponderance of older research studies of preterm birth were quantitative, based on measures developed from the medical or provider perspective (Mann, et al., 1999). Research about preterm labor and birth experiences from an African American woman's perspective is noticeably absent from the literature. The aim of this study was to identify dimensions of the preterm pregnancy experience for further study. Phenomenologists hold the position that it is important to discover and understand how people experience life and to bring to light the meaning people assign to those lived experiences. Qualitative studies were examined at this stage to determine if any previous research explored this phenomenon from the individual's perspective.

The number of qualitative studies continues to increase as researchers look for factors which might explain the higher preterm birth rate for the African American population (Jackson, et al., 2001; Mullings, et al., 2001; Peacock, et al., 2001; Rowley, 2001; Savage, Anthony, Lee, Kappesser, & Rose, 2007). Still, no studies were found that examined the lived experience of the African American pregnancy that ends in preterm birth, and only a few studies addressed the personal lived experiences of pregnancy in African American women with concerns for preventing adverse birth outcomes. A few

studies examined the subjective perspective of pregnancy in African American women, though not preterm birth pregnancies (Green, 1990; Jackson & Phillips, 2003; Mann, et al., 1999; Mullings, et al., 2001; SmithBattle, 1995).

Studies on the Pregnancy Experience

Five studies examined viewpoints and perspectives of African American women regarding their pregnancy experiences (Green, 1990; Jackson & Phillips, 2003; Mann, et al., 1999; Mullings, et al., 2001; SmithBattle, 1995). Two studies were phenomenological, one study was ethnological, and two studies used a mixed methodology. All five studies provided insight into the personal experiences of the participants who described situations that involved some degree of stress during pregnancy.

Mann et al. (1999) used phenomenology to examine personal experiences and viewpoints of pregnancy for African American women. The study presented data provided by four African American midwives and other African American women for whom they provided prenatal care. Neither the midwives nor the participants were currently pregnant, and many of them were beyond childbearing age at the time of study.

The purpose of the study was to determine the personal viewpoints and perspectives of African American nurse-midwives about their own personal experiences of pregnancy and the viewpoints and perspectives of the pregnant women they served. The emphasis of this research was to provide context for the interpretation of research findings concerning racial and cultural differences about pregnancy. Three major themes were extracted from the interview narratives: (a) transition, (b) stress, and (c) support. The participants viewed pregnancy as a transition to maturity. This transition evoked by

pregnancy caused changes in their lives and created stress. Specific stressors included lack of material resources and lack of emotional resources. The participants found that family social support was needed to cope with the transition to maturity and the related stress caused by this transition (Mann, et al., 1999).

Green (1990) undertook an ethnological pilot study at a time when little literature on stressful events as reported by African American childbearing women existed. This pilot study used a convenience sample of 50 African American women and was based on a study by Arizmendi and Affonso (1987) that reported the frequency and intensity of stress during pregnancy and the post partum period for middle class White women. Green suspected that African American women would identify differential patterns of stressful events in childbearing compared to those identified by White women in the Arizmendi and Affonso study. In the study by Green, the subjective experiences of childbearing were verbally characterized as stress that was either intensely external or internal. External issues were the need for housing, monetary concerns, and changes in living patterns. Internal issues were concerns about the welfare of the baby, experiences in which the women were treated badly, and emotional stress such as loneliness and lack of social support.

Green's (1999) findings indicated that African American women experience stress in pregnancy related to lack of emotional support, particularly in relation to feelings of self-worth and self-esteem. For these women, stress from the lack of emotional support appeared to be embedded in a social context that implied inferiority by supplying experiences of disrespect and distracted health care providers. These findings were in contrast to those found by Arizmendi and Affonso (1987) in their study of White

women for whom the experience of pregnancy was characterized by internal stressors such as concerns about infant welfare, complications of pregnancy and the birth experience, and partner relationship.

Jackson and Phillips (2003) used grounded theory as a conceptual model and methodology to locate the stressors confronted by African American women that are embedded in their lived experiences and to develop a race- and gender-specific stress measure drawn from the lived experiences of African American women. This research was conducted to garner a better understanding of African American women's lives and the conditions that imperil reproductive health and well-being. At the core of the research was the perspective that African American women are authorities on their lives and, therefore, possess significant insights pertaining to those conditions imperiling their health (Jackson & Phillips, 2003).

The two-phase study included 545 college-educated African American women from all walks of life, with the purpose of uncovering the stressors that confronted them. The first phase included 444 women who participated in interviews, focus groups, semi-structured interviews, and the pilot testing of a race- and gender-specific stress measure. In the second phase of the study, subsequent to the development of the stress measure, 101 pregnant African American women participated in a replication of the process conducted during the first phase. Recruitment of these women was achieved through response to posters placed in medical offices and referrals by physicians. A snowball sampling process was employed in this phase of the study in which participants identified other prospective participants (Jackson & Phillips, 2003).

The information given to the study participants expanded their perception of the meaning of *stress* in their lives. This information included health disparity data that focused on the health disparities of African American women in particular. This information prompted dialogue among the women regarding their own experiences and offered a way to explain the poor health observed among African American women. The women identified factors such as diet, lack of exercise, family history, and lack of access and utilization of health care services as explanations for observed poor health. However, what resonated most with these women as factors most affecting their health and providing the best explanation for disparity in health outcomes were the burdens of having so many expectations and responsibilities imposed on them as women and as African Americans. Stress was specifically identified as a significant contributor to their own poor health and that of their relatives, friends, and colleagues (Jackson & Phillips, 2003).

Stress was entrenched in the multiple and overlapping contexts of these women's lives. These researchers found that the women's voices confirmed their assertion that the stress encountered by African American women was shaped by many things, such as race, gender, class, social conditions, culture, history, and region (Jackson & Phillips, 2003).

Jackson and Phillips (2003) reported a connection between the identities of African American women and stress in their lives that was revealed systematically by the voices of these women. These researchers reported that African American women have a long reputation of articulating their experiences associated with health and are also

viewed as resourceful collaborators in the quest for answers to concerns with reproductive health outcomes.

Findings of Jackson's and Phillips' (2003) study extended the conceptualization of *stress*, as it identified stressors in the lives of pregnant college-educated African American women through a community-based approach. This approach employed iterative procedures that combined qualitative methodology (focus groups and interviews) and quantitative methodology (development of a race- and gender-specific stress measure) to assist in the development of interventions for stress reduction. An opportunity to confirm and extend the conceptualization of stress and foster development of a community poised to address health concerns was realized as participants formed new associations among themselves with the intent to sustain approaches for stress intervention for eliminating health disparities among this population.

An interpretive phenomenological study by SmithBattle (1995) examined pregnancy-related personal experiences of 16 impoverished postpartum African American and non-Latina White adolescent women from a large metropolitan area on the West Coast of the United States. The study explored the experiences of young mothers from diverse backgrounds, capturing their understanding of their identities and development during their pregnancies.

The participants were recruited based on the following criteria: they were African American or non-Latina White mothers less than 19 years of age at the time when they delivered their babies. The sample population included nine White and seven African American teenagers. At the time of delivery, the teenagers' ages ranged from 14 to 18 years (SmithBattle, 1995).

The young women participated in three monthly home-based interviews. The first interview involved the participants describing their lives before the pregnancy, including their decisions, emotions, and considerations regarding the pregnancy, birth, and early months of mothering. In a subsequent interview, the Berkeley Stress and Coping Interview was used to obtain information about recent encounters that were stressful, pleasurable, rewarding, and difficult as a new parent. The third interview involved the family members. This interview sought information on family history, narratives of family care giving activities, and accounts of whether being a grandparent was pleasurable, rewarding, and/or difficult (SmithBattle, 1995).

This study was part of a larger study that investigated transitions of teenagers in the role of mothering as shaped by personal meanings, family caregiving practices, and defining communities, drawing from the views and practices of each participant. The participants' detailed stories of their lived experiences provided information about their lives before, during, and after their pregnancies. In one group, the young women viewed pregnancy as a means to experience belonging while maintaining social relationships. A second group reported being less vulnerable to the pressures from others to join in harmful activities. A third group, who contended with dangerous communities, oppressive relationships, or abject poverty that had existed prior to their pregnancies, experienced stressful moments, often ending in despair during their pregnancies (SmithBattle, 1995).

The findings of this study by SmithBattle (1995) suggested that despite the unplanned pregnancies and the adjustments, conflicts, stressors, shortcomings, and strengths related to the pregnancies, the young mothers did not share the social scientific

view that pregnancy and young motherhood jeopardized their lives or limited their futures. In fact, the majority of the participants expressed that the experience helped shaped their lives in a positive way. This emphasis of this study showed how the development and unfolding of a stressful life event such as a pregnancy helped form the lives of teenagers through participation in customs and practices of families and communities,.

Mullings et al. (2001) used a community participatory method, the Harlem Birth Right Project, to examine race- and gender-specific experiences in cultural and social environments that influenced health, health-seeking behavior, and perinatal outcomes. The Harlem Birth Right Project sought to involve the community in design, implementation, analysis of research, and improved understanding of the social forces involved in racial disparities in health. This study explored the lives of middle-income women to gain insight into possible risk factors that affect women across and within socioeconomic strata.

The researchers first observed prospective participants at 10 sites, including 3 neighborhood sites, 6 work sites, and 1 housing court. The three neighborhood sites were selected to reflect differing income and infant mortality rates. The first site was a low-income community with the second highest infant mortality rate in Harlem. The second site had higher income levels and a lower level of infant mortality. The third site was characterized by participants of moderate or average income, with the lowest rates of infant mortality (Mullings, et al., 2001).

At all 10 sites, ethnographers observed conditions, types of stressors, and coping mechanisms of African American women from occupational sectors. After 3 to 4 months

of observation at these sites, 26 women of African descent were recruited from the neighborhoods to participate in the longitudinal study. These women were a part of a 1-year study. Due to circumstances beyond their control, four of the non-pregnant women were not able to complete the study. The final sample was 22 women. Of these 22 women, 11 were pregnant. The women who were pregnant were followed throughout their pregnancies and for some part of the postpartum experience (Mullings, et al., 2001).

Near the end of the participant observation phase of the research, 11 focus groups were held in which some of the women in the longitudinal study group participated. Other focus group participants were recruited from area field sites. This mixture of participants enabled the ethnographers to cross-check validity of their field observations to provide insights into the participants' experiences (Mullings, et al., 2001).

Based on the results obtained from the participant observation and focus groups, the researchers developed an open-ended interview administered to 100 randomly selected women in Central Harlem. In addition to this interview, an ethnographic questionnaire was used to assist in understanding the impact of one's cultural beliefs and values on physical and biological factors. A total of 83 participants completed the questionnaire (Mullings, et al., 2001).

The Harlem Birth Right Project maximized validity by using a range of research operations and methodological strategies (e.g., participant observation, longitudinal case studies, focus groups, and questionnaires) to facilitate cross-checking of data, observations, and conclusions. Data were assessed with internal triangulation and by comparing accounts given by different study participants and the observations of the ethnographers (Mullings, et al., 2001).

Results of the study revealed that racial disparities in health involved complex interacting cultural and social forces that proved stressful. The findings suggested that to understand the greater vulnerability of African American women to poor pregnancy outcomes, consideration must be given to cultural beliefs, values, and social relationships. Stressors and chronic strain were factors linked to preterm delivery in African American women in Harlem. These researchers concluded that in addition to specified stressors and strain experienced during pregnancy, pregnancy itself may also serve as a catalyst to increase the magnitude of actual and perceived severity of stress. These researchers concluded that increased stressors in an already stressful life may cause African American women to fare worse in birth outcomes (Mullings, et al., 2001).

Studies on Lived Experience of Preterm Labor

Mackey and Boyle (2000) used a naturalistic phenomenological study to document how women described, interpreted, and managed their preterm labor experience from the onset of preterm labor until after their babies were born. This study is different from the current study because it only solicited the responses of women who were actively in preterm labor.

The study used a convenience sample of 14 young adult women (9 African American and 5 White), ages 20-23, drawn from a geographical area in the Southeastern United States where the population was primarily White and African American. Of the 14 women, 6 were expecting their first baby and were being treated for preterm labor in the hospital, 7 were expecting their second baby, and 1 was expecting her third baby.

This study provided insight into what women described as the cause of preterm labor. Unlike the “storybook” picture of pregnancy in American culture where the

mother-to-be is excited about her pregnancy and spends time during the pregnancy anticipating and preparing for motherhood, the participants in this study did not want to be pregnant but decided to carry the baby to term because they had no alternatives. The unwanted pregnancy was identified as a stressor. The participants of this study described this stress combined with other stressors as the cause of their preterm labor (Mackey & Boyle, 2000).

Each of the participants described the difficulty of managing the extra demands of pregnancy, preterm labor, hospitalization, multiple external stressors, and a chaotic lifestyle. Some participants described being able to manage the stressors in their lives before their pregnancy but noted how difficult it was to manage ongoing stressors while pregnant. Managing stressors and being pregnant were believed to be contributors to preterm labor. The participants described how trying to manage all of these life events sent their lives out of control. While the participants were once able to cope with the various stressors, the combination of stressful events, pregnancy, and bouts of mental illness and/or depression created more stress (Mackey & Boyle, 2000).

The descriptive model of preterm labor showed that stress in the lives of the women had two major derivations: (a) complex family situations and (b) problematic relationships with partners. These two factors together contributed to the stress that the women felt caused their preterm labor. The women in this study described stress as “overdoing it” and believed that premature labor was a sign that their bodies had had enough stress and were, therefore, unable to take any more (Mackey & Boyle, 2000).

This study by Mackey and Boyle (2000) indicated that when a woman had multiple demands on her life, without the skills to manage all she believed she should

manage, the demands only multiplied, regardless of how hard she tried or what she did. The end result of having multiple demands on the lives of the participants was failure to juggle or successfully manage them. Failure is not a culturally defined attribute for the African American woman. Culturally defined roles for African American women are a result of long-standing values, traditions, and family ties that are not easily broken.

This study revealed that both African American women and White women conceptualized stress as a causative factor in precipitating preterm labor. All 14 women experienced complex life situations early in their pregnancies which they described as causative factors related to preterm labor. Preterm labor was a “wake-up call” to the participants that they needed to reassess their lives and concentrate on ways to simplify their daily encounters and responsibilities in order to minimize stress (Mackey & Boyle, 2000).

The findings reported by Mackey and Boyle (2000) are believed to provide insight into the relationship between a stressful, chaotic life and preterm labor, as stress was a dominant theme that all participants believed precipitated preterm labor. The nine women who delivered at term found a friend or family member who provided social support and allowed the women to relax and reduce the stress in their lives. In contrast, the women who delivered preterm did not have anyone in their lives who could provide them with the kind of help and social support needed in order to reduce their stress levels. These researchers concluded that a woman who experiences chaos and stress during her pregnancy, without the assistance of culturally appropriate interventions that help reduce stress and mobilize support, may be at risk for preterm labor.

Philosophical Underpinnings

Phenomenology. Phenomenology was considered the most appropriate methodology for this study because of its efficacy in explicating the personal lived experience of an individual (Patton, 2002). This approach investigates human lived experiences as real and true everyday occurrences (G. E. Russell, 1999). The strength of phenomenology lies in the fact that each person's lived experience is specific, unique, and accurate as he or she describes and remembers them. This methodology captures the human experience through a scientific approach that discovers the meaning people make from their lived experiences.

Background on Husserlian phenomenology. The term *phenomenology* was first used in the early 1700s and is attributed to Immanuel Kant, a German philosopher regarded as one of the most influential thinkers of modern Europe. The phenomenological movement began during the first decade of the 20th century and consisted of three phases: (a) the preparatory phase associated with Brentano and Stumpf; (b) the German, or second, phase associated with Husserl and Heidegger; and (c) the French, or third phase associated with Marcel, Sartre, and Merleau-Ponty (Spiegelberg, 1960).

Phenomenology as a distinct philosophy first emerged in the works of Husserl (1913), who is credited with founding contemporary phenomenology, whereas Heidegger, Sartre, and Merleau-Ponty are credited for the appropriation, refinement, and sometimes rejection of some of Husserl's ideas. These philosophers ultimately adapted Husserl's original phenomenological theories according to their individual interpretations. Although Sartre and Merleau-Ponty offered important and useful

phenomenological perspectives, this overview is focused on the more structured phenomenological approaches of studying human experiences based on Husserl (1982).

The great attraction of phenomenology for Husserl (1913) was its representation as a new science of being. Husserl wanted to create a science that observed individuals in their natural context as opposed to the extreme idealist position (the mind creates the world) and the extreme empiricist position (reality exists apart from the passive mind). He instead created a path that grounded and confirmed the objectivity of human consciousness as it relates to the lifeworld (Kearney & Rainwater, 1996).

Husserl's (1913) phenomenology is considered transcendental because it adheres to what can be discovered through subjective and objective acts (Moustakas, 1994), emphasizing subjectivity and discovery of the essence of an experience. According to Husserl, transcendental phenomenology was a new way of looking at things, a return to things as they actually appear, or a return to the essence of an experience. Moustakas (1994) defined *transcendental* as a condition in which "everything is perceived freshly, as if for the first time" (p. 34).

Transcendental phenomenology seeks to discover the objective essences of a phenomenon from the viewpoint of a detached observer, which contrasts with the existential tradition of phenomenology influenced by Heidegger that regards the observer and the world as inseparable (J. W. Collins, et al., 2000). Transcendental phenomenology emphasizes that the only thing we can be certain about is that which appears before us in our consciousness, which guarantees its objectivity (Husserl, 1913; Moustakas, 1994).

The Husserlian phenomenological research approach was chosen for this study because it facilitated an accurate description of the lived experience of the African

American pregnancy that ends in preterm birth. Participants' descriptions of their lived experiences resulted in the most pure and essential description as they attempted to get to the truth of the matter and to describe the phenomenon as it manifested itself in their consciousness as the people experiencing it.

To understand this methodology, it is important to first review some key concepts used in phenomenological research, data collection, and analysis. The definitions are organized alphabetically as follows: (a) bracketing, (b) essence, (c) horizontalization, (d) imaginative variation, (e) intentionality, (f) intersubjectivity, (g) intuition, (h) lifeworld, and (i) reduction.

Key phenomenological concepts.

Bracketing and epoche. *Bracketing*, in phenomenological inquiries, is the process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomena being studied. "Although bracketing can never be achieved totally, researchers bracket out the world and any suppositions, to the extent possible, so as to confront the data in pure form" (Polit & Beck, 2004 p. 253).

Bracketing is indispensable as a means to achieving a comprehensive understanding of an individual's viewpoint (Husserl, 1913). The investigator must temporarily set aside personal assumptions about the existence of the world. Through the use of bracketing, the researcher must detach and/or remove himself of all preconceived notions regarding the essence of the participants' language and behavior during the interviews (Bailey, 1997; Koch, 1995; Munhall, 1994; Sadala & Adorno, 2002).

Literature has treated the concepts *bracketing* and *epoche*, a Greek word that means "to abstain from judgment or stay away from the everyday, ordinary way of

perceiving the things we see,” as interchangeable or synonymous (Gearing, 2004). Some researchers believe that there is a philosophical difference, a variation of function and purpose between the two terms (Ahern, 1999; Denzin & Lincoln, 1994; Patton, 2002). Patton (1990) described epoche separately from bracketing, indicating that epoche was “an ongoing analytic process” (p. 408) that is integrated into sequential progress throughout the entire research, from the beginning of the study to the end. Bracketing, on the other hand, occurs at the interpretive moments prior to data collection when the researcher holds the identified phenomena up for inspection. Both are critical in preparing the researcher to avoid judgmental interviews and in providing an authentic perspective of the data (Moustakas, 1994; Polkinghorne, 1994).

In the natural attitude, knowledge is held judgmentally, and people presuppose that what they perceive in nature is actually there and that it remains there as they perceived it. In contrast, epoche requires a fresh look at things, requiring people to see what stands before their eyes, what they can distinguish and describe (Moustakas, 1994). In epoche, researchers set aside everyday understandings, knowings, and judgments so that “phenomena are revisited, freshly, naively, in a wide sense, from the vantage point of a pure or transcendental ego” (Moustakas, 1994 p. 33). In order for this to take place, the researcher must change the way he or she thinks, holding in abeyance the things that have been placed in the mind through avenues such as morals, values, and prejudgments obtained from the environment or other people and, instead, capture simply what is present, viewing it in an entirely new way.

Essence. *Essence*, according to Husserl (1913, 1982), is the core condition or equality of something. Without the essence, the thing would no longer be what it is

(McClelland, 2005). Essences are the core meanings mutually understood through a phenomenon commonly experienced. The experiences of different people are bracketed, analyzed, and compared to identify the essences of a particular phenomenon commonly experienced.

The assumption of essence becomes the defining characteristic of a phenomenological study (Patton, 2002). Phenomenology should return to the things themselves, to the essences that constituted the consciousness and perception of the human world, the very nature of a phenomenon that makes something what it is (Husserl, 1913). Knowledge of essences can only be possible by “bracketing” all assumptions about the existence of an external world and the subjective aspects of how the object is concretely given (Husserl, 1982).

Horizontalization. *Horizontalization* is a step in the phenomenological data analysis process in which the researcher lists every statement or horizon relating to the topic and gives them equal value, treating each statement as having worth, as the researcher works to develop a list of non-repetitive, non-overlapping statements (Creswell, 2003; Moustakas, 1994).

Imaginative variation. *Imaginative variation* (also known as *structural description*) is an important concept involved in phenomenological data analysis and is used by the researcher to interpret the textual description of the data, explaining how participants experienced the phenomenon. It requires that the researcher recognize the countless possibilities that emerge from the data that are intimately connected with the essences and meanings of an experience (Moustakas, 1994). The aim of imaginative variation is to grasp the structural essences of experiences (Moustakas, 1994). Through

imaginative variation, the researcher develops enhanced or expanded versions of the invariant themes (Patton, 2002). The full perspectives of the invariant themes are combined together to reveal the true experience.

Application of imaginative variation, according to Moustakas (1994), involves a number of steps: (a) systematically varying the possible structural meanings that underlie the textual meanings; (b) recognizing the underlying themes or contexts that account for the emergence of the phenomenon; (c) considering the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as the structure of time, space, bodily concerns, materiality, causality, relation to self, or relation to others; and (d) searching for exemplifications that vividly illustrate the invariant structural themes and facilitate the development of a structural description of the phenomenon.

Intentionality. *Intentionality* refers to consciousness, to the internal experience of being conscious of something. The act of consciousness and the object of consciousness are intentionally related (Moustakas, 1994). Husserl (1913) believed that the mind is directed toward objects; this directedness is called *intentionality* and is based on the assumption that our own conscious awareness is one thing of which we can be certain. The building of our knowledge of reality starts with our conscious awareness (Koch, 1995). “For phenomenology, consciousness is intentional which means that acts of consciousness are always directed to objects that transcend the acts in which they appear” (Giorgi, 1988, p. 170).

The intentionality of one’s consciousness in essence is understood as the direction of consciousness toward understanding the world. Intentionality describes the basic

structure of consciousness and indicates the inseparable connectedness of the human being to the world (van Manen, 1990). “Through the intentionality of consciousness, all actions, gestures, habits and human actions have meaning” (Sadala & Adorno, 2002, p. 283). Consciousness through intentionality is understood as the agent that grants meaning to objects. Without these meanings, a discussion about the object or object’s essence becomes impossible. The task for the researcher, according to Sadala and Adorno (2002), is to analyze the intentional experiences of consciousness to identify how a phenomenon is given meaning, arriving at its essence. Husserl (1982), stressed the importance of intentionality and explained how the researcher’s role is to study the operations of the intentionality of consciousness by bracketing his or her beliefs and prior knowledge of the phenomenon being researched and by refraining from positing the assumption of the existence of the natural world around him or her (Mastain, 2006).

Intersubjectivity. *Intersubjectivity*, one of the main themes of transcendental phenomenology, is the verbal and nonverbal interplay between the organized subjective worlds of two people where one person’s subjectivity intersects another person’s subjectivity. The subjective world “represents the organization of feelings, thoughts, ideas, principles, theories, illusions, distortions, and whatever else helps or hinders that person” (Munhall, 2007, p. 173).

Husserl (1913) instructed us to see the world not only from our perspective but also from the intersubjective view of others. From a first person point of view, *intersubjectivity* is realized when we experience empathy. An intersubjective experience is an empathetic experience that occurs in our conscious, intentional acts toward other people as we envision things as if we were in their shoes (Smith, 2005). One of Husserl’s

beliefs is that a being who looks and behaves like another person will generally perceive things from a similar viewpoint (Mastain, 2006). This type of belief forms the intentional background by which researchers can examine the experiences being studied.

Intuition. *Intuition* is a key concept of transcendental phenomenology. In phenomenology, intuition means being present. This presence to the object of consciousness means being present to the object whether it is real or an idea, as it presents itself and not as it really is. It is the beginning place for deriving knowledge of human experience, free of everyday sense impressions and the natural attitude (Moustakas, 1994). Descartes (1977) held intuition to be an inborn talent directed toward “producing solid and true judgments concerning everything that presents itself” (p. 22). For Husserl and Descartes, knowledge which is based on intuition and essence precedes empirical knowledge (Moustakas, 1994).

According to Moustakas (1994), all things become clear and evident through the intuitive-reflexive process. When one is able to abstain from the natural attitude or the everyday knowing about a thing and to consider something in its nakedness as it really is, the essence of that thing can be understood. *Intuiting* in the phenomenological sense requires that researchers imaginatively vary the data until a common understanding about the phenomenon emerges. Intuiting takes place when the researcher remains open to the meaning attributed to the phenomenon by those who experienced it. Intuiting requires the researcher to become totally immersed in the phenomenon under investigation and is the step in the process where the researcher begins to know about the phenomenon as described by the participants (Speziale & Carpenter, 2003).

Lifeworld. *Lifeworld* is defined as the natural world. It is a world that is pre-given and is prior to the objectivity of the world (Husserl, 1970). It is a place of interaction between a person and his or her perceptual environment as directly lived and not reflected upon (Von Eckartsberg, 1986). *Lifeworld* can also be understood as the world as each person immediately experiences it. It is a world filled with meaning, made up of assumptions, beliefs, and meanings against which an individual judges and interprets everyday life experiences. *Lifeworld* is all the total sum of a person: who they are and all that they do. It is the sense that people have of themselves, although the way each person experiences life is unique. *Lifeworld* places the person at the center of the research process. With lifeworld, the focus is on the participant's agenda and not the researcher's (Kvale, 1996).

Transcendental-phenomenological reduction. *Transcendental-phenomenological reduction* is a process that is essential for knowledge derivation (Moustakas, 1994). This process is called reduction "because it leads us back to the source of the meaning and existence of the experienced world" (Schmitt, 1967, p. 61).

Phenomenological reduction involves bracketing one's past knowledge about a phenomenon and setting aside assumptions so as to encounter it freshly and describe it precisely as it is experienced (Giorgi, 1997). These taken-for-granted assumptions about reality and the world are referred to as the *natural attitude*. Through reduction, the researcher moves from a natural attitude to a transcendental attitude (Husserl, 1913), seeking openness and curiosity and ensuring that the most pure, precise, and reliable textural description of the meanings and essences of a phenomenon are obtained (Moustakas, 1994).

These key phenomenological concepts were applied to the current study through an adaptation of Husserlian phenomenological methodology and Colaizzi's (1978) method for data analysis, which are presented in Chapter 3.

African American Feminist Epistemology: Black Feminist Thought

P. H. Collins (2000) posited that an Afro-centric feminist epistemology enriches our understanding of the way in which subordinate groups create knowledge from their shared experiences, ultimately enabling them to have a voice in an environment that has silenced and denigrated them for generations. The fact that there are common experiences among groups suggests that certain characteristic themes are prominent from a Black woman's perspective.

Collins (2000) noted that the Black woman's perspective, viewpoint, or standpoint is an explicit epistemology known as Black Feminist Thought. This standpoint becomes necessary to use because Black women do not identify with the majority group and tend to have their own interpretations of their experiences, especially with oppression. Black women also have different life experiences and views of reality than White women (Williams, Brewley, Reed, White, & Davis-Haley, 2005).

Black Feminist Thought substantiates the fact that independent specialized knowledge can be produced by African American women, as it invites African American women to respect their own subjective knowledge base (P.H. Collins, 1993, 1995). It is important to view the occurrences of African American women's daily lives as an essential ingredient to understanding their perceived and lived experiences in a society where race, class, and gender determine and rationalize opportunity and status (J. W. Collins, et al., 2000). It becomes necessary to engage in theoretical interpretations of

Black women's reality by the women who live it. Therefore, research that incorporates the voices of African American women as they describe their lives is necessary to provide adequate care and appropriate research (P.H. Collins, 2000).

Black Feminist Thought influenced this researcher's decision to explore the lived experience of the African American pregnancy that ends in preterm birth. Understanding that their experiences are different from those of other women is crucial to authenticating their stories. Collins (2000) stated that Black Feminist Thought demonstrates the importance of Black women's emerging power as agents of knowledge. By sharing their experiences, Black women create new knowledge, which plays an integral role in research about them.

Three Key Themes of Black Feminist Thought. Three key themes in Black Feminist Thought help provide guidelines for the way in which Black women's voices can be used to explain their lived experiences:

Theme 1. The influence of Black Feminist Thought supports the fact that experience shaped and produced by African American women regarding the encounters in their lives is what they consider their reality, even though other people who have documented their lives may offer a different explanation of this reality. The reality, according to Collins (2000), is that African American women's identities have been shaped by many people in ways that are often erroneous and stereotypical and are designed to subdue assertive Black female behavior. The ways in which their identities have been shaped by others are flawed and stereotypical, (Torres, Howard-Hamilton, & Cooper, 2003) so that assertive behavior can be controlled (Institute of Medicine, 2007, p. 469).

Theme 2. There are intersections of experiences between African American women, although each of their stories and experiences is unique. This theme focuses on the multiple identities of race, gender, and class that are interlocking components of most African American women's identities (P.H. Collins, 2000). It is African American women's position at the intersection of oppressive forces from race and gender (or race, class, and gender) that situates them uniquely as creators of knowledge and voices of dissent in American culture (Ryan, 2004).

Theme 3. The diversity of African American women's religion, age, class, and sexual orientation as a group is composed of multiple contexts from which their individual experiences can be revealed and understood. Because their lives have been shaped by many outside influences, this theme encourages the development, redefinition, and explanation of their own stories based on the importance of their culture. African American women's stories emerge through song, dance, literature, research, and other media that help them share their experiences from their own points of view.

These themes may not initially be obvious to African American women; therefore, the role of Black Feminist Thought is to produce facts and theories about African American women's experiences, clarifying their standpoint (P.H. Collins, 1986). Collins' (2000) asserted that Black Feminist Thought encourages new techniques to study African American women. She emphasized that research findings related to White women cannot be generalized to Black women, as is the dominant practice within research, nor can research findings related to Black women be generalized to White women. "Black Feminist Thought specializes in formulating and re-articulating the

distinctive, self-defined standpoint of African American women” (P.H. Collins, 1986, p. 750).

Black Feminist Thought provides African American women the opportunity to have a voice that originates from within rather than one heard from the outside (P.H. Collins, 2000). Black Feminist Thought supports the methodology used in this study because it encourages articulation of knowledge and experience from the African American woman’s view, allowing her to create new definitions validating her standpoint and shared ideas (P.H. Collins, 1986). Black Feminist Thought espouses that African American women can produce independent, specialized knowledge. African American feminist epistemology as proposed by Collins (2000) is necessary for understanding the lived experiences of the participants of this research.

Summary

In summary, studies of the lived experience of pregnancy and preterm labor provided insight into the etiologies surrounding preterm birth. These studies suggest a strong relationship between stress and preterm birth. Additionally, African American women conceptualize stress as a causative factor in preterm labor. Although the literature supports the fact that various stressors have been associated with preterm labor, the qualitative studies reviewed offer the participants’ conceptualization of what happened to them during pregnancy and what they believe caused preterm labor.

In these studies, many variables appeared to contribute to preterm labor in the African American population. Stress was a consistent variable throughout each study. Therefore, it would be useful to examine what might be different about experiencing

stressors, perceiving stressors, or managing stressors in the African American woman's situation that may contribute to preterm birth.

This research was designed to provide a better understanding of the factors involved in the lived pregnancy and labor experiences of these women. This understanding provides direction for research needed to examine the relationships, causal factors, and disparities that exist for African American women who experience preterm birth. The philosophical perspective of Black Feminist Thought is consistent with the uncovering of the essence of the meanings of the Black woman's experiences as they occur (Williamson, et al., 2008).

Whereas the bulk of knowledge regarding causes of preterm births for African American women focuses on stress and infection, probing the lived experiences of these women is important for examining other factors that may contribute to preterm birth in this population. A better understanding of the lived experiences may provide additional insight into the phenomenon of preterm birth and possible explanations for the persistently disproportionate rates of African American preterm birth across socioeconomic categories, a statistic which has vexed many researchers (J. W. Collins, David, Simon, & Prachand, 2007; Green, et al., 2005; Hogan & Ferre, 2001; Hogue & Yip, 1989; Holzman & Paneth, 1998; Institute of Medicine, 2007; Kistka, et al., 2007; Rowley, et al., 1993; Webb, 2004).

To date, research into the lived experience of the African American pregnancy that ends in preterm birth is lacking. The six studies reviewed here provided various viewpoints and perspectives of African American women related to their pregnancy experience in general (Green, 1990; Jackson & Phillips, 2003; Mackey & Boyle, 2000;

Mann, et al., 1999; Mullings, et al., 2001; SmithBattle, 1995). The perspectives of African American women regarding their pregnancy experiences and ultimate delivery of a preterm baby simultaneously provided a glimpse of the unique complexities for this population and background and rationale for this study.

Chapter 3: Methods

Introduction

This chapter provides a description of the key components of the research study: the (a) study design, (b) setting, (c) sample, (d) recruitment of subjects, (e) procedure for protection of human subjects, (f) instrument, (g) procedure for data collection, (h) procedure for data analysis, (i) establishment of rigor and trustworthiness, and (j) summary.

Study Design

A phenomenological approach was used for this study. Data were collected by interviewing African American women about their experiences of pregnancy that ended in preterm birth.

Setting

This study took place in the rural counties of the eastern panhandle of West Virginia, a narrow stretch of territory in the northeast bordering Maryland to the north and Virginia to the south. Participants included residents in Jefferson, Morgan, and Berkeley counties. According to the 2008 U.S. Census report, Jefferson County had a population of 51,615; Morgan County, 16,325; and Berkeley County, the second most populous county in West Virginia, 102,044. Berkeley County includes the largest city in the eastern panhandle, Martinsburg (population, 17,020), where the participants were interviewed in a local obstetrician's office (United States Census Bureau, 2008).

The participants were interviewed in the conference room of a local obstetrician's office in Martinsburg, West Virginia. This setting was chosen because it provided a place of familiarity, confidentiality, and comfort. Conducting the interviews in this setting was

intended to create a non-threatening environment. The conference room in this office had comfortable, plush, upholstered chairs; a matching veneer-finished conference table; pictures of serene scenes; padded Berber carpeting; private access to the conference room; insulated soundproof walls to provide for confidentiality; and a surround sound system for relaxing music or white noise. Relaxing music was played throughout each interview. Research has shown that a comfortable setting allows for the best expression of rich data as participants are more likely to provide information in this type of environment (Speziale & Carpenter, 2003).

Sample

In a phenomenological study, it is important to select participants in a purposive manner so that a richer understanding of the research under investigation is developed (Creswell, 1998; Miles & Huberman, 1994; Seidman, 1998). Purposive sampling in this study was necessary to ensure that all participants from a range of backgrounds met the specific criteria outlined for study participation.

The strategy for purposive sampling is to capture and describe the central themes that cut across variation (Patton, 2002). Therefore, a maximum variation sampling strategy was desirable because “any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon” (Patton, 2002, p. 235). The strategy for purposive sampling for this research study as noted in the inclusion criteria outlined for the study was as follows: (a) self-identified as Black or African American, (b) 18-42 years of age, (c) able to comprehend and communicate in English, (d) living in one of the counties of the eastern panhandle of West Virginia, and (e) reporting a history of a

preterm birth, regardless of whether the newborn lived, died, or was stillborn, that occurred within the past 2 months to 3 years. Detailed information about the sample population was extracted from the Demographic Data and Personal Questionnaire (see Appendix A).

The strategy underlying purposeful maximum variation sampling was to provide as much participant variation as possible so as to capture the central themes that cut across a great deal of participant variation. In selecting potential participants from the obstetrician’s records, an attempt was made to choose a diverse population with respect to age; weeks’ gestation, educational level, parity, marital status, and level of education (see Table 1). Participants’ varied occupational backgrounds (homemakers, employee of a government agency, administrative assistants, non-managerial employee, and cashier) further enhanced diversity in the population.

Table 1

Demographic Data and Personal Information

AGE	MARITAL STATUS	EDUC	GRAVIDITY (NUMBER OF PREGNANCIES)	NUMBER OF PRETERM BIRTHS	WEEKS’ GESTATION PRETERM BIRTH	YEAR MOST RECENT PTB
28	P	GED +	1	1	21	2008
21	S	12 YRS	1	1	37	2007
42	P	12 YRS	2	2	36	2007
37	M	16 YRS+	1	1	35	2006
34	S	HS + 2 YRS	2	1	31	2007
24	P	12 YRS	2	2	36	2006
38	M	16 YRS	7	3	36	2006

CODES: Marital Status: P = Partner; M = Married; S = Single

Saturation and Sample Size

In qualitative research, the researcher collects data until new themes no longer emerge, at which point adequacy of data, or saturation, is believed to have been met. Unlike quantitative researchers who must wait until the end of the study to analyze the data, qualitative researchers have the advantage of analyzing data throughout the research study. This technique helped to identify when saturation had occurred and when the sample size was sufficient. An appropriate sample size for a qualitative study is one that adequately answers the research question. It is the richness of the data collected from each participant that is most important, not the actual sample size.

In qualitative research, adequacy refers to the amount of data collected, rather than to the number of subjects, as in quantitative research. Adequacy is attained when sufficient data have been collected that saturation occurs and variation is both accounted for and understood. (Denzin & Lincoln, 1994, p. 230).

A suitable sample range and recommended target sample size for phenomenological research can vary from 6 to 12 persons, as long as the sample size produces meaningful findings. Denzin and Lincoln (1994) indicated that as few as six participants is an acceptable number for this type of research, emphasizing that the number should be determined by actual saturation.

In the current study, the final sample population was seven women who met inclusion criteria, were available, and agreed to participate in the study. After two interviews with six participants, their data from the audiotapes were transcribed and entered in NVivo software. The researcher recognized the repetition of salient points and determined that the addition of any new participants would only confirm the findings, rather than add new information. Saturation was determined after data from the six interviews revealed similar and repeated information. According to Speziale and

Carpenter (2003), when the data become repetitive in nature, the researcher can assert that saturation has been achieved.

To be certain that saturation had been adequately met, one more participant was interviewed. No new information was revealed in that interview; therefore, it was presumed that an adequate sample size had been achieved. The seven participants represented a diverse population, fulfilling the requirements for purposive sampling for this study. The two remaining participants who had consented to participate in the study were contacted and thanked for their willingness to participate. They were then informed that an adequate sample population had been reached and that they would not be needed for this study.

Recruitment Procedure

Recruitment of the subjects took place after first obtaining approval from the Institutional Review Board (IRB; see Appendix B) and through the assistance and referral of a local obstetrician who agreed to supply the names of patients who fit the inclusion criteria. Fifteen women from the data source of the obstetrician's office fit the criteria.

Initial contact with the potential participants was made by the office manager of the local obstetrician's office. The purpose of initial contact was to determine if the women were willing to speak to the researcher about the study. Of the 15 women who fit the criteria, only 9 were reached by telephone. The nine who were reached by telephone were diverse in all aspects of the inclusion criteria. No successful attempt was ever achieved to reach the other six women.

During the initial phone call, the assistant to the office manager informed the women of the purpose of the study and received their verbal consent to receive a follow-

up call from the researcher. During the follow-up phone call, the researcher reviewed the purpose of the study and explained how the interview process would work, including agreed upon interview dates, times, and places and the involvement and commitment required for participating. After receiving verbal confirmation from each woman on her interest in participating, two interviews were scheduled.

The prospective participants were also informed that due to work schedule inconveniences, rising cost of gas, and possible need for childcare, a monetary appreciation of \$100 was being offered to them to assist with these needs. This compensation would be given to each participant at the end of the second interview. Although some people argue that offering money may unduly influence people to participate in studies, obscure risks, or impair judgment, offering money to research participants in an effort to enhance recruitment by providing compensation is a common, longstanding practice in the United States (Lederer, 1995). In addition, participants are safeguarded from unwanted influence from compensation through the evaluation of the IRB, ensuring the amount and schedule of proposed payment are ethically acceptable (U.S. Department Health and Human Services, 2001).

Procedures for Protection of Human Subjects

Permission to conduct this research study was obtained through the IRB of Duquesne University in Pittsburgh, Pennsylvania (see Appendix B). This study met the criteria for expedited review for the following reasons: (a) it involved the collection of data from audio recordings, and (b) it involved research on individual characteristics when considering the subject's own behavior, which included perception, cognition, identity, language, communication, socio-cultural beliefs, practices, and/or behavior, and

research employing interviews, and oral history for purposes of research. This study did not require full board review for the following reasons: (a) it did not involve a vulnerable population (the participants were at least 18 years of age), (b) it did not involve invasive and manipulative procedures, (c) it did not place individuals in a vulnerable position, (d) it did not involve pregnant women, and (e) it did not involve mentally impaired subjects.

To protect human subjects, a consent form in English was provided for each participant prior to her involvement. This written consent outlined the details related to the research and the participants' involvement (see Appendix C). Each participant received a copy of the signed consent. In addition, full disclosure of the study was presented. Permission to tape record the interviews and jot down notes was sought prior to the interview process. The purpose and usage of notes during the interview and tape recordings were explained thoroughly.

Confidentiality and HIPAA rights were protected and assured, as all information was kept confidential, under lock and key in a file drawer in the researcher's office. Consent forms and collected data were kept in separate locked drawers to avoid identifying information. To maintain confidentiality, each participant was assigned a number on the Demographic Questionnaire and a corresponding number on the transcribed interview documents.

The material will be kept under lock and key for a period of 3 years after the date of publication, after which it will be shredded. The only person with access to the files was the researcher. The transcriptionist, the office manager, and the assistant to the office manager signed a Confidentiality Statement (see Appendix D) agreeing not to discuss or reveal any information to anyone outside of the research team.

Anonymity was guaranteed through the use of assigned pseudonyms. All identifiable information that might possibly link the participants to the transcribed interviews was removed (e.g., specific job or place of employment, children's or spouses' names, nicknames, etc.) from the transcribed audiotaped interviews.

Each participant was informed that her participation in the research study was voluntary. All participants were informed that they could withdraw at any time without penalty. This information was included on the Informed Consent (see Appendix C) which each participant signed.

Recall of the participants' pregnancies could create emotional upset. Therefore, signs of sensitivity to the subject matter suggested by body language were noted. Attention was given to such signs as wringing of the hands, shaking of the feet, and blinking of the eyes. Each participant was informed of her right to stop the tape recording at any time during the interview process. If needed, a referral arrangement was established with a counselor at the Brook Lane Center in Hagerstown, Maryland; a support group; and other community resources that provide emotional support. No participants expressed the need for counseling services immediately after the interviews. For those participants who did not show any emotional upset at the recall of their pregnancy that ended in preterm labor and birth, a telephone number was provided in the event that unpleasant thoughts or emotions surfaced days after the interview.

Instruments

Two instruments were used for data collection in this research study: a 21-question researcher-designed demographic questionnaire (Appendix A) and a seven-question interview guide (Appendix E). The questions on the interview guide were designed to elicit an in-depth discussion about the experience of pregnancy leading up to preterm birth. The questions in the interview guide were supplemented by probing comments, such as “Tell me more,” and “Please share an example,” to help facilitate a richer discussion.

Procedure for Data Collection

Before collecting data, the researcher exposed her thoughts, ideas, personal biases, suppositions, and presuppositions about factors related to preterm birth. The purpose of doing this exercise was to bring to consciousness and reveal what she believed about the phenomenon. Taking time to do this exercise better positioned the researcher to approach the phenomenon honestly and openly (Speziale & Carpenter, 2003). Exposing personal beliefs assisted the researcher in becoming more aware of potential judgments that could occur during data collection and analysis based on personal belief systems instead of the authentic data collected from the participants. The technique used to expose thoughts, feelings, and biases is bracketing, the conscientious process of setting aside personal beliefs, not making judgments about what one hears or sees, and "remaining open to data as they are revealed" (Speziale & Carpenter, 2003, p. 22). It is essential to engage in bracketing if the researcher is to share the views of the participants. Bracketing allowed the data to be encountered freshly, in order to describe it exactly as it was experienced (Giorgi, 1997).

Researcher as research instrument. In qualitative inquiry, the instrument is the researcher. The credibility of qualitative methodology hinges on the skill level, competence, and rigor of the person who does the field work. No credible research strategy advocates biased distortion of data to serve the researcher's vested interests and prejudices" (Patton, 2002 , p. 51).

As the research instrument, maintaining a stance of neutrality with regard to the phenomenon was challenging. Nevertheless, the researcher adopted a neutral stance to provide the unfolding world of the participants, without adding or subtracting from the data as they emerged (Patton, 2002). As the research instrument, the researcher engaged the participants in the subject matter through the use of open-ended questions that addressed the uniqueness of each lived experience. The use of bracketing assisted in the stance of neutrality.

Ahern recommended 10 tips to employ during data collection in what he termed *reflexive bracketing*, which allows true experiences of participants to be reflected in the analysis and reporting of research. Table 2 provides a brief description of how the researcher applied each of these 10 bracketing tips during the study.

Table 2

Application of Ahern's Ten Tips for Reflexive Bracketing

Ahrens' Ten Tips	Researcher's Bracketed Beliefs
1. Identify "taken for granted" issues	<p>Issues identified included position as a labor and delivery nurse, didactic instructor for maternity and newborn nursing care, certified childbirth educator (CCE), experience with a preterm birth, and status as an African American female. As a first step in phenomenological methodology, I revisited my role in each of the areas. As the primary research instrument, I also engaged in a thorough and systematic process of sorting through my own experiences with the phenomenon. This enabled me to set aside prejudgments. I had to bracket out my own interactions, experiences, and previous beliefs about African American women, etiology of preterm birth, and knowledge regarding both so that I could, as much as possible, be free of any preconceived ideas that could skew observable phenomena. By identifying my experiences as a labor and delivery nurse, didactic instructor for maternity and newborn nursing care, and CCE and the fact that I had a preterm birth and am an African American woman, I was able to set aside predetermined thought patterns and related ideas. Bracketing my thought patterns and related ideas allowed the collection of data to be authentic, systematic, and disciplined, allowing for the emergence of the essence of the lived experiences of each of the participants.</p>
2. Clarify personal value system	<p>Personal value system included awareness of belief that certain personal factors predispose African American women to poor birth outcomes. Reviewing my experience as an African American woman who grew up in a family with lots of aunts and older female cousins brought to remembrance many comments, opinions, and personal experiences these women shared regarding their beliefs about pregnancy, motherhood, high risk pregnancy, and those who appeared prone to having problem pregnancies. This reflection allowed me the opportunity to list those comments and beliefs so that I would recognize them as predispositions of the lived experiences of African American women that could cloud my judgment of any</p>

information the participants might share. In order to hear the participants as if I had heard this information for the very first time, as Moustakas (1994) instructed, I had to recognize that my experiences as an African American woman and as an African American woman who had a preterm birth led me to certain beliefs that I had to consciously set aside in order to collect and analyze the data.

3. Identify any role conflicts as researcher

Potential areas of conflict included difficulty in refraining from forming an opinion of why some of the participants did not respond sooner to symptoms of possible preterm labor or why they did not take the warning and/or advice given them by their physician. To refrain from forming an opinion, bracketing included keeping an open mind during the reading of the transcribed interviews to detach preconceptions about the lived experiences of these women from the feelings that arose during the interview.

4. Identify gatekeeper's interest and influence

The gatekeepers were two obstetrical nurses and the obstetrician who helped recruit the study participants. The nurses were positively influenced by the research and had a vested interest in the research and its contribution to reducing the number of preterm births. An expert in the field of obstetrics, perinatology, and the local chair of the March of Dimes, the interest and involvement by the obstetrician was invaluable. He made every effort to ensure enrollment of an adequate number of participants for the study, provided the place to conduct the interviews, and provided adequate time allotted to obtain the information.

5. Be aware of feelings

During the interviews, there were times when it was difficult to refrain from expressing feelings and actions of compassion when listening to the difficulties described by the participants. While listening to the participants tell their stories, I visualized each of their experiences and bracketed emotions that arose based on my own experience of preterm birth. By reading my journal notes to determine the origin of my own feelings of sadness for these losses, I was able to separate my reactions from these past events and the present research.

6. Question whether anything is new or surprising in data collection or analysis	An unexpected finding was that the participants expressed that their main purpose for participating in the research study was to tell their stories with the hope that other African American women would be helped and would not have to go through what they had been through.
7. Reframe any blocks that may occur	No blocks were experienced during data collection or analysis. Prior to each interview, I mentally reviewed and revisited my own experiences and biases that I had set aside to assist me from intentionally or unintentionally blocking out the participants' free description of their experiences. During data analysis, I acknowledged the themes, recognized their meaning to me, and disregarded it related to the data analysis in order to reframe from blocking, allowing the essence of the participants' experiences to emerge.
8. Objective presentation of the findings	Quotes from all participants were used to write up the analysis. The analysis is written in the first person. Using the actual statements from the participants and writing up the findings in the first person helped to avoid subjective interpretation of the findings.
9. Provide supporting literature review	Supporting literature was provided that addressed lived experiences of African American women who had preterm babies
10. Re-interview a participant or re-analyze the transcript to avoid bias	To avoid bias in data collection, the typed transcribed interviews were reviewed for clarity and accuracy by each participant. Reanalyzing the transcriptions was a regular part of data analysis.

Throughout data collection and analysis, it was necessary for the researcher to look at the phenomenon with fresh eyes, setting aside everyday understanding of the phenomenon. Through the *epoche* process, the researcher had the opportunity to clear her mind as she held in abeyance thoughts that were in her mind about the phenomenon.

Interview process. The purpose behind the interview process was to describe the phenomenon that several individuals shared. The interviews began after bracketing and

epoche were introduced. Data were collected through two separate interviews, which took place sequentially over 2 days, lasting approximately 90 to 120 minutes each day. The researcher was the sole interviewer in the study.

During the first interview, written consent was obtained from each woman by having her sign the Consent to Participate Form (Appendix C). Each participant also received a Letter of Consent (Appendix G). Explanation of the purpose of the research study was provided with additional information regarding how the knowledge gained from the research would be used to provide insight into the etiologies of preterm birth. Additionally, each participant was given a printout of a PowerPoint presentation (Appendix G) on facts pertaining to preterm birth (i.e., rising rates across all populations, costs, and organizations that support research to reduce the continuing rise and cost). This PowerPoint printout was also given to the office staff where the interviews took place, as requested by the obstetrician. The first interview was also used to obtain demographic information by having the participants complete the Demographic Data and Personal Information Questionnaire (Appendix A).

The second interview was an in-depth audio recorded interview; using open-ended questions (Appendix F) designed to elicit responses from the participants regarding their pregnancies that ended in preterm birth. Open-ended questions allowed the participants to choose whatever direction they wanted to go in providing answers.

Description of the Interviews

Through the interview process, the participants were given the opportunity to reflect on their personal experiences and highlight the importance of that reflection.

Interviewing allowed the researcher to enter into the other person's perspective and began with the assumption that what the other person thought about a situation had meaning.

The challenge for the researcher was creating a situation in which it was possible for the interviewee to bring the researcher into her world. Information was shared in a way that allowed the researcher to get close to the data. The researcher's goal was to foster an atmosphere in which the participants would feel relaxed and comfortable responding to the interview questions "in their own words to express their own personal perspectives" (Patton, 2002, p. 287). This atmosphere connected and engaged the participants in a way that opened the door for freedom of comment about their lived experiences.

The participants appeared to be very relaxed in their responses to the questions they were asked. This comfort level may have resulted in part because the researcher was an African American woman like them. According to Collins (2000), African American women understand one another in ways that may not always be articulated. This was confirmed by various comments from the participants, such as, "You know, we Black women understand what it is like when no one else does," "You know how we are, we never take a break," and "The White girls, they know how to rest."

Management of the Data

Tape recorded interviews and field notes were transcribed into digital form. The researcher verified that the interviews were transcribed verbatim by listening to the recorded interview of each participant and comparing it to the transcribed text. The transcribed interviews constituted the major part of the data.

NVivo 8 software was used for data management. Once the data were transcribed, they were entered into the NVivo 8 software application line-by-line. Then codes were identified and translated into categorical themes. Next the collected material was sorted using these categories. Finally, this material was examined closely in order to isolate meaningful patterns (Berg, 2001).

Each participant's transcript was visually color coded. This formatting facilitated easy identification of each participant's expression and themes and aided in the analysis process. Additionally, the specific demographics of each participant were entered, including their pseudonym.

Procedure for Data Analysis

Data analysis was done immediately after each interview, permitting refinement of the interview process as needed to ensure accurate collection and reporting of comments from each participant. This is consistent with methodology used for qualitative research as suggested by Sandelowski (1995). Moustakas (1994) posited that the organization and analysis of data begin when the researcher transcribes the interviews, and is prepared to subject the collected data to phenomenological procedures of analysis.

Phenomenological reduction is purposeful and includes three major elements: bracketing/epoche, as discussed before; horizontilization; and imaginative variation. The task for the researcher is making certain that the steps are followed accurately to ensure a reliable description of the phenomenon. Colaizzi's (1978) methodology was used to assist in analyzing the data. This methodology is based on the following seven steps:

1. Read all transcribed interviews to acquire a feeling of data.
2. Review each transcribed interview and extract significant statements.

3. Spell out the meaning of each significant statement.
4. Organize the formulated meanings into clusters.
5. Refer these clusters back to the original protocols to validate them, noting discrepancies among or between various clusters and avoiding the temptation to ignore data or themes that do not fit.
6. Integrate results into an exhaustive description of the phenomenon as an unequivocal statement of identification as possible.
7. Ask participants about the findings as a final validating step.

Analysis of the data based on application of these steps involved identifying the meaning statements from the long interviews with each participant, grouping the statements into categories, abstracting themes from these categories, extracting meanings at each level of abstraction, and deriving the invariant structure or essence of the experience. A step-by-step description of how this was achieved follows:

1. Read all transcribed interviews to acquire a feeling of data. The researcher listened to the recorded audiotapes of each participant to become familiar with the descriptions and to gain a sense of the content of the entire interview. Bracketing (*epoche*), as described earlier, involves setting aside, “as far as humanly possible, all preconceived experiences to best understand the experience of participants in the study” (Moustakas, 1994, p. 235). Objectivity of the study was enhanced by soliciting the assistance of the data entry coder who acted as an accountability partner when assisting in coding the data. A nurse educator assisted the researcher in remaining as bias-free as possible by searching through the data, looking for themes, and then dialoguing with the

researcher to discuss separate findings. This increased the reliability of the themes that emerged. The detailed steps the researcher employed for adhering as closely as possible to bracketing are outlined in Table 1.

2. Review each transcribed interview and extract significant statements. After the interviews were transcribed, the participants' descriptions of their lived experiences were read to get a feel for what was being articulated and to make sense of the descriptions. All aspects of the data were treated with equal value, meaning that the data were horizontalized (Creswell, 2003; Moustakas, 1994). During this step, each statement from each participant was reviewed, explored, and transformed into codes. This process of horizontalization was confirmed by the data entry consultant, who assisted in entering the data. The data entry consultant provided verification that the process was phenomenologically sound.
3. Spell out the meaning of each significant statement. The researcher explained any hidden meanings in the varied contexts of the phenomenon under investigation.
4. Organize the formulated meanings into clusters. The combined formulated codes were organized into categories. The goal was to allow themes to emerge that were common to all of the participants' descriptions. The categories were referred back to the original descriptions to validate them. This was performed to determine whether there was anything contained in the original descriptions that may have been missed and to assure that the categories did not propose anything not implied in the original descriptions. When it was determined that

the categories were incongruent with the original descriptions, the above steps were repeated. Each formulated code was examined to guarantee that it represented the participants' direct experiences.

5. Refer these clusters back to the original protocols to validate them, noting discrepancies among or between various clusters and avoiding the temptation to ignore data or themes that do not fit. It is through *imaginative variation*, the third step in phenomenological data analysis, where clusters of meanings take place. At this step, statements that were repetitive or overlapped were grouped through the use of imaginative variation. Imaginative variation allowed the researcher to derive structural themes from textual descriptions and to understand that countless possible meanings could emerge from the texts. Imaginative variation was achieved as data were reviewed for all possible meanings and different perspectives were purposefully sought. This was achieved, according to Moustakas (1994), by systematically varying the possible structural meanings that underlie the textual meanings, recognizing the underlying themes that account for the emergence of the phenomenon, considering those things that precipitate feelings and thoughts regarding the phenomenon, and facilitating the development of a structural description of the phenomenon. Through the process of imaginative variation, statements were transformed into phenomenologically acceptable categories, which were grouped into themes. An outside consultant verified that the process of arriving at the essence of the experiences from the emerged themes was

sound. The formulations that surfaced allowed the data to speak for themselves without imposing theories.

6. Integrate results into an exhaustive description of the phenomenon as an unequivocal statement of identification as possible. An exhaustive description of the phenomenon under study was written by integrating the resultant categories into a congruent descriptive statement of themes. An in-depth description of the phenomenon under investigation was formulated.
7. Ask participants about the findings as a final validating step. This research study revealed the essences of the African American pregnancy experience that ended in preterm births. The participants agreed that the descriptions provided and the formulated themes represented the true essences of their lived experiences. Appendix H provides a grid of the codes, categories, themes, and dimensions that emerged.

Establishing Rigor and Trustworthiness

Rigor. *Rigor* refers to the trustworthiness readers can expect in the findings of a study based on specific criteria. Trustworthiness of the data obtained through the interviews is essential. Four criteria that test trustworthiness of qualitative research are (a) truth value (credibility), (b) applicability (transferability), (c) consistency (dependability), and (d) neutrality (confirmability). These four criteria parallel measures of internal and external validity, reliability, and objectivity used in quantitative research (Lincoln & Guba, 1985). In this study, numerous strategies were used to establish rigor and trustworthiness based on these four criteria.

Credibility. *Credibility* refers to the formulation of a plausible research design and methodology that will increase the probability that credible findings will be formed (Lincoln & Guba, 1985). Any one of the following verifies credibility: (a) prolonged engagement, (b) persistent observation, (c) peer debriefing, (d) negative case analysis, (e) progressive subjectivity, and (f) member checks (Byrne, 2001). Another strategy to verify credibility is the researcher's use of reflective journaling.

The strategies used in this study to establish credibility included prolonged engagement with the study through listening to the recordings of the interviews many times, writing and rewriting the transcripts, reading and rereading the transcripts multiple times, and interviewing the same participant more than once. Byrne (2001) suggested that researchers have multiple readings for prolonged engagement during the analysis phase (Byrne, 2001).

Other strategies used to ensure credibility were member checks and reflective journaling. Member checks were accomplished by validating the data analysis with the participants in the study. Reflective journaling consisted of first bracketing any preconceived notions regarding the phenomenon under investigation prior to collecting and analyzing the data and writing these ideas down regularly in a journal. Journal entries were then read and reflected on to identify any biases. Bracketing contributed to the trustworthiness of the study by helping to ensure that personal beliefs did not influence the collection of the data and their analysis.

Finally, in phenomenological research, outside reviewers play an important role in verifying the analysis and, hence, the credibility of the research. Engaging an outside researcher, as suggested by Creswell (1998), allows another person to look for identical

patterns, compare the logic of the research to his or her own experience to see if there is any self-recognition related to past experience, and further verify that the conclusions really fit the data, thus confirming that the data could not lead to entirely different conclusions.

Two outside researchers were engaged to analyze the phenomenological data. One of these researchers was a professor from West Virginia University's graduate nursing program at Martinsburg. The other outside researcher was a doctoral candidate in the School of Anthropology at George Washington University and the president of a consulting firm responsible for qualitative research initiatives. Both outside researchers indicated that they were comfortable with their roles and agreed to provide assistance. Neither outside researcher had access to any information that would have identified the participants. Both had some knowledge of the method and content so that they could challenge the researcher's findings, if necessary.

Transferability/Applicability. *Transferability and applicability* can be thought of in terms of "fittingness." *Fittingness* means that data are fully and richly described, accurate, open to the identification of common themes, and not geographically bound. Fittingness occurs when the data fit in contexts beyond the original study. It is determined by the users of research and facilitated by rich description.

Transferability refers to whether or not the findings of the study have similar meanings and relevance to other studies of like kind. While the goal for qualitative research is not to provide generalizations, this sort of research does look for general similarities of findings under similar environmental conditions. *Applicability*, also

measured by fittingness, evaluates how well the results fit into other contexts (Sandelowski, 1986).

Guba and Lincoln (1981) proposed that transferability or fittingness is the alternative for generalization when the research method is qualitative. In this study, fittingness refers to whether or not other African American women outside of this study who have experienced a pregnancy that ended in preterm birth will be able to relate to or see their story in the study data. To establish fittingness, participants' responses were analyzed, the data were broken down into themes to answer the research question, and the findings were framed in terms of the methodology of the study (i.e., phenomenology and Black Feminist Thought). These steps prevented researcher bias and prevented the researcher from trying to fit the findings inappropriately. To enhance applicability, a technique suggested by Sandelowski (1986) called *peer debriefing* was used, in which a qualitative researcher knowledgeable in the field of preterm birth helped identify potential biases and reviewed interpretive processes in the study.

Dependability. *Dependability* of the research findings refers to the stability or instability of the data patterns over time. This technique is similar to test-retest and internal consistency reliability noted in quantitative studies. In qualitative research, a step-by-step replication of the analysis is often used to assess the dependability of the data. It is usually achieved by involving another researcher or consultant to collect and analyze the data independently. The data and results are then checked for comparability (Stommel & Willis, 2004). An outside consultant was contracted to analyze the data. This consultant and the researcher reviewed the data and checked for comparability. Colaizzi's (1978) data analysis methodology was used to ensure replication of the analysis.

To ensure this criterion for rigor and trustworthiness in this study, contact between the researcher and assistant was constantly maintained throughout the study. In addition, dependability was assured by reading and re-reading the text in order to permit researcher reflection and repetitive examination and consideration of all data.

Peer examination supported the establishment of dependability. Participants' transcripts and summaries were reviewed by two professors of nursing, both with PhDs in nursing, and two seasoned obstetrical clinical nurses employed at an area hospital. Each was asked to determine the accuracy of the connections made between participants' key phrases/words and the research questions.

Confirmability. *Confirmability* is the process of minimizing bias during the research process and in the final product (Khan, 2006; Sandelowski, 1986). Confirmability is the objectivity or neutrality of the data, both of which were achieved with the use of an audit trail. An audit trail is a mechanism of maintaining extensive notes reflecting the researcher's analytical thought process that occurred during the course of the study. Specific documents kept to aid in an audit trail were the researcher's journal, audiotapes, transcripts, and observation notes. Through the use of audit trails, other researchers can follow the processes or track the decisions made and steps taken in the study. Additionally, audit trails assist in helping other researchers understand the rationale behind the findings (Lincoln & Guba, 1985; Sandelowski, 1986).

Achieving confirmability in this study was facilitated by choosing Colaizzi's (1978) method of data analysis, which has a built-in system of going back to the transcripts for verification of the themes. Additionally, this method allowed for a return to the participants for verification of the exhaustive description of the phenomenon. To

ensure fidelity to the phenomenon, the tenets outlined by Lincoln and Guba (1985) were followed: (a) ample data were collected that provided a thick description of the lived experiences of women whose pregnancy ended in preterm birth, (b) a journal was kept in which an audit trail and contextual field notes were maintained, and (c) the advice of experts was used in both content and methodology as a peer review process.

Other strategies ensuring confirmability included confirming and clarifying the interpretation of the findings with the participants throughout the interviews. Additionally, the participants' answers were frequently repeated during the interviews to ensure an understanding of what was being said, and phrases such as "My understanding of what you are telling me is . . . ," "Am I correct in understanding that you said . . . ," and "Let me make sure that I understand you correctly," were used for clarification. Confirmability of the data is considered achieved when credibility, auditability, and applicability have been reached (Guba & Lincoln, 1981; G. E. Russell, 1999).

Summary

This chapter provided an overall description of the research study. Details regarding the data collection and analysis process were described.

Chapter 4: Findings

In this chapter, the findings are presented, including a description of the sample and the major themes that emerged describing the lived experience of preterm birth by the study participants. Excerpts from the participants' verbatim descriptions obtained during the interviews are used extensively to illustrate these themes.

Description of the Sample

The sample of this study consisted of seven African American women whose pregnancies ended in preterm birth. Sample size was determined by saturation as outlined in Chapter 3. The final seven participants identified themselves as English speaking African Americans, between the ages of 24 and 42 years (mean 32 years), and living in either Jefferson County (two participants) or Berkeley County (five participants). Two were married, three were living in partnered relationships, and two were single. Two participants held bachelor's degree, one an associate degree, and the remainder had at least a high school education. The participant group primarily had white-collar jobs in the surrounding communities, with two participants being homemakers. All had at least one pregnancy and a history of a preterm birth within the past 2 years; two had preterm babies who did not survive (one baby died as a result of abruptio placentae and the other from congenital anomalies); two had preterm babies that had to stay in the Neonatal Intensive Care Unit for several additional weeks as a result of prematurity; and three preterm babies required minimal intervention. The gestational age of the preterm births included one extremely preterm baby at 21 weeks gestation, one very preterm baby at 31 weeks gestation, and five moderately preterm babies at 35-37 weeks gestation. There were significant variations among the participants which provided for a diverse population

related to the phenomenon of interest (see Table 1). These variations included age, weeks' gestation, educational level, parity, marital status, level of education, and occupational status.

Preterm birth was defined, as described in Chapter 1, by gestational age and based on definitions used by the IOM (2007) and the CDC (2007). The IOM defines *preterm birth* as a birth that occurs before 37 completed weeks of gestation, and the CDC defines it as a birth that occurs at 20-28 weeks gestation (extremely preterm), 29-32 weeks gestation (very preterm), and 33-37 weeks gestation (moderately preterm).

A description of the population was compiled from the Demographic Data and Personal Questionnaire (see Appendix A). Pertinent information regarding gravidity, number of preterm births, weeks' gestation of preterm births, age of the participants, marital status, and the year the preterm birth occurred are included in Table 2. To protect the identities of the participants within the small counties in which they each reside, no additional information is provided.

Thematic Findings

From 789 pages of transcribed data, 342 preliminary codes emerged and were abstracted to 21 codes. These 21 codes were abstracted into 14 categories: (a) Extended Kin and Support Systems, (b) Expectations and Beliefs as an African American Woman, (c) Strength, (d) Know Thyself, (e) Cultural Beliefs and Practices (f) Emotions, Feelings, (g) Influence, Opinions, Views, Beliefs, Attitudes of Other People (h) Feelings of Something Being Wrong, (i) Being Pregnant is Stressful (Causes Worry, Anxiety, Fear, and Disquietness About The Baby) (j) Comparison of Birth Experiences, (k) High Risk Pregnancy, (l) Medical Advice, (m) Too Much To Do (n) Stressors. At the next level of

analysis, through the use of imaginative variation, the 14 categories were abstracted into 10 clusters that represented the essential elements of the phenomenon: (a) Helping Hands/They Were Always There For Me (b) How They Go through Life as Black Women, (c) This is How We Prove We Are Good Enough, (d) Culture is a Part of Who I Am, (e) Familial Expectations (f) My Baby Is Constantly On My Mind, (g) Am I Going to be OK? (h) Forced to Choose, (i) Finding Balance, and (j) Things That Caused Me Stress (see Appendix H). These 10 clusters were revisited multiple times and were combined and reduced to 8 dimensions: (a) Social Support, (b) Strong, (c) Expectations of Me, (d) Fear/Worry About My Unborn Baby, (e) There's the Pregnancy and Then There's Me, (f) Choose Between Following Medical Advice to Me and Responding to Conflicting/Demanding Needs of My Family, (g) Can't Seem to Balance All I Do, and (h) Unexpected Stressors Are Added Insult to Injury. These eight dimensions were revisited and distilled into 4 dimensions: Social Support-Strength To Make It Through The Day, Can't Be Weak, Gotta Be Strong, How I Respond, and Out Of My Control. Two Themes emerged: Theme 1: Strong Black Woman Ideal and Feeling Trapped (see Table 3).

In the description of emergent themes, excerpts from the data that illustrate the themes are used. These excerpts are representative of the themes. Each theme was present across all the participants' lived experiences. Some of the excerpts are quite long to ensure that the findings are understood. The rationale for this is provided by researchers who suggest inclusion of longer excerpts support themes and provide relevance to a study (McLellan, MacQueen, & Neidig, 2003).

Table 3

Emergent Themes and Dimensions

Theme 1: Strong Black Woman Ideal	Dimension: Social Support—Strength to Make it Through the Day
	Dimension: Can't Be Weak, Gotta Be Strong
Theme 2: Feeling Trapped	<p>Dimension: How I Respond</p> <ul style="list-style-type: none"> a. Expectations of Me b. Fears/Worry About My Unborn Baby c. There's the Pregnancy and Then There's Me d. Choose Between Following Medical Advice to me and Responding to Conflicting/Demanding Needs of my Child/Children/Family <p>Dimension: Out of my Control</p> <ul style="list-style-type: none"> a. Can't Seem to Balance All I Have to Do b. Unexpected Stressors are an Added Insult to Injury

Theme 1: Strong Black Woman Ideal. Participants described their pregnancy as affected by expectations of African American women to be strong. These expectations from family, friends, other African Americans, and Caucasians influenced the way the participants thought, the things they did, the decisions they made, their overall responses to life in general, and especially their responses to situations they encountered while pregnant. Participants described performing numerous tasks while pregnant, often to prove to others that they indeed were strong Black women who could withstand a great deal.

The participants' perspective of being a strong Black woman was synonymous with the ability to survive. The obstinate strength that the participants described was viewed as the epitome of what African American women should be. Examples of phrases that symbolized strength and withstanding whatever came their way were, "You can make it," "God will give you the strength," "Be tough," and "You can handle it."

***Ruth:** My mother said... "If I didn't give you the stepping stones for your foundation, you'd end up like a lot of other kids. But not my kids! You're gonna be tough, cause God's gonna give you the strength," she said. "Where would my kids be today if I didn't live it before you?"*

This strength was described as an inherent cultural characteristic of Black women, which the participants indicated was passed on to them by their mothers and grandmothers.

***Sarah:** I think being considered strong is typical of Black women. We are trained to deal with anything. We are! It is bred into us, you know. And I believe it comes directly from slavery. They had their babies in the fields, and nobody gave a damn whether they were in pain or not, and they moved on. And this strength is woven into our cultural fabric.*

Dimension: Can't be weak; gotta be strong. Within the context of the dimension "Can't Be Weak, Gotta Be Strong," the participants described how their lives were lived according to what others thought of them and what they thought of themselves. One thing that seemed to be most prominent was the need to not be viewed as weak. Being viewed as weak seemed to dispel the collective spirit of shared strength that was an image of Black women. The participants' self-worth seemed to be measured by their likeness to other Black women, or to the strong Black woman ideals in their lives (i.e., mother, aunt, grandmother, girlfriend, and co-worker) that were viewed as women who were not weak.

An attitude or drive to be strong, not weak, influenced how they functioned throughout every day of their lives.

Participants described the importance of not showing signs of weakness, speaking to the legacy of strength from their mothers and grandmothers. They described being labeled strong Black women, which was inherent in their communities and culture, often forcing them to keep up this image during times when they should have rested.

Participants found themselves keeping a pace that did not allow for rest because they felt that resting would be a sign of laziness. Participants felt that they would rather endure exhaustion before being labeled or described by family and friends as weak or lazy.

Participants often pushed themselves beyond what was physically or emotionally reasonable, often keeping their feelings to themselves as they endured and coped with hardships without giving in to physical or emotional demands. Participants described how they seldom sat down because they were concerned that they might appear lazy or unable to carry out the responsibilities assigned to them. As a result, the participants kept very busy, often refusing to rest or take time to enjoy themselves. Participants felt that as long as they were busy they would be fulfilling their roles as mothers and wives/significant other.

Participants also described how their mothers and grandmothers fostered the attitude of being strong, not weak. Several participants reported that their grandmothers scolded them if they came to the participant's house and found it in disarray, often recounting how when they were young and having babies, they kept a spotless house, whether they felt like it or not.

Participants attributed this level of thinking and this mindset to their mothers, grandmothers, and foremothers, whom they believed passed this attitude on from previous generations through cultural and family traditions.

Esther: Well, I don't want anyone to say that I am being lazy . . . And with regards to my husband, I did not want him to think like I was milking my pregnancy, like he had to wait on me hand and foot, like, come on now, you can get up and do a little something. He never said it, but I just always thought like, maybe is he going to think this or you know. I just did not want to be lazy or have anyone think I was lazy. I didn't want anyone saying, "You're just lying around, you're not really doing anything." And my mom and my grandmother would always say what they did when they were pregnant. My grandmother had 12, so of course she would say, "Ah, these young women don't know what it is like to carry a baby these days. I'm telling you, I did this and this and that, and I just pushed them out!" You know, she would just say how being pregnant was nothing for her. She said, "But these days, the women, they gotta lie around all day, [Laughs] and don't do a thing! Sleep all day," She said, "I was up at the crack of dawn, and we lived on a farm, and you milked cows!" . . . Even when I did not feel good, I was not going to lie around, cause somebody would say, "Get up, stop laying around, cause you are going to make the baby lazy." Or, "The baby is going to be stubborn." Or, "You're going to have a hard pregnancy." That type of thing. This is what they told my cousins when they were pregnant. She was like, "Ah, you're just lazy, and you're going to have a lazy baby, stubborn baby!"

Sarah: I think, culturally, we are expected to be strong, cause women were just taught to keep on moving. Get up, shake it off, and keep going, you know, no matter what! . . . We have always been strong. Umm, so, I think it was considered a weakness to dwell on things that cause you to not function. You'd be looked upon as less than a woman. A Black woman isn't defined by her job but by the amount of work she can do. Without complaining. Cause guess what? That's the brunt end to it. The good way, the hardest way. The proudest people are the people that can bear the most work. That is what defines you. That is the hat you wear. You were a "beast of burden." And women, Black women today are still "beasts of burden." We take it, and we get it dumped on us. We volunteer at the church even though we don't have the time. We are cooking chicken at 2 in the morning, cause that's the only time we got. We work those jobs even when we physically should be off our feet . . . Cause who would I be if I'm not working? It's not our children that defines us, unfortunately, it's our work, it's how we are perceived, how much we can do, how much we can bear, how successful we can micromanage everything and get it done.

One participant whose baby died due to prematurity talked about how she was expected by her mother and grandmother, as well as by herself, to be stoic and strong when she attended a baby shower for a friend not long after her baby died. This participant, like all of the participants, felt that there was a need to prove to anyone who watched her and to herself, that she was not emotionally, physiologically, or psychologically weak but was a woman of strength, able to deal with life and death without crumbling. Even though this particular participant indicated that she was dying on the inside as a result of her son's death, she described how it was important that no one knew this, for fear of being perceived as being weak.

Leah: I held my friend's baby, like a week after I had lost my baby, and I went home and puked and cried, but I had to hold the baby because everyone was looking at me, and I can't let them think that I am not OK. You know, and so I held her baby and I pretended it was all OK, and I went to the, you know, the baby showers and I really wasn't OK, and everybody looked at me like and, [Whispers] "That's the one that lost the baby. She's the one that lost the baby." But I had to act strong, pretend to be strong

Some participants expressed how they had to be strong like their mothers and grandmothers during their pregnancies. This was the case whether their pregnancies ended well or not. They could not give in to feelings of weakness, sadness, tiredness nor cater to themselves because to do so would not be an acceptable image of Black women.

Sarah: I have a sister and brother. But my maternal grandma lost a child. She had a still born child. She was eight or nine months pregnant. My aunt lost a child as an infant. Both of my great grandmothers lost babies. I don't know what happened, but there was one that died that I believe was premature. And my mother had a hard, difficult pregnancy with me. I guess something with the uterus or something that is going on with the uterus, but she did deliver but she didn't have any more. I guess I'm just like her, you know, and she's just like my grandma. They were strong, no matter what happened to them....Oh, and my aunt, paternal aunt, my

paternal grand aunt had lost a baby. My paternal cousin had a baby at 35 weeks. Lots of losses, but this one made it. He's 11 now.

Dimension: Social support—Strength to make it through the day. Study participants described how their strength to make it through the day came from the support their mothers and grandmothers provided throughout their pregnancies. The participants described this support as being just what they needed when they felt overwhelmed by the pregnancy and by daily responsibilities.

Deborah: My mother was there for me. At the time, my boyfriend was locked up with my third pregnancy, so I kind of went through that alone, as far as being in the house by myself, but my mother was always there for me, you know, always.

Sarah: You know, my mom would do anything for me . . . and take me everywhere, or she would pick me up from work, even if it meant sitting there another hour or if it meant getting up an extra hour early, she did this for me. I did not have to drive anywhere; she always took care of whatever it was I needed.

Mary: When I was pregnant with my son, it was easier because we were living with my parents. It was much easier. If I needed a break, my mom was there. When I had a break, I could get away more . . . Just having my mom especially around was a major support for me . . . When I was pregnant with my daughter, we lived across the street from my parents . . . And when we lived separately, this was major, not just physically but stressful emotionally because I depended on her in so many ways and for so many things . . . Even though we lived across the street, it was just not the same. Not being in the same house with her made a big difference. Being away in my own house, I had to do a lot for myself and my son, whereas before, my mom did a lot for us. Having her right here with me was so very helpful . . . she was always strong! Then, when she got sick and then died, I felt alone. I had to go through my pregnancy mainly without her. This was tough! But, I made it, we made it.

Theme 2: Feeling Trapped. “Feeling Trapped” emerged from the participants’ descriptions that indicated feelings of being trapped, paralyzed, stuck, or ensnared by their current situation. Every day of their pregnancy was a day spent fulfilling the needs of the family. Every day was spent carrying out their

roles as mothers, daughters, wives/partners. Participants often neglected themselves as the needs of others always came first. It did not matter that they were pregnant. Pregnancy was not a reason to be pampered, or treated differently.

These situations experienced by the participants caused them to feel as though they had no options, that they were trapped. Participants expressed that they did not have many choices, or not having any freedom to rest, sit down or be still was a common complaint. Catering to everyone else's needs, including the needs of their pregnancies, was how the participants described everyday of their pregnancies. The daily, non-stop catering, care, and overwhelming responsibilities were wrought with conflicting feelings because as Black women, this was what was expected of them, but as a human being, they were physically and sometimes emotionally exhausted trying to maintain that image.

***Sarah:** Everything at that point just became overwhelming to me. Like for some reason that weekend and the beginning of that week was just like I can't do this anymore...Everything looks like hurdles, like you're just spinning and not going anywhere, 'cause you're stuck. You're not moving forward, and you're not moving backward, you're just trying to deal with it.*

***Abigail:** I would be so stressed out by all that was going on in my life, especially if it was a new interruption, that I could not get myself together that whole day. I would lose a whole day. I would have to start over fresh. It would set me back. That day I missed out on everything I had to do. I just got set back so much that my daughter wouldn't get no dinner that night. We would eat out. She would eat out, because it just messed up my day. There was nothing I could do at all. I just cried, or I was just nasty, and nothing went right . . . no matter which way I turned, there were issues, issues with my daughter, issues with my pregnancy, issues with me, issues with my mom, issues at work, just issues!*

***Lydia:** Because I felt like there was so much to do that I still had to get it done. And I felt like if I bring this baby here, you know, I don't have this done, I don't have that done. And so the whole time I was trying to do all of those things. And I had help, I had my mother and my sisters, but, I just*

felt like there was so much stuff that I needed to do, that they could not do for me. Cause if they would do it one way and they left, I would just turn around and do it another way. But as I look back though, I wish that I had stepped back and let them do it when they wanted to do those things and volunteer. I wished that I had stepped back, but I just couldn't. I was stuck in the middle. I think that if I had, I would have gotten more rest, um, I could have...probably, just would have gotten more rest, which I probably needed. But whenever I would rest, I couldn't because, you know, I should be able to handle all of this you know. Mama did!

Although the word *trapped* was never used by the participants, the descriptions they provided of their lived experiences paralleled the definition of *trapped* according to the Merriam-Webster On-Line Search: “a position or situation from which it is difficult or impossible to escape” (Merriam-Webster, 2009). Descriptions of being trapped, situations in which the participants’ felt their options were limited, were noted in every interview session.

Participants’ lives seemed to be dictated by the needs of everyone but themselves. By the time the participants took care of their children, spouse or significant other, family concerns, and job responsibilities, there was little room to devote to their personal and physical needs. The participants’ perceptions of their world and the numerous roles and responsibilities expected of them often left them with feelings of being trapped in a role, a culture, or a situation that demanded certain responsibility. These conflicting roles and responsibilities resulted in feelings of being trapped. When it was suggested by their physicians that they reduce their activity levels, their mothers and grandmothers would remind them that when they were pregnant they did not sit around resting because “there was always work to be done.” Participants’ lives were not lived in freedom because they were always bound by the expectations associated with being strong Black women. The

lack of freedom created feelings of being trapped. This is depicted in Figure 2, which illustrates the connection between the two themes.

In addition, these women were trapped by their thoughts, the people who influenced them, their identities as Black women, the things that affected them, the things that stressed them, personal concerns for their own health and safety, added responsibilities on top of an existing stressors, and feelings of constant scrutiny from their family and outsiders. They did not see a way to change or get out of their circumstances.

There was never a time during their pregnancy when the participants felt free from their responsibilities as mothers, daughters, wives, and partners. These responsibilities were expected and passed on from their mothers and grandmothers. Participants described the stress they felt every day, all day, trying to live up to one expectation after another, from their mothers or grandmothers. They felt that they could not deviate to the left or the right.

Lydia: My mom expected me to do just like her, after all, this is what we're expected to do, there's no getting around it. If you don't hear it from your mom, your grandmother will be singing the same tune [laughs]. But seriously, They didn't give me much room, they always reminded me of who I was and my job as a mother.... You know, she would just say how being pregnant was nothing for her. She said she kept busy all day, and I did the same thing. I was busy twenty-four seven. I wasn't about to let them catch me resting. I don't think I coulda rested even if I needed to. Even if I did, I wouldn't be able to relax thinking about all I needed to do.

Additionally, the participants described feeling trapped by customs and traditions passed down from their maternal ancestors. Some participants embraced traditions and cultural practices, while others ignored them. Either choice resulted in feeling trapped by the stressors. When the participants ignored or chose not to follow tradition, their mothers or grandmothers expressed disapproval. When the participants perpetuated traditions,

they were angry at themselves because they did not really believe in some of the things that their mothers and grandmothers did. Sometimes the trapped feelings were a result of expected roles and responsibilities, while other times, feelings of being trapped arose from expected perpetuation of cultural practices and superstitions.

Ruth: She [her mother] was very traditional, very superstitious to some degree, very strong in cultural practices, Um, she carried the family beliefs to the end. If you walked in the house and [Laughs] before you move into a home for instance, if you're moving into a new dwelling, do not move a stick a furniture into that house until each time you had that house swept, because you knew not what dwelled before you got there. You would put cayenne pepper on the back and the front door seal. You know, sweep it out the door. Um, she would [Laughs] and I was like, "Mom, I am not going through all that." She said "Oh, but you will" And if I moved, I can't go into the house. I would see if the pastor would come over here and bless the house for us. Because even though I did not have him to do it, the thought was there. If I don't do this, what in the world is gonna happen? So it was almost like she would put a spell on us. Those beliefs were very, very true to us. Um, we moved in the place we are right now, and he looked at me and was like "What in God's name are you doing?" I said, I'm putting down some red cayenne pepper around the door seals [Laughs]" He said, "I'll be back". He had to leave; he couldn't stay there and watch me go through the little rituals, you know.

The theme "Feeling Trapped" had two dimensions: (a) "How I Respond" and (b) "Out of My Control." These dimensions individually addressed aspects of the participants' lived experiences that that caused them stress. How the participants responded to certain stressors did not always diminish the effect of the stress, as their responses to the stressors sometimes caused them more stress when they were unable to control the situation or their emotions. This was especially true when the stressors were a result of things that happened to them that were beyond their ability to control or fix. The participants described how they felt in control over responsibilities that they personally chose to do but did not feel in control of responsibilities assigned to them or expected of them.

Dimension: How I Respond. Stress response emerged as a major factor within the experience of feeling trapped. Situations during pregnancy that created stress included finding enough time to do all the things for which they were responsible, making decisions about providing care for the immediate needs of their family versus following the advice of their physician, concerns for their unborn baby, concerns for their own health and safety, and concerns for how confronting new stressors would impact an already stressful life.

The dimension “How I Respond” can be examined in relation to four general sources of stress: (a) expectations of me, (b) fears/worry about my unborn baby, (c) there’s the pregnancy and then there’s me, and (d) choosing between following medical advice to me and responding to conflicting/demanding needs of my child/children/family.

Expectations of me. Participants described the struggle they had while pregnant between what other people expected of them and what they expected of themselves. Participants described their pregnancy as impacted by the expectations of family, friends, other African Americans, and Caucasians regarding how they should think, act, and perform. Participants described the stress they felt in having to act like others wanted them to act, cleaning the house when they did not feel like it, and being the one expected to care for all family members regardless of how they felt physically. The participants expressed the emotional and physical difficulty in trying to be “all things” to everybody and the ways in which this created stress.

Lydia: *The expectations of how we should deal with our pregnancies do not give us much room to just go home and relax and put up our feet. I think it is put on from my parents, my grandparents, my family, and those that I associate with, even other Black people that I go to church with and things like that. All of their stories when we would discuss and talk with other females in my age group, the same thing. It is that they are suppose*

to still cook and clean and mop the floors and do all those types of things like that...Talked to other Black women about the things that they have had to go through when pregnant, and we all said, "Man, we're in the same boat." And some of these women did not even have preterm babies, but they felt like they had to do all these things, I mean, cook the dinner, get the kids ready, just everything, and mop floors, whatever had to be done. Do laundry. And it's like it couldn't wait. And I'm like, that's how I felt. It can't wait, it has to get done! It's like a time line! Now that's a pressure that turns into a stressor! That's exactly what it was!

Participants described how the image of a strong Black woman was at times a stressor because it was an image that often had unrealistic expectations. The image of this woman is one who endures pain, suffering, and physical exhaustion on the body without complaint or emotional breakdown. The expectations associated with this image, combined with existing stressors in life, often left the participants feeling as though they had no options. They were trapped by this image, the very thing that, through generations, was their strength.

Sarah: *Every Black woman I ever knew, I don't care if they were successful or not, every Black woman I ever knew is defined by the amount of work she does. This is an awful thing to have to live up to, as it was forced on us from slavery. Even though that was years ago, we women still are controlled by and have to live with that. As a result, I feel as though I am forced to do things that I am not in a position to do. Sometimes such pressures compromise your health. Being pregnant is not different . . . It doesn't matter if you have a high risk pregnancy, what matters is that this is what is expected of you and, therefore, you will do what you have to do to live up to those expectations.*

Although there was pride associated with the image of a strong Black woman, the participants described how maintaining such an image was not always a positive thing, as they felt trapped by the expectations associated with it. These high expectations coming from their mothers, grandmothers, and other Black women who perpetuated the image, often resulted in stressful feelings that they did not have the freedom to be "normal." The

participants felt that, although they knew they were free to be who they were, they still felt trapped by their thoughts, their expectations of themselves, others' expectations of them, and their frustration when they could not be like other women (e.g., White women) and do the things other women did. For example, the participants indicated that they did not feel as though they could cry when experiencing emotional pain or loss. Instead, they had to remain stoic and strong, no matter what they encountered. Failing at holding up an image of strength was not an option.

Esther: I patterned myself after my mama. My mom would say, "Well, I mopped the floor when I was pregnant, this and that." . . . And my mom would say, and my grandmother would always say what they did when they were pregnant . . . She said, "I was up at the crack of dawn and we lived on a farm, and you milked cows!" Even when I did not feel good, I was not going to lie around, cause somebody would say, "Get up, stop laying around . . . we had to keep going, when other women were pampered, Oh, but not us Negroes." . . . I feel the same way. I know a white lady that goes and she sits down all like this and acts like, you know, that everyone should glorify her when she is pregnant. And I'm like, "Am I really jealous of her because I did not act like that when I was pregnant?" I don't know, I just think that's just how in my family, this is how we are . . . This is how my mother was and my grandmother. We all have the same issues. We can't do like them . . . there's no sitting there glorifying yourself while you are pregnant.

One participant described in detail how trapped she felt, in trying maintain expectations of her during a very painful time in her life when she lost her baby. Her grandmother had handled losses without a lot of emotion and expected her to do the same. Whether she felt she could handle it or not, she was expected to do so, which resulted in "acting" strong in order to carry out those expectations placed upon her. Failing at holding up an image of being a strong Black woman was never an option, no matter the circumstances or situation.

Leah: This seemed to be the way my family handled things [grandmother lost pregnancy]. I don't know if they grieved at the time. I can't imagine

that they did, because there was just said in such a, said in passing, you know. My grandmother never talked about it to me . . . My grandfather or my mother or somebody else told me. About all of them, it was never something that I ever remember any one of those people saying anything about anything, and it could have been because I was young, but I don't remember it coming up, I don't remember any anniversaries, there is no gravestones marking it, nothing . . . and when I lost my son, that was the first thing that went through my mind, I gotta act like I'm alright, I gotta act strong, because everybody would be saying, "You know, she hadn't been right since she lost the baby." I remember hearing that as a kid, "She hasn't been right since she lost the baby." And I thought, I gotta be right, I gotta act right . . . So I held my friend's baby, like a week after I had lost my baby, and I went home and puked and cried, but I had to hold the baby because everyone was looking at me, and I can't let them think that I am not OK. You know, and so I held her baby, and I pretended it was all OK, and I went to the, you know, the baby showers, and I really wasn't OK, and everybody looked at me like and, [Whispers] "That's the one that lost the baby. She's the one that lost the baby." But I had to act strong, pretend to be strong, just like I have had to do with each of my pregnancies.

Fears/worry about my unborn baby. Participants described the stress of constant concern about whether their unborn baby would be born too early, sick, or with complications. Some participants found their concerns stemmed from complications from a previous pregnancy.

Lydia: *The thought of taking my daughter earlier than when she was due. That was a stressor. With my pregnancy, the stressor always was, I just did not want to get a bad report when I went to see Dr. X. I think that's what I was so stressed out about. Like when I walked through those doors, I wanted a good report. When I found out I had high blood pressure and gestational diabetes, it was like every time, what are they going to tell me? Was my sugar level up? I probably am going to have to do insulin! Were they going to have to take my child early? Or something's wrong. That was a great big stressor! I think the level of importance determines how stressful I am. For me having a healthy baby was more important than anything. Whatever would affect this or trigger this from being anything but a good outcome was a stressor for me*

Deborah: *For one, my stress level could be reduced if I knew that my baby was going to be OK. The constant worry and wondering if this pregnancy was going to turn out OK had me stressed to the max. So I was very happy each time I went to Dr. X to hear him say that I was not so much at high*

risk this time as I was with my first pregnancy. But still, he said he had to keep an eye on me.

Sarah: *...I constantly worry about the outcome, about whether my baby is going to be OK or if I'm going to be OK . . . I knew my body. You know, I don't smoke, I drink socially, but I am a control freak. I don't have, you won't ever see me drunk somewhere or even drunk at home. I don't do that. I watch what I eat. I read the labels. I know my body. I take care of my body. And then I felt that my body let me down. And now I can't trust it. I don't know what it is going to do or when it is going to do it until . . . What if it is doing something and I don't know about it. You know, what if something is going on with the baby and I don't know about it. Emotional stressors affect you in unknown ways. And everyone was like, "Be positive!" You know you really don't have a reason, I mean you do, but positive is like a long ways a way. That's like 8 months away, 7 months away. You know. At least for me I have to get past 24 weeks, because I saw 25 weeks, 26, 27, 28, 29 week babies make it. So for me, my benchmark was 24 weeks. And once I get past that, I can relax a tiny bit.*

There's the pregnancy, and then there's me. Participants described their lives being altered because of the pregnancy, which created stress because their pregnancy was a constant reminder of what they could or could not do. Additionally, the pregnancy caused them stress because it either affected their existing health or caused new health concerns. Pregnancy itself was a stressor because of the physical perception of feeling trapped in a body that housed a high risk pregnancy, as well as feeling governed and dictated by the pregnancy that altered their normal lifestyles.

Sarah: *But every day you're pregnant is a stress, and it's a steady contrast. You're pregnant, but its high risk, so you stress every second, but you are told "Don't be stressed," you know, spend time with your family, relax, do some things you want to do, but you can't, you know, you can only do so much. This is my list of things I can do with my husband and you know, this is it, right there, it's [my list] two inches long, I can hold hands and snuggle and that's it. That's all . . . Always torn! Between being true to yourself and being true to your baby. Because there is nothing wrong with you. You're not disabled, you're able to do everything, but you can't! Because there is another person involved that doesn't have the luxury of making decisions or saying, "I don't wanna do that." You've gotta think about yourself, but you have to think about this other person. The other person is more important, but we all know that, but you're not*

important, but I really am too! ...In your everyday normal life, I am important. But my body says, "You are not important." It's not about you. And everyone tells you, "It's not about you! It's about the baby." And yet, if something happens, then you live with the guilt because the stupidity of wanting an omelet, that thing you want so badly can become so stupid that the stress of it all could cost your pregnancy!

Mary: *I found myself doing those daily chores I did, going up and down the steps with laundry and all that kind of stuff like that. I just felt that it was difficult and challenging because early on I just felt that this was overwhelming. I just felt like before I could run up and down the steps, and then as soon as I get to the bottom of the steps I was just like, "Whew," out of breath. I was exhausted, and I was not even that far along. I was only 2 or 3 months into my pregnancy, and my body just was not allowing me to take care of things as it had before.*

Another stress came from their enlarging bellies, which was a visible sign of pregnancy that evoked feelings from happiness and wonder to feelings of frustration.

Sarah: *I think you get to the point at the end of your pregnancy where you just can't do it. You're just like, "I just can't do this anymore!" You struggle with this phase like where two people fight for space. You can't sleep, can't get comfortable. You're peeing all the time, you're just tired. Everything looks like hurdles. I thought, "I do not want to go up these stairs." I didn't wanna go up the stairs. It makes my legs hurt, I just don't feel like it. I can't get comfortable, I can hardly do anything. It's all too stressful . . . So we are being told by all kinds of people, not to stress, but no one is giving us the tools that will help us not stress, because the pregnancy alone is a stressor. Every day, every second of the day, all day my thoughts were of my pregnancy, because it is not like you can take off your pregnant belly and take a break from it. You know. I wanna exercise. I can't exercise when I'm pregnant, not when you're high risk . . . You can't excise like that. You can't go jumping around the gym. Everyone says don't stress. Be de-stressed. How can you not be stressed when all you can think about is the fact that your flawed body is trying to carry something that it wants to expel and that literally there is a twisty tie that is keeping it all together? And you can't exercise, you can't get on the floor and do crunches, can't get on the treadmill, can't walk the dog, can't even relax with a glass of wine, you can't do anything. You can't do anything! How do you de-stress? Like, how do you de-stress when your whole thing is stressed? [Laughs] . . . I wanted gingerbread cookies. It had to be gingerbread man cookies for Christmas when I was pregnant. Nobody had the time to make them. I couldn't make them, so, and literally the little stupid things became major, and then part of me would say, "I could go right over there and make them myself." And the other voice*

would say, “But if you do that, you know what will happen! You’ll start to contract and then your baby will be born early!” . . . But what about me?

Pregnancy caused the participants further stress when they experienced physical symptoms like cramping and/or low back pain because their mothers and grandmothers told them not to worry about the symptoms. They were told that they should listen to their bodies and just go on about their daily normal lives because if the body said it was time to labor, the time was right. So they looked at these symptoms as a normal part of pregnancy and listened to the advice from their mothers and grandmothers.

The times when the symptoms concerned them were times when they felt that their bodies were in control and not themselves. These were the times they described feeling trapped by the pregnancy and feelings no longer “in charge.” This was not a sense of wishing they were not pregnant but a sense of being restricted as a result of the pregnancy. Some participants expressed, in hindsight, that perhaps the pregnancy would not have ended the way it did if they had sought medical attention at early onset of symptoms.

***Leah:** Different people would also tell me different things about their experiences during pregnancy. They told me to expect this and this, um, my friends, most of them, I think I had the first baby, so none of them knew anything to tell me. I just thought if the water broke, it’s OK; it’s time for the baby to come! This is what [mom] said to do, so I did not think anything any differently. No one ever told me about any warning signs of preterm birth, just that when it is time to labor, my body would tell me. But I did a lot of reading, and from what I read and what I was told, there seemed to be a conflict. I know for me, it would be an even bigger conflict if I ignored the advice coming from my mom, so I just listened.*

***Deborah:** I know I had had a preterm baby before and I was stressed then. I figured if I was not careful, because I had so much stress on me this time, because I was trying to do all the things I normally do. So I listened to my mom . . . The main thing she said I needed to do during my pregnancies was to listen to my body. If I felt something was not right, check it out. The*

other thing was to allow my body to tell me when it is time. Usually she's right, but this time I kept telling myself, something is not right.

Choose between following medical advice to me and responding to conflicting/demanding needs of my child/children/family. Participants described other sources of stress, such as having to decide to care for the immediate needs of their child, children, or family member over the needs of their unborn babies. These decisions became stressful when the participants felt compelled to ignore the advice of their physicians for the well-being of their immediate family. Stress set in when meeting the needs of the family had to come first.

Sarah: *And so, because I was Mom. And moms don't rest. But the doctor says you have to rest, but your kids are looking at you like, "Mom, we need you." So just that struggle between taking care of the two you have and taking care of the one you don't have yet, that was hard. That's hard. This is what creates stress on you. . . . Sure, there are some things that you have to do. I mean, you gotta work, you know, and even though the doctor doesn't want you to, you have to! You have to provide, if you have other children, you have to provide for them, you don't have a support system, you have to get to the store, there are things that you have to do . . . So if I have to wait for help, I'm gonna do it myself. But the guilt of knowing that, everyday, and on any level, you're still playing Russian roulette with your baby . . . I had to work for insurance and still, needing the money, and I had two other kids that I needed to provide for.*

Dimension: Out of my Control. This sub-dimension can be broken down into two general sources of stress: (a) can't seem to balance all I have to do and (b) unexpected stressors are an added insult to injury. Both are a result of what the participants described as things that they seemed unable to control. The lack of control resulted in experiences of stress. Their inability to control the situations made them feel as though they had no options, no recourse. As a result, the participants felt trapped, which caused them stress.

Can't seem to balance all I have to do. Participants described the stress of trying to juggle all of the daily responsibilities placed on them while they were pregnant. They felt stressed all day and every day as a result of trying to find some stability in their lives. Participants described responsibilities at the beginning and ending of each day that normally would be manageable, but because of additional superimposed responsibilities, these normal responsibilities were perceived as major events. For example, normal routines like getting ready for work or getting the children ready for school did not usually cause them stress, but during pregnancy these normal routines seemed to more physically and mentally taxing. For some participants, a day was described as stressful if it was so packed with things they had to do that they never had time to relax before it was time to start all over again. Even during the times when one participant mentioned she relaxed for a while, she said her mind was not relaxed because she was thinking of all that needed to be done before she could finally retire.

Lydia: *I went to work early because I felt like I had so much to do when I got up, that while my son was in school, I could come home, I could wash clothes, I could do this, I could do that, before I got him out of school. Did things before my husband popped in the door before he went off to class. So I just felt like the earlier I went in, the more I could get done. That was my reasoning for always going in early. In addition to this, I have a son, a 7-year-old son, so I had to always tend to him. I had to go to, um, his parent-teacher meetings, soccer practice, because I had to take care of him. Um, cook dinner, and just things like that, it was basically the same throughout my whole pregnancy. None of that really changed.*

Deborah: *Waking up, getting ready, going to work, getting my daughter ready, dropping her off at day care, and going to work, from work, picking up my daughter from day care, dropping her off at my mother's, and going to school. From school, going back to get her, going home, fixing her dinner, our dinner, feeding her, and then, uh, studying, well, relaxing myself, cause I hadn't got a chance to relax myself from work to school and back, just trying to relax myself, get off my feet, and put her down to bed, and I'm going down to bed . . . same thing every day, all day. Very stressful!*

Ruth: *I'd get up, get the kids some breakfast, get the kids dressed, get myself dressed, go take them to day care and school. I'd go to work, work until 4, 7-4 was my shift. I'd go pick the kids up from day care, come home, and cook dinner, um. We always would go outside and go for a bike ride or go outside to the playground because the playground is right behind where I live at. Um, get the kids a bath, and go to bed. Whew... I did the same thing every day. This seemed to stress me.*

Esther: *Very full, very stressful day, from 7:15 am to 10 o'clock at night with each passing moment . . . the day proved to be more stressful, um, whether interacting with my siblings as I tried to get 5 siblings on one page about what it was that our mother wanted regarding the family estate. This proved to be very stressful. In addition, caring for my son, taking care of all the household chores, being that mom for my daughters, just things I had to do.*

Unexpected stressors are an added insult to injury. Participants described that barely managing everyday stressors was compounded by unexpected stressors. Dealing with certain unexpected stressors seemed to “push them over the edge.” Unexpected stressors, such as the death of a mother for two participants, caused them more stress on top of an existing stressful life. These two women described what it was like watching their mothers slowly die and the increased stress when their mothers actually died. Participants described this kind of life stress as emotionally and physically draining.

Mary: *Cause like I said, my mom was really sick, I found out she was dying. I already had a lot on me, but dealing with this just seemed so much. Like, while she was in the hospital, I would leave from Virginia, drive home, pick up my son, and we would go back to the hospital to be with her. I did this everyday to visit my mom in the hospital. So, I think that drained me, because I did it every day. Because I did not want her to go a day without seeing us, whereas I had brothers and sisters, but they weren't visiting, so I figured if they were not going to go, I was going to be there every day. So I think that drive, then getting home around 10 or 11 at night, and doing it all over again, I think this really drained me emotionally . . . Then, when she died, I felt alone. I had to go through my pregnancy mainly without her. I cried a lot. It seemed more than what one person should have to go through. This was tough!*

Ruth: *It was personal issues that compounded life; I had lost my mother April 2006, and was still going through grieving and mourning of losing her. And on top of her I had a lot of responsibility. She left me responsible for estate. I was her POA, and my siblings were not too happy about this, but with all that being said, I was dealing with that, and during this time, I became pregnant. It was stressful because even though I had personal things going on that were difficult at times to deal with, none of them compared with the stress of dealing with those things coupled with the loss of my mother.*

Other participants described unexpected stressors that seemed to push them beyond their ability to cope physically and emotionally.

Lydia: *My emotions were so messed up . . . I had so much going on at one time . . . My emotions were very sensitive . . . It did not take much to “push me.” OK, I will give you an example. I had something that threw a hindrance in my day. My daughter was having problems at school. I had to go to the school because it was to the point that she did not want to get on the bus to go to school. So I go in there, you know, and my emotions are all upset, and I am crying. I mean I cried for the longest time that they would not let me leave the school being pregnant and having to drive myself so upset like that.*

One participant described that she “lost it” as she referred to a situation where she was left without a car because it caught fire while she was driving it. Having to endure the hardships associated with getting to and from work without the means to do so added additional stress to an existing stressful life.

Deborah: *After my car blew up, I had to rely on my boyfriend’s dad to help get me where I needed to go. That was a big thing for me because my transportation was gone, you know, some time I didn’t even have a ride to work, you know. That was really hard. There were times when I had to push my daughter in the stroller, walk her to where I had to go, and then walk to work... Talking about stress! It was stressful by itself having to deal with things with my boyfriend being locked up. This I was handling OK. But when the car blew up, this was like too much on me. I could feel myself about to cry. I kinda went back and forth with fighting back tears and being so mad, like I could explode!*

Several participants spoke about the stress they were under prior to their pregnancies which added to the stressors experienced during pregnancy. One participant spoke about learning that her mother had terminal cancer.

Esther: It was personal issues; I had lost my mother April, 2006, and was still going through grieving and mourning of losing her. And on top of her I had a lot of responsibility. She left me responsible for estate. I was her POA, and my siblings were not too happy about this, but with all that being said, I was dealing with that and during this time I became pregnant. It was stressful because even though I had personal things going on that were difficult at times to deal with, none of them compared with the stress of dealing with those things coupled with the loss of my mother.

Inequality was another stressor the participants dealt with prior to pregnancy. Participants talked about the difficulty they had dealing with the fact that they did not feel that they had the same opportunities in life as White women. Participants talked about how these feelings were heightened during their pregnancies as they observed White women receiving pampered care, while they struggled.

Mary: Black women have had to deal with, you know, being treated different than White women. We have been single parents the longest and we were single parents when it wasn't cool to be single parent, and when nobody else was a single parent we were a single parent. You know what I mean? And we deal with that because we had to. We were boxed into the stereotypical role. We didn't have the same luxuries, the same chances, the same opportunities. And so, you earned like Black men, I mean they may be sold back in slavery; they might be killed, so you can't depend on them. But White women had it good. They had their man helping them, and if they didn't, they were given a better chance. We had our families, but they had their own problems. If you can't rely on them because they are busy, who can you rely on? Only yourself. That's the one person that will never let you down, one person you can count on, yourself. And people wonder why we are stressed to the hilt!

Lydia: Just being around some of my co-workers, white women that are pregnant, um, they do take their pregnancy different than us. They say, "Go home and relax, prop your feet up." They take it more serious than we do because they have it easy. We feel like we have to be so hard core and that, you know, we have to prove to everybody that we are just as

good as them, and that we can do this and we can do that instead of just worrying about the baby, relaxing and not stressing, and things like that. For my pregnancy, I could not just relax, and prop up my feet without feeling guilty. And being around my family and other African American women, we don't do that. But my co-worker who is White, is a really good friend, she is pregnant, and like when she went home, she did not do anything! She just relaxed herself. We were actually pregnant the same time. But she would say how she would just go home and she would take a nap when she got home and she would just relax and do things like that. And I'm like, "I can't do that. "I've got to go home and do this, this, and that"

Sarah: *I believe one significant reason why Black women are treated differently than White women is because our point of reference is different. For us, motherhood defines who we are. You got the baby on the hips while you vacuum, make dinner, make your phone calls, go out and do this and do that. For us, pregnancy is secondary. It is just another thing on the "To do list." When you look at the history of White women's pregnancies, they lie down when they are pregnant. They had this you know, this huge shower and everybody came and they, and the mother-law comes over and she stays for six months and they are, it's like a celebration, they are allowed to do it, you know what I mean? They are allowed to rejoice in that. If something happens, then they are also allowed to grieve. They are allowed to come and they get casseroles and you know, people spend time with them and they are allowed that. And with Black women, when we have a baby, you get like, you get that week to get out the hospital, you get the flowers, you tell people to come over and you get the call that's like I'm not coming because I don't want to bother you, you call me when you want me to come over. I don't wanna bother you. And then you sit there on the sofa and you say to yourself, I'm not like them, you know. I don't have that kind of luxury. You know what? I gotta make dinner. I gotta do this and do that.*

Because there was nothing they could do to change their current situation, these unexpected stressors added to the pregnancy stress.

Deborah: *When my car broke down, this was a big interruption and stressor for me, because sometimes you know, I had short hours in my pay, you know, sometimes if I didn't get there on time, or I had to leave early because there was a little problem with my daughter when she fell down the steps when I was at work. I had to leave, get her, and take her to the hospital... So, I mean, it was a lot of stress, and my boyfriend being, you know, in jail. That was a big unexpected stress while I was pregnant. Very stressful. Um, and actually that is one of the routines that I left out. Going to see him before school sometimes, and set the appointments to go see*

him. Me and my daughter would go to the jail to see him for 20 minutes or half an hour, and dropping her off, then go to school, or you know, or I'm going home, however which one fall in place. All these extra strains coming at me at the same time... And the financial was stressful because he wasn't there to help me. And ah, yea, that was very stressful!

Summary

From the data analysis of this study, two major themes emerged that captured the lived experience of the African American pregnancy that ends in preterm birth as described by the study participants. These two themes were “Strong Black Woman Image” and “Feeling Trapped by Stressors.” These themes represented the distilled essence of the responses given by the study participants which reveal in rich detail the lived preterm pregnancy experiences of these seven African American women.

The perceptions, attitudes, and experiences of the participants were recorded, providing valuable insight into their worlds. Phenomenological reduction and data analysis were performed on the data collected through the use of semi-structured, in-depth interviews in an effort to provide a better understanding of the lived experience of the African American pregnancy that ends in preterm birth.

Chapter 5: Discussion of Findings, Implications, and Recommendations

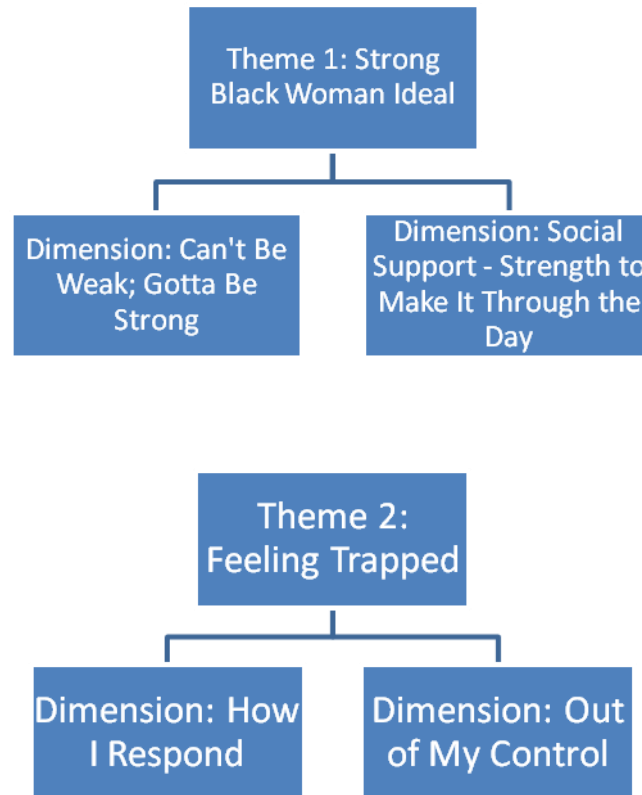
This chapter includes discussion of the thematic findings as they relate to existing knowledge regarding African American pregnancies that end in preterm birth. Consistent with the phenomenological methodology, an in-depth analysis of the literature as it relates to emergent themes was performed after the data were collected and analyzed. Concepts related to the thematic findings in relation to African American women's predisposition to preterm birth are presented and discussed. Finally, the chapter presents conclusions, strengths and limitations of the study, implications for nursing, and recommendations for future studies. The intent of this discussion is to interpret the findings with regard to the existing research evidence and established knowledge.

As outlined in Table 2, and again in Figure 2, the two major themes that emerged from this study captured the lived experience of pregnancy ending in preterm birth of each of the study participants. Both Theme 1, "Strong Black Woman Image," with dimensions of "Can't Be Weak, Gotta Be Strong," and "Social Support—Strength To Make It Through The Day," and Theme 2, "Feeling Trapped," with dimensions "How I Respond" and "Out Of My Control" will be discussed.

Discussion of Thematic Findings

Probing the lived experience of the study participants revealed new perspectives on the phenomenon of pregnancy ending in preterm birth among African American women. Reflection on and review of extant knowledge related to the extracted themes revealed the potential association between contemporaneous theories on intergenerational processes and preterm birth.

Figure 1. Diagram of themes and dimensions.



Theme 1: Strong Black woman image. The strong Black woman image was the standard set by African women years ago and is the standard or “yardstick” African American women use today to judge themselves (Amankwaa, 2003). It is an image associated with strength, perseverance, courage, and independence that has been threaded through the African American culture and passed on from generation to generation by African foremothers as far back as slavery. It was the foremothers who cultivated this image within and among families, workers, and community members through their hard work, obstinate strength, and ability to survive and endure life’s challenges (Angelou, 1969). African women have always been the backbone of their traditional societies. They

have always stood as a symbol of pride. This symbol of pride is still revered today, as the long history of transmission of the strong Black woman image and the myth behind the image have endured from generation to generation.

Numerous studies have examined the image of Black women and the relationship to group identity and cultural cohesion (Beauboeuf-Lafontant, 2008; Lacewell-Harris, 2001; Nelson, 1995; Shambley-Ebron & Boyle, 2006; Wyatt, 2008). According to Neal-Barnett (2003), Black women are the most resilient members of the human race, possessing the ability to triumph against overwhelming odds. This resiliency was characteristic of African women generations ago and is apparent in the lives of Black women today. The resilience has contributed to the “strong Black woman ideal.”

This “strong Black woman ideal” has also served to promote a cultural understanding of the roles and responsibilities placed upon African American women. It is an intrinsic part of the African American community and culture that is fostered and fanned by many. The title *strong Black woman* conveys beliefs about the characteristics of Black women for those who interact with them (Lacewell-Harris, 2001). In fact, people perceive the strong Black woman ideal as African American women’s image of perfect womanhood. Lacewell-Harris (2001) indicates that:

In her contemporary form, the strong Black woman is a motivated, hardworking breadwinner. She is always prepared to do what needs to be done for her family and her people. She is sacrificial and smart. She suppresses her own emotional needs while anticipating those of others. She has a seemingly irrepressible spirit unbroken by a legacy of oppression, poverty, and rejection (p. 5).

Participants in this study described how important it was to them to endure hardships, pressures, and stressors because they were expected to do so as African American women. The decision to persist, persevere, and stand, no matter the

circumstances, is an attitude or ideal that has described the African American woman for generations. It is these very qualities that align with the ideal of a strong Black woman.

The impact of older generations on younger generations in perpetuating the theme of the strong Black woman is highlighted by research findings (Amankwaa, 2003; Robinson, 1983; Wyatt, 2008) that self-sufficiency, independence, and self-concept are lessons passed on and learned by many Black girls from their mothers, grandmothers, and other women who raise them. The role these women play in shaping the ideal of the strong Black woman for younger Black women is immense.

The shaping of this ideal begins at an early age, as Black girls are socialized to portray strength of character as well as physical strength and stamina to do that which is necessary in order to survive. They are taught to press forward, despite the situation and without asking for help. Not surprisingly, strong Black women are at the center of this socialization process for Black girls (Lacewell-Harris, 2001).

Participants in this study described similar stories about how they had been raised with the ideal of being strong Black women and how they had internalized and carried over this ideal into motherhood. Participants described being reared in environments in which they were expected to be strong and handle whatever came their way, regardless of how mentally, physically, or emotionally challenging or exhausting the situation seemed.

Researchers have reported that the strong Black woman ideal has served to build self-assurance in other Black women. This is an image of a woman who has overcome obstacles, borne the double burden of principal caregiver and nurturer of children, and displayed extraordinary perseverance, strength, stamina, endurance, and resilience. This ideal has persisted in the minds of African Americans despite the mental pain associated

with fulfilling the role of a superwoman (Amankwaa, 2003; Chisholm, 1996; P.H Collins, 2005; Wyatt, 2008). In fact, the cultural and social strong Black woman identity that has been placed upon Black women by their mothers, grandmothers, and/or the community may compel them to deny themselves and their needs (V. Chambers, 1996; Morgan, 1999; Robinson, 1983).

The strong Black woman ideal has been a pervasive symbol of pride in African American culture, one that is crucial to building and maintaining a positive self image in a society that seems to negate that image. There is current controversy, however, over whether this strong Black woman ideal, in her perfection, is beneficial or detrimental to one's health (Amankwaa, 2003; Chisholm, 1996; Lacewell-Harris, 2001).

Black females have nearly been destroyed psychologically and physiologically by trying to maintain the strong Black woman ideal, referenced as a woman with super human strength (Wyatt, 2008). This ideal is believed to have a negative effect on the psychological development, psychosocial functioning, and physiological well-being of African American women. The negative effect that this image brings is stress from trying to live up to the expectations associated with the strong Black woman ideal (Halle & Johnson, 1989).

The participants described how important it was for them to maintain this identity throughout their pregnancy, regardless of the physical or emotional demands they faced. In addition, participants described how the ideal of strong Black woman was often a part of conversations between them and their maternal relatives and other Black women who were like mothers to them.

Throughout the interviews, the participants recounted the days of their pregnancies, referencing conversations in which their mothers or grandmothers told them, “Be strong,” “Get through it,” “Be tough,” “Press on,” and “You can handle it.” These frequent conversations were reminders of the importance of maintaining the image of strength often attributed to Black women.

Can't be weak; gotta be strong: A dimension of theme 1. According to Neal-Barnett (2003), the opposite of strong is weak, and to pair the word *weak* with *Black woman* is to create an oxymoron. “In the minds of many Blacks and Whites, a weak Black woman simply does not exist” (Neal-Barnett, 2003, p. 1). Being a strong Black woman means that one cannot be vulnerable, needy, imperfect, or depressed. If a Black woman was perceived as having any of these negative attributes, she was perceived as weak. Rather than be seen as weak, a Black woman will refuse to admit she is stressed and will keep her feelings and emotions bottled up inside while she cares for everyone else.

Joan Morgan (1999), author of “*When Chickenheads Come Home to Roost*,” defined the gender role of Black women as a strong Black woman who does not show weakness or neediness. Instead, she always remains stoic and competent. She is a dependable rock that everyone can look to for social support and strength. Showing weakness would be perceived as a character flaw or deficit. Chisholm (1996) suggested that for African American women to admit that they are weak “is to expose one’s vulnerability and to be perceived as a failure to live up to the tradition set by previous generations of women” (p. 74).

There is no current research that addresses the impact of the ideal of a strong Black woman and its effects on pregnancy outcomes. At the same time, a review of the literature did provide information on three concepts which may shed some light on the association between the strong Black woman ideal and the role stressors may play and its impact on pregnancy and pregnancy outcomes: (a) memes (mimicking/imitation), (b) intergenerational transmission (IGT) of parenting, and (c) intergenerational epigenetic inheritance (IGEI).

These three concepts may affect African American women in a way that is unique to them: Memes, an element of cultural ideas and practices, transmitted from generation to generation through non-genetic means; IGT, a process where either purposely or inadvertently, an earlier generation psychologically influences the attitudes, behaviors, beliefs, and perceptions of the next generation; and IGEI, where the genetic inheritance is not changed but gene expression is altered in later generations. Memes and IGT, which are discussed next under Theme 1: provides insight into the sociocultural aspects of the participants' lives, and, help explain the impact the strong Black woman ideal had on pregnancy outcomes. IGEI, discussed later under Theme 2: Feeling Trapped provides insight into the possible explanations for the biophysiological mechanisms which may affect the African American women's pregnancy outcomes.

Memes. A *meme* is defined as an element of a culture that may be passed on by non-genetic means, a unit or element of cultural ideas and practices that is transmitted from one mind to another or from generation to generation through imitation, speech, gestures, or customs through non-genetic means (Dawkins, 2006). A meme is the simplest unit of cultural replication that is transmitted when one person consciously or

unconsciously imitates another person (Aunger, 2002). Memes are spread by the behaviors of their hosts through imitation, involving the copying of observed behavior by one person to another person. Memes are likened to the spread of social contagions such as fads, which are seen as imitation of ideas (Dawkins, 1989). According to Dawkins:

Examples of memes are tunes, ideas, catch-phrases, clothes fashions, ways of making pots, or of building arches. Just as genes propagate themselves in the gene pool by leaping from body to body via sperms or eggs, so memes propagate themselves in the meme pool by leaping from brain to brain via a process which, in the broad sense, can be called imitation. (p. 192)

Memetic theory postulates that once a thought or idea is inside our brain, those thoughts may influence our goals, work ethics, and parental styles. Meme theorists believe that through imitation, attitudes and beliefs are imprinted in the minds of those who are closest to the host who exemplifies these traits (Dawkins, 1989).

Understanding memes begins with recognizing that many of our thoughts are not generated within our own brains but are acquired from the thoughts of the people with whom we spend much of our time. Meltzoff (1988) studied imitation in infants for more than 20 years, noting that humans are good at imitation almost from birth, and noted that infants learn to do an act from seeing it done. Infants were able to imitate a wide variety of vocal sounds, body postures, and actions on objects, and they readily imitated almost anything. Meltzoff's study provides an understanding of how imitation relates to meme transmission. Earlier research by Meltzoff indicated that newborns not only have the capacity to imitate behavior as early as birth but also have some underlying capacity to defer imitation to a later time.

An example of imitated behavior is noted in an adage that has been circulated for generations, without an identifiable origin:

Sally made a fine ham using a family recipe that begins by cutting a section off both ends of the meat. One day her daughter asked, “Why do you trim the ham before you cook it?” Her mother replied, “Because that is the way my mother, your grandmother always does it.” The daughter asked the grandmother why she always trimmed the ends off of the ham before she cooked it, and the grandmother replied, “Well, to tell you the truth, I really don’t know why I do it, except this is the way my mother, your great-grandmother use to do it. She’s in the other room, why don’t you ask her.” “Great granny, why did you always cut the ends of the ham off before you cooked it?” “Why dear, I did that because my pan was always too small!”

This story is an illustration of how humans copy and imitate actions and behavior of others that may span generations.

African Americans have generations of deeply ingrained values and beliefs about being strong Black women that are generic only to them (Wyatt, 2008). Why they felt they had to be strong is believed to be a result of imitated behaviors that have been passed on from generation to generation. The participants reported that they imitated their mothers and grandmothers, which is in line with what the research explains about the transmission of memes.

Participants’ behavior, values, beliefs, and choices related to being strong Black women mimicked those of their mothers and grandmothers in many situations, including pregnancy. Regardless of whether the participants imitated their mothers’ behavior consciously or unconsciously, the imprint of the thought patterns were believed to be deeply embedded, like the grooves on a record, and difficult to erase (S. Blackmore, 1998; Dawkins, 1989).

Participants talked about how they handled life’s situations much like their mothers and grandmothers, as they imitated their work ethics. They too, worked tirelessly, from sun-up to sun-down, managing the home, caring for the family, and

meeting everyone's needs while often neglecting themselves. There were times when imitating this type of behavior resulted in the participants pressing through or ignoring physical symptoms, such as cramping and contractions, that may have been associated with preterm labor. Imitating behavior, as in the example of memes, may have an impact or be indirectly connected to poor pregnancy outcomes for the African American woman.

Intergenerational transmission (IGT) of parenting. In addition to imitating their mothers and grandmothers, participants described how being raised by them influenced their lives. This influence on character and values can be understood through the examination of intergenerational transmission (IGT) of parenting.

Intergenerational transmission (IGT) is similar to memes, as it refers to a process through which, purposely or inadvertently, an earlier generation psychologically affects and influences the attitudes, behaviors, beliefs, and perceptions of the next generation. Whereas memes are cultural units transmitted from one mind to another through non-genetic means, IGT is the non-genetic transfer specifically through parenting within a family from generation to generation. It is reflected in the influence of one's own childhood experiences on his or her childrearing practices and attitudes. This concept appears to be relevant to the study because the participants' attitudes, values, beliefs, and decision-making styles regarding being strong Black women may have been influenced by IGT.

Van IJzendoorn (1992) indicated that parenting serves as a role-modeling, a type of social learning process where the child takes on parental behavior that resembles how one's parents, grandparents, and great-grandparents were raised. This influence typically

spans a minimum of three generations: (a) grandparents, (b) parents, and (c) their children (Van IJzendoorn, 1992).

Participants' lives were noted to have been greatly influenced by the traditions, values, and beliefs of their mothers and their grandmothers, as each generation embraced the strong Black woman ideal. The decisions the participants made concerning themselves, family, children, spouses/significant others, and their pregnancies were either similar to those made by their mothers or grandmothers when they were of childbearing age. Participants often stated that their attitudes and beliefs about being a mother and wife/significant other were a result of how they had been raised. They spoke of making the same decisions about their pregnancies as their mothers or grandmothers had either made or told the participants that they had made. Some participants talked about how they believed that their preterm births were significantly related to their mothers' and grandmothers' poor pregnancy outcomes. They did not refer to being influenced by what had happened to their mothers and grandmothers, but did talk about being "just like them," in reference to how they handled their pregnancies and how they handled their losses.

The IGT of African American women's parental influences on their daughters regarding the ideal of a strong Black woman is not new. For generations, Black girls have been taught how to be strong Black women through the socialization process. They were socialized to perceive life through their mothers' and grandmothers' lens. The maternal influence regarding their roles as strong Black women may have impacted how they went about their daily lives, how they dealt with stressors, and how they handled their pregnancies.

Managing one's pregnancy is a result of the IGT parenting style, especially the mothers' and grandmothers' ideals of how their homes should be maintained, regardless of their pregnancies. Participants were told by their mothers and grandmothers not to worry about doing too much during pregnancy because when their body was ready to deliver, they would know, and the timing would be right.

Transmission of parenting styles and intergenerational concepts are often transmitted without awareness from one generation to another (King, Burgess, Akinyela, Counts-Spriggs, & Parker, 2006; McWright, 1999; Pagano, Hirsch, & McAdams, 2002; Stein, 2003). Examples of these concepts include (a) IGT of divorce (Wolfinger, 2000); (b) the roles of grandparents in value transmission and socialization (McAdoo & McWright, 1994; McWright, 1999); (c) value attributions and value transmission between parents and children (Whitbeck & Gecas, 1985); (d) generational study of transmission of risk for sexual abuse (Leifer, Kilbane, Jacobsen, & Grossman, 2004) and, (e) child abuse and neglect (Main & Goldwyn, 1984).

A few researchers (Bower-Russa, Knutson, & Winebarger, 2001; Kaufman & Zigler, 1998; Leifer, et al., 2004; Muller, Hunter, & Stollak, 1995; Rodgers, 1995; Simons, et al., 1991; Thornberry, Freeman-Gallant, & Lovegrove, 2009; West Virginia Vital statistics, 2006) reported that parents who abuse their children showed evidence of strong IGT of abusive parenting for several generations. Thornberry et al. (2009) explored the impact of parental stressors on the IGT of antisocial behavior, finding that childhood antisocial behavior extends back to the parent's adolescent development (Thornberry, et al., 2009). These findings demonstrate the powerful effect of IGT on the lives of children and their children's children, and raise a question of whether there could

be some correlation between IGT of parenting styles and poor pregnancy outcomes. More research is needed in this area.

These research findings regarding the impact of IGT may help explain the occurrence of preterm birth in African American women. This pattern of IGT parental styles may override information and education presented by anyone outside of this circle of influence. Adverse birth outcomes can result when the recommendations from the mothers or grandmothers are contrary to medical practice. The level of influence of the participants' mothers and grandmothers can be seen in the unrelenting desire and determination the participants exhibited in striving to be strong Black women and in IGT of parenting styles.

Although no research was found about the relationship of IGT of parenting and preterm birth, the current study sheds some light on its influence on African American women's choices for their pregnancy management. This passing on and down of beliefs and expectations via IGT is believed to be one factor in understanding the occurrence of preterm birth in African American women. Exactly how this customary process would be carried out may not be clearly understood at this time; however, IGT may be a powerful reinforcing engine of continued transmission of the cultural ideal of a strong Black woman that African American women seem to embrace.

In addition, these findings point toward the need for a better understanding of the memes and IGT as they relate to African American pregnancy outcomes.

Social support—Strength to make it through the day: A dimension of theme 1.
Additional insight into the lived experience of the African American pregnancy that ends in preterm birth is gained through an understanding of “Social Support—Strength to

Make it Through the Day,” the second dimension of the larger theme “Strong Black Woman Ideal” that is comprised of the relationship of social support and pregnancy outcomes. Social support is believed to promote maternal health for the pregnant woman (Lederman, 1984).

Pregnancy is typically a stressful experience characterized by psychological and physical changes. Supportive relationships have been shown to enhance feelings of well-being and personal control, which helps women perceive the changes they go through during pregnancy as less stressful (Norbeck & Anderson, 1989a). Although pregnancy is not uniformly stressful for all women, a growing body of knowledge that indicates that women who experience especially high prenatal stress are at greater risk for poor outcomes than women who experience mild to moderate amounts of stress (Lobel, Dunkel-Schetter, & Scrimshaw, 1992; Turner, Grindstaff, & Phillips, 1990). Therefore, the effects of social support for these women may be beneficial to help buffer the effects of stress, resulting in better pregnancy outcomes.

Research documents that social support is a significant determinant of individual differences in reaction to stress (J. W. Collins & David, 1993). When examining the critical effect that stress has on African American women’s lives and the potential contributions of stress to preterm birth, social support in the lives of African American women was found to build stress resistance and serve as a buffer when stress is present (N. L. Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993; Edwards, et al., 1994; Glazier, Elgar, Goel, & Holzapfel, 2004; Mullings, et al., 2001; Savage, et al., 2007).

Within the context of the dimension “Social Support—Strength to Make it Through the Day,” the participants described how much they relied upon the assistance of

their mothers, grandmothers, and mother figures to help them maintain an attitude of strength by reminding them how strong they were or how strong they needed to be. Participants described how they were able to manage the many responsibilities placed upon them by having their mothers and/or grandmothers there to provide social support for them. The importance of social support to pregnancy is evidenced (Booth, Mitchell, Barnard, & Spieker, 1989; Browne, 1986; Gottlieb & Mendelson, 1995; Liese, Snowden, & Ford, 1989; Mercer, 1995; Mercer & Ferketich, 1990; Norbeck & Anderson, 1989a; Norbeck & Tilden, 1983; Younger, 1991), with most studies revealing that social support was a buffer for stress.

Authors Rothberg and Lits (1991) and Hodnett and Fredericks (2003) found social support to be positively correlated with birth weight, while Norbeck and Anderson (1989a) found a decrease in pregnancy-related complications when women received strong social support. Mann et al. (1999) examined the personal lived experiences of pregnancy for four African American nurse-midwives, finding that social support was very important for relieving some of the stressors during pregnancy. Finally, in an earlier study, Mann et al. (1999) reported that supportive relationships in pregnancy were viewed as important for shaping the identity of the pregnant woman as a mother, enhancing her self-esteem, developing and supporting her parenting efforts, and refining her ability to maintain an intimate relationship and give unconditional love while creating a feeling of social connectedness.

The findings by Mann et al. (1999) emphasized that effective social support during pregnancy was a critical element affecting the quality of the personal experience of pregnancy. Studies by Mackey and Boyle (2000), Lewis (1988), and Green (1990)

found that utilization of traditional African American networks (family and community), especially including the support of the mothers of the pregnant client, helped reduce the amount of stress the participants experienced.

Some researchers contend that social support is believed to reduce the incidence of preterm birth, as it provides a buffer during times of stress (Mackey & Boyle, 2000; Mann, 1999). However, other studies have shown that social support may not be a main or buffering effect of preterm birth (N. L. Collins, et al., 1993; Hedegaard, Henriksen, Secher, Hatch, & Sabroe, 1996; Pagel, Smilkstein, Regen, & Montano, 1990). This would hold true for participants in this study; especially if the persons providing the support are visual reminders of how inadequate they are as Black women because they are unable to maintain the image associated with their gender and race.

Participants' perceptions of how the social support they received from their mothers, grandmothers, and/or matriarchal figures played a part in their pregnancies were predominantly positive. The connection between support and pregnancy outcomes may be more complicated for African American women. In fact, the support may be negative or even precipitate premature birth outcome in a fragile pregnancy. The people to whom the women looked for their support may be the same ones who encourage, uphold, and expect them to emulate and maintain the strong Black woman tradition, regardless of how tired, sick, overwhelmed, or stressed they were. African American mothers, grandmothers, and mother-figures may be "pillars" of strength who, on the one hand, supported them as embodiments of the strong Black woman, while, on the other hand, reminding them of just how inadequate they were as Black women when/if they

did not show the same strength and stamina that is attributed to Black women. This dissonance may be an additional stressor instead of a support for women.

For the participants, social support was viewed as both a support and a stressor. Social support was considered a stressor when those providing the support were a reminder of how inadequate they were as strong Black women. Normally social support from the participants' mothers and/or grandmothers would have provided a buffering effect to their pregnancy. However, because the mothers and grandmothers represented women who were "pillars" of strength, and were viewed as strong Black women by the participants, their social support was at times a stressor. The expectations placed on the participants by their mothers and grandmothers, as they often reminded them that they had to be strong, may have created more stress. There they were, "trapped" between needing social support from their mothers and/or grandmothers, and having to be reminded of their strength, and expected to perform as women of strength. This situation created stress from feeling as though there were no other options. These findings may shed light on future research that looks into just how effective matriarchal social support is for African American women if the matriarchal social support contributes to stress.

Theme 2: Feeling trapped. The next theme, "Feeling Trapped," provides insight into those factors in the participants' lives that may have caused them to feel they had no recourse and no way out of the situations they faced. Participants' perception of their world often left them feeling trapped by stressors associated with the multiple roles they played their culture, and the demands placed upon them. Feeling trapped essentially points to the inability to meet the unrealistic expectations of two or more situations; "a

position or situation from which it is difficult or impossible to escape” (Merriam-Webster, 2009).

The numerous roles and responsibilities expected of the participants often left them feeling trapped by their thoughts, by the influential women in their lives, and by the customs and ideal of a strong Black woman dictated by a culture that demanded that they hold true to the standards and expectations assigned to the role. These factors when experienced together caused the participants to feel as though they did not have any other recourse. They simply felt trapped, with no way to change their present situation. Feeling trapped caused the participants stress.

The Strong Black Woman Ideal can lead to an inevitable downward spiral in which women feel trapped between two warring personas: (a) their public image or ideal of strength attributed to Black woman and (b) their inner self who may be struggling physically and emotionally trying to maintain an ideal that is expected. African American women have traditionally tried to live a life that is exemplary of Black women. The strong Black woman ideal is an inescapable part of their lives, passed on through many generations, as far back as slavery. Although the ideal has been associated with self-worth, perseverance, and strength, it simultaneously has become a stressor for some women as they have felt trapped by the ideal. This sense of feeling trapped along with the harmful effects of the stress may contribute to preterm birth.

Two dimensions of Theme 2 reflect how participants responded to stressors and how they felt as though their lives were out of control because of new and unexpected stressors that added insult to injury. These two dimensions are (a) “How I Respond” and (b) “Out of My Control.”

How I respond: A dimension of theme 2. The dimension “How I Respond” points to the response to certain stressors. Participants in this study were overwhelmed and frustrated as they tried to meet the expectations placed on them by the constant demands of their families, their jobs, their pregnancies, and their role as strong Black women. More and more they found themselves unable to manage the many expectations they were responsible for meeting. This resulted in feelings of being trapped, as the combined and dissonant values, beliefs, and expectations the participants had for themselves coupled with those expected of them as strong Black women, caused additional stress.

The expectations of the historical strong Black woman ideal did not allow the participants the luxury of stopping, sitting down, or taking care of themselves. Instead of this ideal providing the participants with strength, they often felt weighted down by the burden of having to be strong in order to maintain an ideal and role that was often physically and emotionally taxing. Participants felt caught between maintaining such an ideal and choosing not to be governed by its expectations. Either way, the situation caused feelings of being trapped.

When trapped, participants would often fulfill what they thought was the strong Black woman ideal no matter the cost to them physically, to avoid hearing their mothers and grandmothers say that they needed to be stronger. It was not uncommon for the participants to over exert themselves to the point of exhaustion in order to make sure that they fulfilled every need and every role assigned to them, not only as mothers and wives/significant others but also as strong Black women. These expectations created an environment of stress, as the participants’ lives seemed to revolve around the needs of

everyone except themselves as pregnant women. The needs of others always seemed to trump their personal needs.

Equally, the participants were stressed at themselves because they, too, had high, often unachievable and unrealistic, expectations of themselves that they tried to uphold. They were figuratively trapped between who they were on one hand, and who they were told to be and who they felt they should be, on the other hand.

These conflicting demands affected how they responded to the stressors and how the stressors and the stress response made it difficult for them to maintain control. Participants' response to the stressors did not necessarily alleviate the stress; instead, they seemed to feel even more trapped by it. It did not give them freedom to take care of themselves without feeling guilty. These feelings of being trapped by the stress of expectations seemed to surface when the participants did not see a way to change or alter their circumstances, and the demands and expectations as a strong Black woman, the demands as a mother, spouse, and the demands of the pregnancy.

The strong Black woman ideal is at the heart of the paradox that has many Black women suffering emotionally and physically from what Randolph (1999) called the "Strong Black woman Blues" because they cannot figure out whether to view this ideal as "a friend or an enemy, or an asset or a liability" (p. 24). Perhaps living up to this ideal in non-pregnant circumstances was less of a stressor; but, in pregnancy, the ongoing, non-stop expectations in all the roles they were expected to perform exacerbated their existing stress load.

In a national survey of more than 1 million African Americans by Black Entertainment Television (BET), the National Medical Association, the National Black

Nurses Association, and the National Dental Association, 79% of the Black women who responded said that they had experienced mental health problems as a result of trying to maintain the strong Black woman ideal that expects women to strive to be the accomplished professional who can handle any life crisis, while simultaneously caring for the family, friends, neighbors and the community (Randolph, 1999).

Other research has suggested that African American women may internalize their role designation into an unobtainable superwoman, strong, Amazon, masculinized or matriarchal image, with roles and responsibilities that may be in direct opposition to their emotional, physical, and psychological needs (Amankwaa, 2003; Carrington, 1980; V. Chambers, 1996; P.H. Collins, 1990). This ideal has them trapped and may place undue burden and create further psychological and physiological taxing of the body.

Authors Halle and Johnson (1989), report that a number of behavioral scientists believe that Black females have been nearly destroyed psychologically and physiologically by trying to maintain the strong Black woman ideal. As noted earlier, this strong Black woman ideal contributed to feeling trapped as mentioned in the strong Black woman theme.

Research indicates that there are negative physical and psychological consequences for African American women who try to fulfill this ideal (Boyd, 1995; Harris, 1996; Morgan, 1999; Young, 1989). The stress response of trying to fulfill all of the unrealistic roles associated with this ideal may have caused the participants to feel trapped emotionally, psychosocially and physiologically. This trapped feeling and the stress response associated with it may have had a negative impact on the participants' pregnancy outcome.

The extensive research on stress and its association with preterm birth has predominantly examined White women. Very little research examines stress, pregnancy and African American women. Research that examines stress in the White population cannot be generalized to other races. Stress may affect those of one race differently than it affects another, and how one population deals with stressors may be different than how other populations deal with stressors. Finally, how the multiplicity of different stressors affects one population may be different than how it affects another.

For African American women, complex interactions rather than a single risk factor may be significant in explaining why they may be more impacted by stressors than other women. Perhaps one reason for this disparity is the number of stressors, unique to them that these women experienced. Stressors are believed to impact the immune system. Psychosocial stressors and perceived life stressors are suspected risk factors for bacterial vaginosis. Bacterial vaginosis has been associated as a risk factor for preterm birth and is known to be more prevalent in Black women than in White women (Bodnar, Krohn, & Simhan, 2009). This example points to a possible link between Black women's response to a unique combination of stressors and their higher number of preterm risk factors. Further research in this area of study may uncover other stressors that may be specific to pregnant African American women.

Out of my control: A dimension of theme 2. Participants described how difficult it was for them to balance the plethora of responsibilities of caring for their families, maintaining their homes, and working on their jobs while dealing with the physical and psychological effects of their pregnancy. For the participants, their ability to manage their lives began to wane significantly when unexpected, acute stressors arose. These

unexpected, acute stressors, coupled with the existing difficulties created an atmosphere which they felt they could no longer effectively manage, either emotionally or physically. For example, one participant talked about how she “lost it,” from an emotional perspective, when her car caught on fire as she was trying to get her daughter to the sitter so she could go to work. She was already overwhelmed by the amount of responsibility she had to endure since her significant other was in prison and unable to provide any social support. The fact that the car blew up only compounded her stress level, making her feel out of control as she was unable to manage all of the responsibilities.

Acute life events experienced by the participants during their pregnancies, coupled with the inability to strike a balance due to the excessive demands placed on them, created an environment of stress. The stress participants experienced may have been exacerbated by the superimposed responsibilities of new and unexpected events, which may have created more stress for them. The unabated stress may have contributed to preterm birth as it is believed to activate the hypothalamic-pituitary-adrenalin system, which has been implicated in the onset of labor (Wadhwa, et al., 2001).

Stress increases the release of corticotrophin-releasing hormone (CRH) from the hypothalamus, which promotes prostaglandin production resulting in cervical softening and uterine contractions as it potentiates the effects of oxytocin, which causes uterine dilation and effacement. Uterine dilation and effacement for the patient who is preterm may result in preterm birth of the baby (Culhane, et al., 2001; Dole, et al., 2003; Dominguez, Dunkel-Schetter, Mancuso, Rini, & Hobel, 2005; Hogue & Bremner, 2005; Kramer, et al., 2001; Lobel, et al., 2008; Roesch, Dunkel-Schetter, Woo, & Hobel, 2004; Wadhwa, et al., 2001; Whithead, Hill, Brogan, & Blackmore-Prince, 2002).

Experience with multiple stressors may have caused the participants to feel as if they were no longer in control of their lives, resulting in a challenge to allostasis.

Allostasis, which is the body's ability to maintain homeostasis as it adapts to acutely stressful environments, is challenged in situations of frequent stress when there is an excessive demand on the body's regulatory systems (McEwen, 1998b).

Women who are unable to manage inordinate amounts of stressors during their pregnancies may experience high allostatic load. Allostatic load provides a measure of cumulative effects of exposure to stressors and the physiologic stress responses that occur over the life-course. High allostatic load as quantified by an index of biomarkers occurs when the body's normal physiologic responses to stressors are no longer able to adapt as a result of the stressors (Lu & Halfon, 2003; McEwen & Stellar, 1993).

Research has shown that some pregnant women are able to manage inordinate amounts of stressors during their pregnancy yet may never experience high allostatic load, while others do experience allostatic load managing only a handful of stressors (Hobel, Goldstein, & Barrett, 2008) Hobel, Goldstein, and Barrett (2008) hypothesized that one reason some women may experience high allostatic load while others do not may have something to do with the kind of stress they may have been under prior to the pregnancy. There are indicators that suggest that the cumulative effects of stressors may "weather" African American women, which makes them more susceptible to adverse birth outcomes (Geronimus, 1992). Weathering, which is a build-up of wear and tear on the body, makes them more susceptible to poor pregnancy outcomes.

Heavy psychological and physical load, such as exposures to violence, negative health behaviors, loss, racism, low socioeconomic status, and lack of social support are

examples of the many stressors that may contribute to increased allostatic load and negative birth outcomes for African American women (Hobel, Goldstein, & Barrett, 2008). For women who experience allostatic load, the somatic function over the life course is impacted, resulting in the wear and tear physiologically experienced during an acute stress response by activating the autonomic nervous system. This build-up of “wear and tear” on the body may lead to dysfunction over a period of time, manifesting in increased risk of negative birth outcomes (Hobel, et al., 2008, p. 337).

Jackson et al. (2001) hypothesized that the stressors that precede pregnancy in African American women, especially exposures to violence, negative health behaviors, loss, racism, low socioeconomic status, and lack of social support, may be exacerbated by the pregnancy and are believed to intensify with the introduction of additional stressors. It may be that African American women have a higher allostatic load than White women, which could be linked to poorer pregnancy outcomes.

If there is a difference between Black and White women’s experiences with allostatic load, it may be explained by gendered racism. *Gendered racism* is a term coined by Essed (1991) for the combination of gender and race which is generic to Black women. As females, Black women experience some form of sexism similar to that experienced by White women. As a member of the African American race, they experience some form of racism that is similar to that experienced by African American men. But they are unique in that they have to endure the effects of both. The Black female shares racial oppression with Black males and sexual oppression with White females. Her situation is still unique because she may be oppressed sexually by males of any race and racially by Whites of either gender. Because the Black woman has had to

also endure negative stereotypes imposed upon her throughout history, she may experience sexual oppression in a different way than White women experience sexual oppression (Halle & Johnson, 1989).

Gendered racism proposes that African American women are exposed to unique forms of oppression due to their simultaneous “Blackness” and “femaleness” (Essed, 1991). This positions Black women as a double minority, with limitations and stressors imposed on them because of who they are. Although research in the areas of racism and sexism often tests the two phenomena separately in African American women’s lives as if they were independent processes, African American women experience the two simultaneously, whereas White women may only experience sexism (A. J. Thomas, Witherspoon, & Speight, 2008).

As a stressor, gendered racism, coupled with other acute stressors, may exacerbate allostatic load for African American women. Additional research is needed to shed further light on the relationship between pregnancy, preterm birth, African American women, stress, and allostatic load. Failure to examine gendered racism in studies of pregnant African American women may be a serious oversight that could result in the underestimation of stress and factors affecting allostatic load that may help in understanding adverse birth outcomes.

In a study by Jackson et al. (2001), 474 African American women collaborated in an interactive research process to test a pilot stress instrument. An analysis of the qualitative and quantitative data from the responses of a subsample of 167 college-educated women was conducted to determine how the women experienced racism as a stressor. After the instrument had been tested, it was used to assess stress. The responses

of the women revealed that the stressors of gendered racism that precede and accompany pregnancy may be risk factors for adverse birth outcomes.

The experience of gendered racism is believed to heighten the participants' cumulative burden. The participants' response to the stressors from the events during the course of the day, coupled with the stressors of gendered racism, may have increased their susceptibility to adverse birth outcomes. What is certain about gendered racism, whether it is conceptualized as a form of stress or whether it is a factor that intensifies the impact of stress, it is associated with unfavorable effects on health (Giscombe & Lobel, 2005).

These findings are consistent with findings in this study. Further research on the body's response to prenatal stress for African American women is needed.

Intergenerational Epigenetic Inheritance (IGEI) and Transmission. The biophysiological effects of stress as a result of various stressors, may impact generations. Insight into how generations of African American women may be impacted by parental experiences and exposures may be understood through the examination of intergenerational epigenetic inheritance (IGEI), where genetic inheritance is not changed but gene expression, which is the phenotype, is altered in later generations (Harper, 2005). This concept may provide additional insight on the African American pregnancy and preterm birth.

IGEI is a physiologic phenomenon, which refers to changes in phenotype (appearance) or gene expression caused by mechanisms other than changes in underlying DNA sequence. Stress precipitates a physiologic response that is mediated through IGEI. Organisms in future generations then react to stressors in a fashion similar to their

ancestor who had the experience. Harper (2005) claimed that just as maternal stress during the latter half of a daughter's gestation could affect the daughter's physical growth, it may also affect the grand-offspring's physical growth.

Epigenetic inheritance is an alternative explanation that goes against the idea that one's inheritance is strictly through the DNA code that is passed from parent to offspring. Instead, the parent's experiences, in the form of epigenetic tags, can be passed down from generation to generation even when offspring do not personally experience the condition that led to the parental trait (Genetic Science Learning Center, 2009).

Exactly how the mechanisms involved in epigenetic changes take place in humans is not yet fully understood. What is known is that epigenetic modifications occur in cell differentiation, so that different genes are expressed and different messages are altered. Additionally, they are inherited by the daughter cells in cell division. During this time, most of the epigenetic changes are erased in the germ cells that produce the next generation, but some modifications survive and are passed on to the next generation (Harper, 2005).

Cowley and Griesel (1966) found that male grand offspring of female rats that were prenatally malnourished performed more poorly than controls, despite the fact that their mothers had been on a standard diet from conception through weaning. The effects of a low protein diet lingered across subsequent well-fed generations before reverting to original state. These findings in rats are clear examples of the epigenetic transfer from mother to offspring of adjustment conditions during the mother's early development.

A comparable phenomenon has been reported for human physical growth. Susser and Stein (1994) reviewed follow-up studies of the effects of Nazi embargo of food

supplies to western Holland during the days of WWII, during which time, fertility declined. For the women who experienced severe dietary restriction during the last trimester of pregnancy, but delivered viable offspring, there was a correlation between the neonate's birth weight and maternal weight at delivery. A follow up sample to the second generation which was conceived and reared under no food restrictions, indicated a lingering relationship between the mother's birth weight and the birth weights of their offspring.

IGEI seems to imply that experiences during a crucial period of life could influence more than one generation through altered gene expression. Comparatively speaking, if a pregnant woman's grandmother had been exposed to stressors during their pregnancy with their daughters, then the daughters (fetus) and the daughters' reproductive cells may have received the gene expression that may modify the stress response regulatory mechanisms that occurs at a systems level. The current understanding is that at least three generations may receive the gene expression that may modify the stress response as a result of the parent being exposed to an environmental stressor: (a) the pregnant mother, who is the first generation; (b) the fetus, the second generation; and (c) the reproductive cells of the fetus, the third generation (Genetic Science Learning Center, 2009).

IGEI and the transferring of the gene expression that regulates the stress response may negatively impact pregnancy outcomes. If the participants' grandmothers experienced environmental stressors while pregnant with the participants' mothers, then the participants may experience the triggering of switches for a stress response pattern that is passed down from generation to generation. Exactly what types of environmental

conditions trigger the activational effects of hormones in subsequent generations is not fully understood. However, according to researchers, specific stressors, such as stress from racism, may be one type of environment condition that may elicit a range of different behaviors depending on the cues present in the environment at that time (C. A. Blackmore, et al., 1993; David & Collins, 1991; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Rowley, 1994). Shepard, Michopoulos, Toufexis and Wilson, (2009) indicated that individuals exposed to a psychosocial stressor such as racism, may respond differently to the effects of a gonadal steroid than individuals not exposed to chronic stress.

Stress was noted as one of the emergent dimensions of the theme “Feeling Trapped.” In addition to the acute and chronic stressors the participants experienced during their pregnancies, the trigger activation of the gene expression that regulates stress response that was passed down from their mothers and grandmothers prior to their birth may contribute to poor pregnancy outcomes in combination with allostatic load.

Since allostatic load affects multiple regulator systems, there is the possibility that a pregnant women who experiences chronic life challenges or stressors may experience physiological effects on the pregnancy. This scenario, coupled with the matriarchal transferred gene expression that modifies the stress response, may play a strong role in exacerbating a situation for the participants.

When situations are perceived as being out of one’s control, it adds another level of stress on top of existing stressors. Although the participants may not have been aware of any IGEI transmission, or may not have reported any overt issues of gendered racism, they still may exist. Either situation may place the participants at a disadvantage

physiologically, as they are not able to control the effects of each. They are trapped by their past, trapped by their present situation, and trapped by the future generational effects of IGEI and gendered racism. These trappings may have long term negative reproductive effects for them and their offspring, as persistent high-effort coping with exposure to acute and chronic stressors are known to have a profound biophysiological effect which could lead to dysfunction of the systems over time (James, Keenan, Strogatz, Browning, & Garrett, 1992; McEwen, 1998a).

Because allostatic load affects multiple regulator systems, it can impact the pregnancy in ways that may result in preterm labor and birth because of the release of stress hormones (glucocorticoids and catecholamines), which causes an increase in heart rate and blood pressure, and a decrease in blood flow to the placenta. This cascade of events results in uteroplacental insufficiency, thus compromising the fetus.

No research was found relating IGEI to stress, African American women, allostatic load, pregnancy, or preterm birth. Current data are lacking regarding the possible relationship of IGEI to pregnancy and preterm birth. This paucity of data clearly underscores the need to expand research initiatives to consider gene-environment interactions for better understanding of the impact IGEI may have on pregnancy and preterm birth.

Conclusions

The purpose of this study was to grasp the essential meaning or themes of the lived experience of the African American pregnancy that ends in preterm birth in order to provide an understanding of these experiences as they relate to the phenomenon of preterm birth. That purpose was realized by rigorously employing the phenomenological

methodology that permitted obtaining the lived experiences of the study participants as only they could report. Through interviews, narratives describing the essence of these experiences were obtained, and the general themes “Strong Black Woman Ideal” and “Feeling Trapped,” which were commonly shared by the participants, emerged. The dimensions “Can’t Be Weak; Gotta Be Strong,” “Social Support—Strength to Make it Through the Day,” “How I Respond,” and “Out of My Control,” resonated with each participant.

From an examination of the existing knowledge in the literature, specific concepts were reviewed that emphasize intergenerational influences on participants. These concepts closely aligned with the themes that emerged from the study.

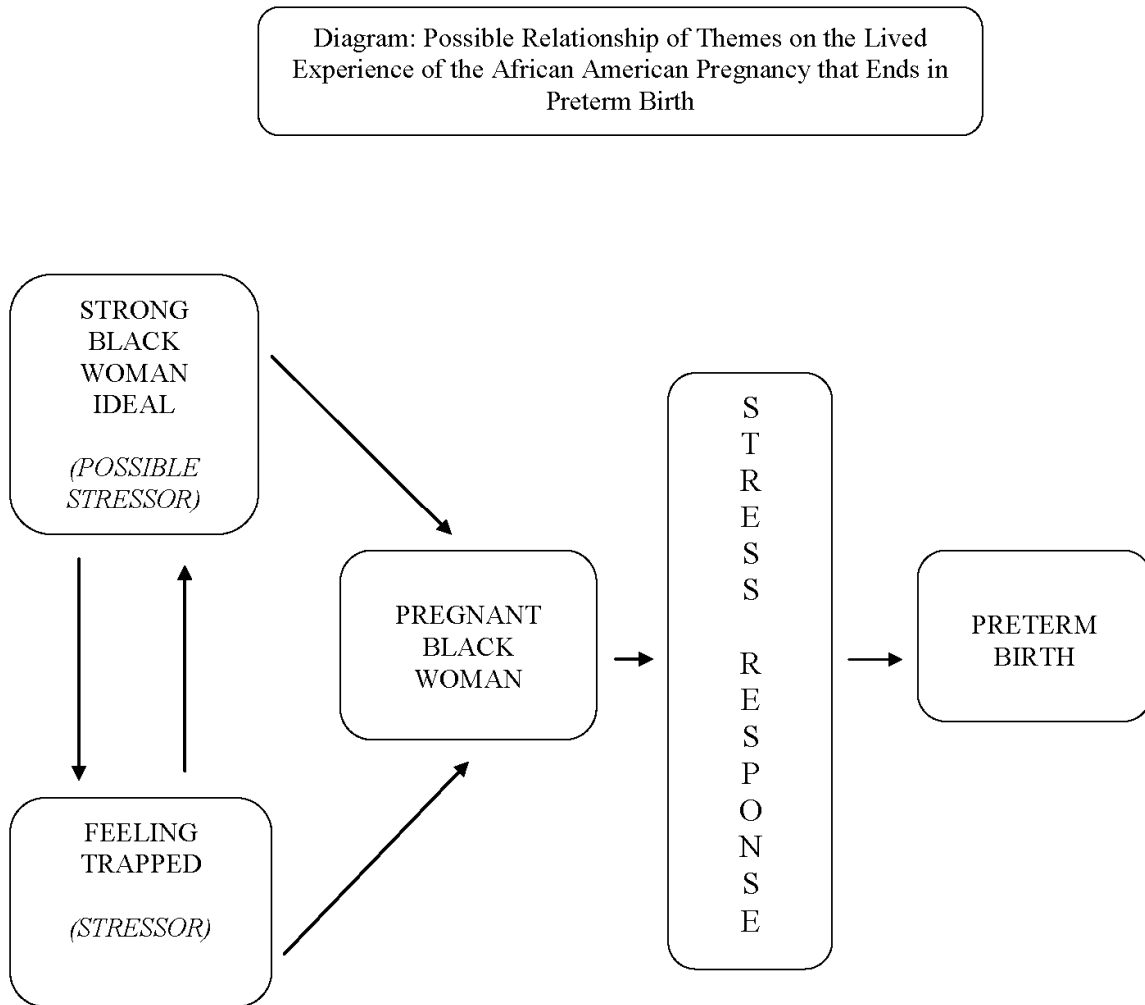
Current data are lacking regarding the impact that memes, IGT, and IGEI may have on pregnancy and preterm birth. However, these three concepts provide a glimpse of the possible complexities which may surround the African American pregnancy, as they are closely aligned with the themes “Strong Black Woman Ideal,” and “Feeling Trapped.” This study on the lived experiences of African American pregnancy that ended in preterm birth provided direction for fruitful research regarding how the lived experiences of one generation may impact future generations.

An illustration of the themes derived from this study and how they relate to the lives of the African American women are noted in Figure 2. The two essential themes: Strong Black Woman Ideal and Feeling Trapped described the essential aspect of the phenomenon. This illustration provides a simple visual presentation of the possible relationship of the themes on the lived experience of pregnancy that ends in preterm birth. These themes may reflect influences passed on from generation to generation

through various means, such as memes, IGT, and IGEL, which may impact pregnancy in a way unique to African American women, as they initiate a stress response by the body that may precipitate preterm birth.

An examination of the lived experiences of the African American pregnancy that ends in preterm birth provides insight for future research to understand factors that may be related to preterm birth for this population. Specifically, while it is safe to say that stress, stressors, and stress responses are experienced by all pregnant women, African American women are unique in their experiences because of the cumulative effect of living a life that is driven by being trapped by an often unattainable, unhealthy expectation of the “strong Black woman ideal,” in combination of cultural expectations, experiences of life events, such as gendered racism, that is unique to them, and possible intergenerational transmission of various factors. The impact of any one of these factors, or a combination of several, may contribute to poor pregnancy outcomes.

Figure 2. Possible relationship of themes on the lived experience of the African American pregnancy that ends in preterm birth.



Consideration of the findings and subsequent analysis resulted in the following conclusions regarding possible risk factors for African American women:

- The cultural expectation is that a “strong Black woman” can skillfully shoulder life’s myriad demands
- The availability of strong psychosocial resources is a myth that compounds stress within a pregnancy.
- Gendered racism may be a particularly salient source of stress for pregnant African American women as their health is inextricably linked to the high stress states or stressors created by a social system with persistent undercurrents of racial discrimination. Conscious awareness of racism as a stressor may not be necessary to result in psychosocial stress responses.

Other possible risk factors suggested by the research that warrant further investigation include the following:

- Stressful life styles may prematurely age African American women thereby affecting biologic processes that are necessary for healthy pregnancies.
- African American women appear to experience high stress, but they may not appraise the events as stressful or social support may mediate their stress.
- Whereas some research indicates that social support buffers a stressful situation and reduces the chances of poor pregnancy outcome, social support may also create an atmosphere of stress if those providing social support cause the recipient of the support to be stressed by their presence. In this case, social support may serve as a detriment to a pregnancy.

- Stress as it relates to preterm birth, appears to be associated with behaviors imitated, consciously and unconsciously, as members of a group observe and copy one another.
- Intergenerational transmission of parenting behaviors and memes may involve imitation of stressful behavior.

These possible risk factors highlight the specific types of stressors experienced by African American women and the sources of these stressors. A better understanding and recognition of sources of stress, including those that may be passed down through generations, may help to improve reproductive outcomes and preterm birth rates particularly in African American women.

Strengths of the Study

A major strength of this study was the examination of data from the participants' perspective. Each participant's lived experience was specific and unique as she remembered and described the phenomenon. The lived experiences provided insight into the experience of preterm birth and the dimensions underlying it in this population. This research provided a clear picture, as contributions to research can be best made by acknowledging the unheard voices of Black women.

Strength of this study lies in its methodology, which may be beneficial to future research. Phenomenological research offers an opportunity for participants' voices to be heard and provides a framework for organizing those voices into theory that can guide future explorations. Future explorations in the phenomenon of preterm birth from the perspective of the African American woman will help researchers gain perspective on causes of preterm birth in this population.

Limitations of the Study

This study has sampling limitations as it examined the lived experiences of African American women in a specific region of West Virginia. In addition, it examined a primarily white collar population. Therefore, replication with a different population may be warranted. As with all qualitative research, the sampling method is aimed at variation to increase the richness of data extracted to identify essences. It is not aimed at representation of the population of African American women whose pregnancies ended in preterm birth. The user of the research must make the determination of applicability based on the description of the sample.

Implications for Nursing Research

Given the seriousness of preterm birth as the single most important cause of perinatal morbidity and mortality, a focus on research efforts that looks at various aspects of the lived experience of African American women may provide additional insight that will assist in revealing possible causes or contributors to preterm birth. Several possibilities for future research exist. This section discusses possible avenues for further research that may help develop some of the findings revealed by this study. Below are several recommendations.

Measuring the strong Black woman ideal and strategies to reduce negative effects. Research that quantifies and measures the impact of the strong Black woman expectations and identifies ways to quantify and measure the impact this ideal has on pregnancy outcomes is needed. The strong Black woman ideal is believed to have been passed on through memes and IGT.

Development of questionnaires and inventories that measure components of a strong Black woman ideal may provide useful data. This information would provide a basis for researching the influence of various components in preterm birth. Once the characteristics of this ideal are understood as being positive or detrimental to their pregnancies, Black women may be able to free themselves of this ideal, and begin to reduce the stress associated with trying to maintain such an image.

Once a tool for identifying the variables associated with the strong Black woman ideal has been developed, a tool that measures the amount of stress this ideal produces may be necessary in order to assess for a correlation between the strong Black woman ideal, stress, and preterm birth. Screening for stressors, such as the stressor of trying to attain the strong Black woman ideal, may allow the health care providers the opportunity to examine stress in relation to this ideal.

Strategies that investigate just how our actions are driven by our conscious and unconscious thoughts, which have been partially conditioned by our knowledge acquired from our parents, perhaps through memes (efficiency of parenting) and IGT, may be needed to help maternity patients unlearn old thoughts in order to deal with ongoing challenges that might predispose them to preterm birth. Because people use old thoughts to deal with new challenges, there is a tendency to repeat behaviors of the past. Further research is needed to develop interventions that will assist African American women unlearn behavior associated with being a strong Black woman that might be a stress-inducing and/or detrimental to their health.

Interventions that will assist African American women in learning how to be strong women without neglecting themselves are needed. There does not appear to be an

easy or quick fix that will counteract the negative image effects of living in a society that has regarded African American women as “beasts of burden” and martyrs because this ideal is deeply embedded in their thoughts. Early identification of women who feel that their role is one of superwoman may eliminate or decrease the incidence of preterm birth in this population. Therefore, further research is needed in understanding the impact memes and the role of IGT of parenting may have in the cultural perpetuation of the strong Black woman ideal that may be viewed as a stressor. Identifying these types of stressors prior to pregnancy may decrease the risk associated with trying to achieve or maintain this ideal.

Currently, African American women’s worldview may hamper turning away from the historical strong Black woman ideal ingrained in their culture. Identifying strategies that help Black women see that this ideal does not need to define who they are should be that they have alternative choices to the superwoman ideal. Alternative choices may help change their mindset of striving to be a strong Black woman. This may prove helpful in freeing Black women from a life-time of stress that results in mental, physical and emotional exhaustion. Such a tool may also help health care workers identify prenatally, which women are negatively affected by trying to maintain the strong Black woman, and which women may be more susceptible to preterm birth.

Measuring stress levels. Research that looks at the relationship of being a strong Black woman and stress is needed. Further research would need to look at the degrees of a strong Black woman ideal and compare them to see if those who rank the highest are more likely to experience preterm birth as compared to those who rank the lowest. Findings from such research could contribute to practice, as these findings may be useful

in educating nurses, African American women, and the public about factors that predispose African American women to stress and strategies to overcome them. Early identification, assessment, and stress-reducing interventions for a woman who has a high level of stress associated with the strong Black woman characteristics could mean the difference between a pregnancy with good instead of poor outcomes if known early on in the pregnancy.

As suggested in this study, the strong Black woman ideal contributes to stress, but research that determines just how much the strong Black woman ideal relates to stress. A possible stress-screening instrument might be helpful in measuring prenatal stress in African American women during pregnancy. This screening tool might be used for early identification of African American women experiencing high stress. The results of the screening tool would identify whether a woman is experiencing mild, moderate or severe levels of stress. Interventions that would include ways to de-stress would be helpful in meeting each woman's needs.

Until such instruments are devised, a screening tool which asks simple questions during prenatal visits to assess the woman's stress level would be helpful. These questions could include the following:

1. Is there anything happening in your life right now that is causing you stress?
2. What is the source of the most stress today? This week?
3. What is it that you worry about the most?
4. What are you doing to help cope or deal with worries and stress?

Asking all of these questions are good ways to help the patient talk about stress in her life.

Currently, there is no single instrument that incorporates all of the critical components needed for adequate screening of maternal stress in women. More research is needed to identify valid indicators of stress and appropriate interventions. Furthermore, there is no known tool that specifically screens for maternal stress experienced by African American women. Because their stressors have been identified as being specific to them (e.g., gendered racism), the development of such a screening tool that assesses for perceived stressors may be of significant benefit to health care workers in understanding how psychosocial stressors may affect pregnancy outcomes for this population. A single, comprehensive instrument, specifically designed to measure the degree to which situations in one's life are considered stressful, and to assess the person's sense of control over her daily life demands may assist in early identification of women who may be at risk for stressors that might disrupt allostasis. Various kinds of Perceived Stress Scales have been designed to provide this type of data; however, one specific to African American women and the stressors unique to them is needed.

Pregnancy race-specific risk factor. Additionally, development of a race-specific risk factor inventory such as Beck's (2002) Postpartum Depression Predictors Inventory-Revised (PDPI-R) tool may prove helpful in identifying exactly which risk factors may make African American women susceptible to preterm birth. Unlike the PDPI-R, a race-specific risk may need a self-reported assessment from these women. Phenomenological research has shown that a person's lived experience and what he or she perceives as stressful may provide a more accurate measure of stress because it accounts for the individual's response to the situation rather than measuring the

occurrence of actual stressful events. The lived experience provides a perspective that no other methodology can provide.

The goal of such a tool would be to allow health care providers the opportunity to screen for the identified perceived pregnancy stressors that include stressors related to being an African American woman. A person with stress that specifically relates to the identified stressors, not to exclude race, before and during the pregnancy, may have an ongoing detrimental effect during each trimester of the pregnancy. Identifying race-specific risk factors and stressors will allow for the acknowledgment of any factors that might normally predispose the woman to higher risk of having a preterm baby once she becomes pregnant. More research is needed to identify valid indicators.

Focus groups for the development or improvement of questionnaires. Focus groups may prove helpful in assisting women to identify how the role of being a strong Black woman, feelings of being trapped by this role and other expectations, may have contributed to preterm birth as a result of the stress associated with each. Focus groups which provide opportunities for women to interact with other African American women around concerns that impact their lives may prove beneficial in identifying the common need or expectation to be a strong Black woman, defining what this really means to them, and discussing ways to eliminate the stress associated with trying to obtain this ideal. Focus groups are a useful means for eliciting the views of the people, and are effective for the development or improvement of questionnaires in specific populations. Through such group interactions, a clearer understanding of the lives of pregnant African American women during their pregnancy may contribute to the existing knowledge regarding the impact attaining and functioning according to the strong Black woman ideal

characteristics, stress from feeling trapped by this ideal and how they relate and interact with poor pregnancy outcomes such as preterm birth.

Intergenerational epigenetic inheritance and transmission. Ongoing research is needed to determine the magnitude of such indirect exposure to stressful environments or stressors, and how it affects the body physiologically, impacting pregnancy outcomes is needed. What this research provided was an understanding of how the environment one is exposed to may influence the disease or condition in the offspring, possibly affecting the second and third generations who were not directly exposed to that environmental condition (Youngson, 2008).

To provide a convincing case for epigenetic inheritance, an epigenetic change needs to be observed in at least three generations in order to properly evaluate the different sources of IGEI (Harper, 2005, Jablonca & Lamb, 1995; (Simons & Johnson, 1998) and how it might affect pregnancy outcomes. Further research, requiring insightful design, on stress reduction interventions is needed to assist in reducing the preterm birth rate for African American women.

Research examining the role of allostasis, allostatic load, and stress. Further research on the physiological effects of stress in relation to preterm birth is needed. Any new stressor, on top of existing stressors, may interfere with allostasis, resulting in altered stress response. Research examining the relative contribution to allostatic load of the unique stressors reflected in the two themes “Strong Black Woman Ideal” and “Feeling Trapped” may be useful in parsing out the contributors to preterm birth, thus assisting in the possible explanation of the racial disparity in preterm birth rates. Insights into causes of preterm birth will facilitate the study, development and testing of strategies to reduce

the number of preterm births that occur daily. Although a number of studies looked at various risk factors for preterm birth, socioeconomic, biological, and environmental factors do not explain the disparity in preterm births between African American women and White women (Jackson, et al., 2001; Mathews, et al., 2003; Mullings, et al., 2001; Schoendorf, et al., 1992). Research is needed that examines other factors less studied that may contribute to the persistent disparity between African American women and White women in the rates of preterm birth. A critical gap in the research to date has been the lack of study into the lived experiences of African American women, which, according to Patricia Collins (2001), is central to understanding Black women's needs, desires, and places in society. A better understanding of African American women's lived experiences of pregnancy and preterm birth in this study provided potential clues into factors underlying the disproportionately high rates of preterm birth among these women. Further collaborative research that reexamines the measures and methods employed in investigations aimed at uncovering the link between stress and poor birth outcomes is needed.

Implications for Nursing Practice

Nurses are in a unique position to develop models for culturally knowledgeable care that gives African American women the information and tools they need to assist in reducing the amount of stress experienced during their pregnancy. Providing culturally appropriate and culturally sensitive care are basic grass roots nursing skills that could make the difference between pregnancies that goes to full term versus one that ends in preterm birth.

Nurses who are knowledgeable of how stress and stressors affect African American women during their pregnancy, and ways to help intervene, alleviate, or reduce those stressors, may help reduce the number of preterm births. As interventions effective in reducing stress are identified and refined, they can be brought into the clinical practice to assist in reducing the preterm birth rate for African American women.

Culturally competent models of care that provide detailed instructions of ways to alleviate or reduce feelings of being trapped and stressed may be beneficial in helping to modify behavior that may reduce the incidence of preterm birth. Once culturally competent models of care are developed, new interventions that help women reduce risk factors and achieve positive birth outcomes may be helpful.

To meet the African American woman's specific need, nurses may need to modify their approach from the traditional viewpoint that does not take in consideration issues that they may struggle with as a result of their race, gender, and culture. This can be easily achieved since nurses are in a unique position to customize the culturally competent care provided for these women. Interventions that will provide them with the information and tools they need to assist in reducing the amount of stress experienced during their pregnancy must incorporate an understanding of how these women react to stressors.

Culturally specific interventions that assist with ways to better cope with stressors need to be identified, refined, and brought into clinical practice. Asking African American women what they consider to be helpful ways of coping, rather than assuming what is helpful, may assist in providing interventions that are more appropriate for their care. Better coping is believed to reduce adverse stress responses.

Systems in place that educate African American women about types of stressors they may encounter would be helpful. Nurses can provide educational interventions that do more than teach these women about stress reduction techniques but actually provide interventions that assist them in reducing stressors is needed. In providing this kind of care, nurses need to be culturally sensitive and culturally competent in the types of educational and relaxation techniques that may assist African American women in reducing stress. Standard interventions such as yoga, meditation, and relaxation training may not be sufficient to reduce stress in African American women. Meditation or relaxation may increase stress for African American women since they equate resting to “being lazy,” therefore, this type of intervention may not prove helpful. Interventions need to incorporate cultural competence to better help African American women reduce stress through coping styles and stress reducers that are specific to them. Nurses may become knowledgeable about coping styles and interventions that help reduce stress through the use of focus groups with other African American women, designed to allow dialogue which may identify coping styles and stress reduction techniques that these women use. The focus groups may become a form of intervention fostering the exchange of resources and experiences. Support groups and other group processes, generated from focus groups may help eliminate or reduce the number of preterm births in this population, as these women may reveal approaches for stress intervention.

Some research has demonstrated that social support systems may provide stress relief during pregnancy. However, social support has not been found to be a buffer in all instances. Social support for the participants of this study appeared to be both a benefit and detriment. Therefore, nurses should not assume that social support interventions will

be helpful for all African American women, especially if the social supporters are their mothers, grandmothers, or other close African American women. Their presence and assistance could create more stress. Social support interventions may need to be tailored so that the supporters function to reduce, not augment stress.

When establishing interventions that foster positive pregnancy outcomes for African American women, nurses need to be cognizant of the fact that stress from the effects of racism may not be as obvious as other types of stressors that these women may identify. Stress from racism may be more hidden and more difficult to pinpoint because it may not be personally lived, but experienced by other women in the family (i.e., grandmother, great-grandmother) who may have passed on through conversations of lived experiences their feelings associated with racism and oppression. Interventions must therefore include ways to assist African American women in identifying and then de-internalizing feelings of racial oppression. Because thoughts have a direct influence on our emotions, attitudes and behaviors, nurses are in a position to assist patients in interventions that replace the bad thoughts (de-internalizing feelings of racial oppression), with good thoughts and words of affirmation. Interventions that would boost self-esteem, such as through positive or positive repetitive thoughts with each prenatal visit may help to reduce feelings of racial oppression. Nurses who provide affirmative statements may help retrain the patient's brain and shift away from the negative stereotype associated with African Americans.

Retraining may take some time in helping to undo the damage that has been done, because changing their mindset to incorporate new values, new visions, and new beliefs will not come easy, as bringing about such change is often daunting. Change has been

noted to come more readily, and is more successful one individual at a time, one step at a time. If African American women are individually helped to understand that they are a key part of an intergenerational cycle that may include a destructive pattern of behavior handed down through generations, they may be able to interrupt this cycle and keep it from affecting their children and children's children. Grasping the seriousness behind the need to change their thinking, and being proactive and diligent about finding ways to alter this behavior may help several generations avoid poor pregnancy outcomes.

Nurses often serve as change agents who are instrumental in helping people understand the need to alter any detrimental thought processes. Nurses who teach cognitive reframing and/or thought stopping, which are techniques based on Aaron Beck's (1976) theory that a person's emotional response to an event is determined by what meaning is placed on the event, may be instrumental in helping to modify detrimental thought processes of African American women. By doing so, nurses help these women decrease the effects of cognitive stressors, such as intrusive thoughts or negative feelings from stressors, which could trigger a physiological response process with the release of stress hormones that are associated with preterm labor and subsequent early delivery.

New health care delivery systems might incorporate communities of lay African American women supporters who understand the oppression of racism. Empowering the communities in which African American women live is an adjunct to empowering the women individually. Empowering communities to become more effective at helping reduce stress, regardless of its origin, is needed to promote and perpetuate better pregnancy outcomes for African American women. Lay community members can be

trained, much as a doula is trained, to provide support for pregnant African American women as they try to break through or down damaging cultural beliefs, values, and racial oppression that may contribute to pregnancy stress.

Communities empowered to help women deal more effectively with stress may help to ensure a better pregnancy outcomes, as proposed by Persily and Hildebrandt (2008). The Theory of Community Empowerment which provided direction for improving health in communities through development of effective interventions at individual and community levels may assist nurses in developing interventions specific to the needs of African American women.

Summary

One of the most persistent health disparities in the United States is birth outcomes between African American women and White women. Infants born to African American women are more than twice as likely to die within the first year of life compared to those born to White women. This disproportionate infant mortality rate between African Americans and Whites is attributed to a twofold increase in the number of preterm births and low birth weight (LBW) births (birth less than 38 weeks gestation) and nearly threefold increase in very low birth weight (VLBW) and very preterm births that exist among African American infants (Lu & Halfon, 2003).

This study was undertaken to help fill the gap in understanding the increased incidence of preterm birth in African American women. By recording the lived experiences of these women, the study provided some context for understanding preterm birth in African American women. Two major themes were extracted that capture the lived experiences of the study participants: “Strong Black Woman Ideal” and “Feeling

Trapped.” Permeating both of these themes was the experience of stress these women felt in having to live up to self- and other imposed expectations of strength as well as feeling trapped by these expectations. These expectations were handed down from generation to generation and reflected both conscious and unconscious expectations.

A review of the literature provided a broader understanding of these themes. Studies (Amankwaa, 2003; Wyatt, 2008) showed that the need to be “a strong Black woman” has been described in the literature in terms of not showing weakness, remaining strong despite adversity, and living up to expectations of strength passed on from generation to generation. From this review, three concepts were investigated that might provide supportive information that might help explain the themes that emerged from the study. These concepts were IGT, memes, and IG EI. These concepts may have contributed to the perpetuation of the Strong Black Woman Ideal and Feeling Trapped themes. These concepts helped explain the association between the women’s early infancy and childhood experiences and socialization, and their subsequent beliefs, attitudes, and perceptions as adult women. A better understanding of these traditional values and beliefs provided some insight into the possible connections that affected their pregnancy outcomes.

Consideration of these concepts and their relationship to the major themes of the study indicates that experiences, beliefs, and attitudes of the African American women’s family of origin may have an ongoing generational impact on these women and their children. Specifically, racial stressors continue to affect current and future generations not only socio-culturally, psychologically, but possibly physically. Examination of the possible impact of IGT, memes, and IG EI is important to our understanding.

This study made it more evident that stress, regardless of whether it is experienced directly or indirectly, could be a factor related to preterm birth. The detriment of stress can be seen throughout generations. The “strong Black woman ideal” has the potential for creating an unhealthy striving that becomes a vicious cycle repeating itself generation after generation. The “strong Black woman ideal,” ostensibly a positive ideal contributed to the possibility of feeling trapped when the women could see no options but to live up to the ideal, which had been set in motion during slavery by the oppressors and maintained by members of their own culture. The resulting stress may be severe enough to increase allostatic load, which could contribute to preterm birth.

A radical shift is needed in the minds of nurses who intervene to help reduce stress. Attention should be given to how stress is managed prenatally and what may have transpired in that persons’ life intergenerationally.

The purpose of this phenomenological study was to describe the lived experience of African American pregnancy that ends in preterm birth. The emergent themes “Strong Black Woman Ideal” and “Feeling Trapped,” described the essential aspect of the phenomena, and provided insight pertaining to preterm birth that expands the body of knowledge. Knowledge and insight gained from this study will assist nurses in helping to reduce the number of preterm births for the African American population.

Studies such as this one offers opportunities for valuable information to be disseminated so that there is early identification of those African American women who may be at risk for preterm birth. This new insight into the lived experience of African American pregnancy adds to nursing knowledge as it provides groundwork for future research for theory development, intervention planning, and nursing practice.

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Appendix A: Demographic Data and Personal Questionnaire

Instructions

These questions relate to your personal life. Please indicate your response by placing an X where appropriate or by writing the requested information on the line provided. Please do not leave any questions blank. If a question does not apply to you, write N/A. These questions refer back to your pregnancy that ended in preterm birth.

Number: _____

1. What was your age? _____
 2. What was your Marital Status?
 - Single
 - Married
 - Divorced
 - Separated
 - Widowed
 - Partner
 3. What was your religion? _____
 4. Who lived with you at home during this pregnancy? _____
 5. Where did you reside during this pregnancy (city & state)?

 6. How many years of school had you completed? _____
 7. What was your occupation? _____
-

8. How many pregnancies, including miscarriage/abortions had you had prior to this pregnancy? _____

9. How many living children did you have at the time of this pregnancy?

10. What were the age(s) and sex of all your living children?

11. How many preterm births had you had at the time of this pregnancy? _____

12. How many weeks gestation was the birth of your recent preterm baby?

- _____extremely preterm (20-28 weeks; 5-7 months)
- _____very preterm (29-32 weeks; 7-8 months)
- _____moderately preterm (33-37 weeks; 8-9 months)

13. Have you have had more than one pregnancy that ended in preterm birth?

- Yes
- No

If yes, please indicate the number of weeks' gestation for the birth of that preterm baby.

- _____extremely preterm (20-28 weeks; 5-7 months)
- _____very preterm (29-32 weeks; 7-8 months)
- _____moderately preterm (33-37 weeks; 8-9 months)

14. How many months (weeks) pregnant were you when you found out that you were pregnant? _____

15. Did you seek prenatal care during this pregnancy?

Yes

No

If you answered yes, please indicate how many months pregnant you were when you began prenatal care _____

16. If you began prenatal care, were you able to keep all of your appointments?

Yes

No, I missed

a. ___one appointment

b. ___two appointments

c. ___three appointments

d. ___ appointments

17. Did you receive prenatal care from a midwife or obstetrician?

Midwife

Obstetrician

18. What things hindered or prevented you from seeking prenatal care or keeping your appointments?

19. Did you use recreational drugs (marijuana, cocaine, etc.) during your pregnancy?

Yes If yes, what kind(s)? _____

No

20. Did you smoke cigarettes during your pregnancy?

Yes If yes, how many cigarettes a day? _____

No

21. Did you drink alcoholic beverages during your pregnancy?

Yes If yes, how many drinks a day? _____

No

Appendix B : IRB Approval Letter



DUQUESNE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
424 RANGOS BUILDING ♦ PITTSBURGH PA 15282-0202

Dr. Paul Richer
Chair, Institutional Review Board
Human Protections Administrator
Phone (412) 396-6326 Fax (412) 396-5176
e-mail: richer@duq.edu

April 11, 2008

Ms. Clarise Ottley
2381 Welltown Road
Martinsburg, WV 25401

RE: “African American Women’s Lived Experiences of a Pregnancy That Ended in Preterm Birth” Protocol #08/43

Dear Ms. Ottley:

Thank you for submitting your research proposal to the IRB.

Based upon the recommendation of IRB member, Dr. Kathleen Sekula, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110. In addition it is approved by Dr. Joan Kiel, HIPAA Officer, as HIPAA compliant.

The consent form is attached with IRB approval and expiration date. You should use the stamped form as original for copies that you distribute.

The approval must be renewed in one year as part of the IRB’s continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form in one year, you will

need to have it renewed. In correspondence please refer to the protocol number shown after the title above.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You should retain a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, please feel free to contact me at anytime.

Sincerely yours,

A handwritten signature in blue ink that reads "Paul Richer".

Paul Richer, Ph.D.

C: Dr. Kathleen Sekula
Dr. Joan Kiel
Dr. Mary Ann Thurkettle
IRB Records

Appendix C: Informed Consent

Duquesne University
Institutional Review Board
Approval Date: April 11, 2008
Expiration Date: April 11, 2009



DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

- TITLE:** African American Women's Lived Experiences of a Pregnancy That Ended in Preterm Birth
- INVESTIGATOR:** Clarise H. Ottley, RN, MSN, CNS
Doctoral Candidate, Duquesne University School of Nursing
2381 Welltown Road
Martinsburg, WV 25401
(304) 264-4424
- ADVISOR: (if applicable):** Mary Ann Thurkettle, PhD, RN
Duquesne University School of Nursing
521 Fisher Hall
Pittsburgh, PA 15282
(412) 396-1817
- SOURCE OF SUPPORT:** This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing at Duquesne University.
- PURPOSE:** You are being asked to participate in a research project that seeks to study African American women's lived experiences of a pregnancy that ended in preterm birth. Any information you choose to provide will take place during two agreed upon interview sessions. During each interview session, you will be asked demographic and personal information (Appendix A) and questions about your pregnancy that ended in preterm birth (Appendix E).

These questions will be asked of all participants. At any time during the interview sessions, you have the freedom and right to refuse to answer any questions that you feel may be in violation of the Health Insurance Portability and Accountability Act (HIPAA).

Each taped interview will last approximately one to one and a half hours. The two interviews will take place in the private conference room located in the office of Dr. James E. Brown, local Obstetrician and Honorary Chairman of the local March of Dimes. These are the only requests that will be made of you.

RISKS AND BENEFITS:

There are no known risks or direct benefits from participating in this study. There is the concern that a recall of the lived experience may generate feelings of sadness or distress. In the event that these feelings surface, counseling sessions are available at the Brook Lane Health Services in Hagerstown, MD. Ms. Brianne, Patient Advocate and Admissions Counselor, may be contacted at 1-800-342-2992, extension 174.

Your participation will contribute to the existing nursing knowledge and may assist in the understanding of why African American women experience preterm births at rates higher than any other race.

COMPENSATION:

Participants will be compensated \$100 by check for two interview sessions, payable at the end of the second interview session. This compensation is being offered to help defray the increasing cost of gas and childcare. Participation in the project will require no monetary cost to you.

CONFIDENTIALITY:

Your name will never appear on any of the research. Your name will not appear on any written material. No identification will be made in the data analysis. The audio tapes will only be used for the purpose of the study and will be heard only by the researcher and members of the research team. Anyone hearing the audio tapes will sign a confidentiality statement that they will not reveal the contents, materials, or consent forms, and audio tapes will be stored in a locked file. All materials will be destroyed at the completion of the research.

RIGHT TO WITHDRAW:

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time without penalty.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and have been provided this opportunity to have questions answered. I understand what is being requested of me. I further understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Mary Ann Thurkettle, Advisor of Dissertation Committee, (412) 396-1817, and/or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412) 396-6326.

Participant's Signature

Date

Researcher's Signature

Date

Appendix D: Confidentiality Statement



DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

I understand that I have access to confidential information. I agree to keep all information pertaining to this research confidential. I will not discuss or reveal any information to anyone outside of the research team.

Name: _____ Signature: _____

Title: _____

Date: _____ Witness Signature: _____

Appendix E: Interview Guidelines for Researcher

As a nurse researcher, I am interested in learning about your experience with preterm birth. This information would assist in providing insight into the escalating percentage of African American women who experience preterm birth. I would like to learn about your most recent pregnancy that ended in the preterm delivery of your baby.

1. “Tell me what it was like being pregnant.”
2. “Tell me the best thing about being pregnant.”
3. “Tell me the biggest challenge of being pregnant.”
4. “Tell me about a typical day being pregnant, beginning with when you awoke in the morning and ending with going to bed at night.”
5. “Tell me what you were doing the day you went into labor.”
6. “Tell me about any cultural practices, beliefs, or perspectives regarding pregnancy.”
7. “Tell me anything else you would like to tell me about your pregnancy experience.”

Appendix F: Letter of Consent



DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Date

Name
Address
City, State, Zip

Dear

I am a Nursing doctoral student at Duquesne University, currently undertaking a study examining the lived experience of African American women whose pregnancy ended in preterm birth. I am writing to ask if you would be willing to participate in this study, as your name was selected for inclusion from among the clients of Dr. James E. Brown.

There is no particular benefit to you for participation in this study other than knowing that you will contribute to the research on the causes of preterm birth. A monetary compensation of \$100 in the form of a check, payable when you return for the second interview, will assist with the price of gas and childcare.

Please know that recalling your pregnancy and the experience of preterm birth may cause emotional distress. If at any time questions asked elicit discomfort, you may refuse to answer. Your name will not be used, nor will anyone be able to identify you as a participant in this study. Your consent to participate will be implied through the completion of the questionnaire. Any questions regarding your participation should be directed to Dr. Paul Richer, Chair, Duquesne University Institutional Review Board, at 412-396-6326.

Thank you for your consideration in participating in this study.

Sincerely,

Clarise H. Ottley, RN, MSN, CNS

Appendix G: PowerPoint Presentation Outline Presented to Office Staff and Participants

- DID YOU KNOW THAT . . . ?
By Clarise H. Ottley, RN, MSN, CNS
- At birth, baby Amillia Taylor, whose feet we saw, was barely longer than a ballpoint pen?
- DID YOU KNOW THAT . . . ?
- Born at 21 weeks and 6 days' gestation and barely bothering the scale at 280 grams, Amillia is believed to be the world's most premature baby to survive?
- DID YOU KNOW THAT . . . ?
- The doctors who spent 4 months trying to keep her 24-centimeter figure alive at the Baptist Children's Hospital in Miami are declaring her a "miracle baby"?
- Although Amelia is at home now, she will still have to be monitored closely, requiring asthma medication and extra oxygen for months to come?
- DID YOU KNOW THAT . . . ?
- Despite such a miracle as baby Taylor, approximately 70% of the cases of neonatal mortality (death rate in 2002 was 15 times that of those infants who were born term)? (Goldenberg, 2002; Goldenberg & Rouse, 1998; Lewit, Baker, Corman, & Shiono, 1995; Martin, Hamilton, Ventura, Menacker, Park, & Sutton, 2002; McCormick, 1985).
- DID YOU KNOW THAT . . . ?
- Almost half of long-term birth-related neurological morbidity and 35% of all U.S. health care spending has been for preterm infants?
- DID YOU KNOW THAT . . . ?
- In 2005, the annual societal economic cost associated with preterm birth was \$26.2 billion, suggesting that major infant cost savings could be realized by preventing preterm birth? (Institute of Medicine, 2007; Russell, Green, Steiner, Meikle, Howse, Poschman, et al., 2007)
- Cost of Preterm Birth
- Medical care services:
 - 16.9 billion (\$33,200 per preterm infant) - 2/3 total cost

- Maternal delivery cost:
 - 1.9 billion (\$3,800 per preterm infant)
- Special education services:
 - 1.1 billion (\$2,200 per preterm infant)
- Lost household and labor market productivity:
 - 5.7 billion (\$11,200 per preterm infant)
- DID YOU KNOW THAT . . . ?
- Preterm labor and birth (less than or equal to 37 weeks gestation) still remain unmanageable problems in the United States, as well as other developing countries?
- All Preterm Births by Gestational Age, U.S., 2003
- DID YOU KNOW THAT . . . ?
- Despite great strides in improving the survival of infants born preterm, little is known about how preterm births can be prevented?
- Often the prognosis of preterm neonates is poor?
- DID YOU KNOW THAT . . . ?
- This high rate of premature births in the United States constitutes a public health concern?
- DID YOU KNOW THAT . . . ?

There are three primary reasons for this health concern?

- 1) A troubling increase in the rates of preterm birth in the past decade;
- 2) The emotional and economic cost to families and communities resulting from the birth of a preterm infant; and
- 3) Notable disparities in the rates of preterm births across populations in the United States, with the greatest disparity among African American women.
- DID YOU KNOW THAT . . . ?
- Approximately 467,000 live births annually (11.5% of all live births) occur before term in the United States?
- This is nearly one premature infant born every minute of every day?

- DID YOU KNOW THAT . . . ?
- Despite the advances in medical technologies, therapeutic perinatal and neonatal care, interventions, improvements in access to prenatal care, and a decrease in smoking during pregnancy, the incidence of preterm birth has changed little over the past 40 years? (Martin, Hamilton, Sutton, Ventura, Menacker, & Munson, 2005)
- DID YOU KNOW THAT . . . ?
- In 2003, the preterm birth rate for the United States rose to 12.3% (a 16% increase since 1990), which represents more than a 30% increase since 1981, and that in 2004, preterm birth reached 12.5%?
- Preterm Births as a Percentage of Live Births in the United States, 1990 to 2004
- DID YOU KNOW THAT . . . ?
- The preponderance of this increase has been among African American babies born at 32 to 36 weeks' gestation?
- DID YOU KNOW THAT . . . ?
- African American women have the highest preterm birth rate of all ethnic groups, at 17.8%, as compared to Asian Pacific Islander women at 10.5%, 11.5% for White women, 11.9% for Hispanic women, and 13.5% for American Indian/Alaska Native women? (Institute of Medicine, 2007)
- Preterm Births by Maternal Race/Ethnicity, U.S., 1993-2003
- DID YOU KNOW THAT . . . ?
- African American women also have the highest very preterm birth rate (29-32 weeks' gestation) of all races, which is 3 times higher than very preterm birth rate for White women? (Edwards-Rich, Kreiger, Majzoub, Sierler, Liberman, & Gillman, 2001, p. 124).
- DID YOU KNOW THAT . . . ?
- Out of the estimated 90% of neonatal deaths in the United States caused by preterm births, 75% occur in infants born at less than 32 weeks' gestation? (Piotrowski, 2004)
- Infants born at less than 32 weeks' gestation are 70 times more likely to die from prematurity than those born 33-37 weeks' prematurely? (Institute of Medicine, 2007)
- DID YOU KNOW THAT . . . ?

- One-fifth of these infants born at less than 32 weeks' gestation do not survive the first year of life?
- DID YOU KNOW THAT . . . ?
- Extremely preterm births (20-28 weeks' gestation) for African American women are 4 times higher than White women, which accounts for more than half of the infant mortality gap that has existed for the past 50 years? (Collins, David, Simon, & Prachand, 2007; Institute of Medicine, 2007; Rowley, 2001).
- DID YOU KNOW THAT . . . ?
- African American women are also more than 5 times (21.5% compared to 9.2%) more likely to have repeated preterm births than White women? (Kistka, Palomar, Lee, Boslaugh, Wangler, Cole, et al., 2007).
- DID YOU KNOW THAT . . . ?
- The high mortality rate for African American infants has led researchers to calculate that the disparity that exists between African American preterm babies and White preterm babies account for 60 % of the overall preterm birth gap between the two races? (Schempf, Brenum, Lukacs, & Schoendorf, 2007).
- DID YOU KNOW THAT . . . ?
- West Virginia has little racial diversity compared to other states, with fewer than 5% of all births to women of non-White races, where only 3.2% of the 51.4 % of women who live here are African American?
- For many decades, West Virginians have ignored this minority health disparity because of the smaller numbers?
- Despite this small proportion, African American women still represent the population at greatest risk for poor reproductive health? (West Virginia Prenatal Wellness Study, 2006).
- DID YOU KNOW THAT . . . ?
- Since African American women nationally experience preterm birth at an alarming rate of 17.8% compared to 11.5% for White women, the need to address this disparity is very timely, especially in West Virginia?
- DID YOU KNOW THAT . . . ?
- The ever increasing rate of preterm birth for all races, but especially for the African American race, has continued to puzzle researchers?
- DID YOU KNOW THAT . . . ?

- Researchers have found that neither socio-economical, physiological, nor environmental risk factors have been able to explain the adverse birth outcome disparity between African American women and White women?
- DID YOU KNOW THAT . . . ?
- Current research is looking at the interplay between various factors which may help explain the adverse birth outcome disparity which exists between African American women and White women?
- DID YOU KNOW THAT . . . ?
- Research which relies upon and acknowledges the authoritative voices of African American women for understanding their lives and those conditions that imperil health and wellbeing will provide answers to causes of disparities in reproductive outcomes among these women? (Jackson & Phillips, 2003).
- DID YOU KNOW THAT . . . ?
- A window into the lived processes of pregnancy for African American women may provide a more in-depth understanding of the contextual factors associated with preterm birth?
- DID YOU KNOW THAT . . . ?
- There is no current research that describes the lived experiences of African American women whose pregnancies have ended in preterm birth?
- DID YOU KNOW THAT . . . ?
- I am the first PhD candidate in the School of Nursing at Duquesne University in Pittsburgh, Pennsylvania, and my dissertation (research proposal) is titled *African American Women's Lived Experiences of a Pregnancy that Ended in Preterm Birth?*
- DID YOU KNOW THAT . . . ?
- This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing at Duquesne University?
- DID YOU KNOW THAT . . . ?
- Knowledge gained from this study will add to the larger literature on preterm birth?
- DID YOU KNOW THAT . . . ?
- This study may be useful in uncovering promising factors for further investigation of possible etiologies pertaining to preterm birth for African American women?
DID YOU KNOW THAT . . . ?

- Organizations which support research that looks at factors related to preterm birth in all populations are:
 - The United States Department of Health and Human Services (USDHHS) through the *Healthy People 2010* initiative,
 - The National Institute for Child Health and Human Development, and
 - The March of Dimes
- DID YOU KNOW THAT . . . ?
- Not all research on preterm birth is supported by well known organizations, such as the March of Dimes?
- Some are supported by the private practices of local obstetricians?
- A local obstetrician has agreed to support my research efforts by allowing me to interview patients who are African American women with a history of preterm birth?
- DID YOU KNOW THAT . . . ?
- The confidential names of these potential participants will be generated from a patient list provided by Office Manager?
- DID YOU KNOW THAT...? . . .
- Two tape-recorded interview sessions with each selected African American woman will take place over the next 2 months in the private conference room?
- DID YOU KNOW THAT . . . ?
- Any knowledge of these interviews, as well as contact with these participants, must remain confidential?
- Confidentiality and HIPAA rights must be protected and assured at all times and at all cost?
- DID YOU KNOW THAT . . . ?
- The office staff and any other supporters who are involved in this research study will be acknowledged in the final written and oral dissertation proposal defense, which will be electronically submitted along with thousands of other dissertation proposals for anyone to view?
- DID YOU KNOW THAT . . . ?
- I am grateful for the opportunity to make a difference in reducing the preterm birth rate that has claimed the lives of far too many babies?

THANK YOU FOR THIS OPPORTUNITY . . .

- Together, we can make a difference in reducing the number of preterm births in the United States.
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Appendix H: Categories, Themes and Dimensions

20 Codes	14 Categories	10 Clusters	8 Dimensions	4 Dimensions	2 THEMES
1. Mom/Mother	1. Extended Kin Support Systems	Helping Hands/They Were Always There For Me	Support	Social Support-Strength To Make It Through The Day	THEME 1: STRONG BLACK WOMAN IDEAL
2. Help, Assistance, Support					
3. Expectations, Beliefs Of African American Women	2. Expectations and Beliefs As An African American Woman	How They Go Through Life as Black Women	Strong	Can't Be Weak, Gotta Be Strong	
4. Race					
5. Fortitude, Determination, Strength of Mind, Independence, Resolve	4. Know Thyself	This is How We Prove We Are Good Enough			
6. Culture, Tradition, Beliefs, Convictions, Practices, Vision	5. Cultural Beliefs and Practices	Culture Is A Part Of Who I Am			
7. Reflection, Thinking, Beliefs			6. Emotions, Feelings		

8. People's Opinions And Views	7. Influence, Opinions, Views, Beliefs, Attitudes Of Other People	Familial Expectations	Expectations Of Me	How I Respond	THEME 2: FEELING TRAPPED
9. Mismatched Expectations					
10. Intuition, Presage, Forewarning, Sense of Premonition, Portent	8. Feelings Of Something Being Wrong	My Baby Is Constantly On MY Mind	Fear/Worry About My Unborn Baby		
11. Knowledge, Awareness					
12. Comments, Concerns, and Worry About The Baby					
13. Comparison Of Experiences Of One Pregnancy With Another Or With Other People Who Had A Baby	10. Comparison of Birth Experiences	Am I Going To Be OK	There's The Pregnancy And Then There's Me		
14. Pregnancy	11. High Risk Pregnancy				
15. Physical					
16. Symptoms					
17. Family History Of High Risk Pregnancies					

18. Doctor	12. Medical Advice	Forced To Choose	Choose Between Following Medical Advice To Me and Responding to Conflicting Demanding Needs of My Family		
19. Family Issues					
20. Busy, Demanding, Challenging, Schedules	13. Too Much To Do	Finding Balance	Can't Seem To Balance All I Have To Do	Out of My Control	
21. Stress, Pressure, Anxiety	14. Stressors	Things That Caused Me Stress	Unexpected Stressors Are Added Insult To Injury		