PATIENTS' PERCEPTIONS OF PATIENT EDUCATION AS ENABLEMENT

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ABSTRACT

The efficacy of nursing interventions such as patient education from the recipient's or participant's viewpoint has been studied infrequently. This qualitative study examines perceptions of participants in childbirth classes, represented by Lamaze classes. Semi-structured interviews are conducted at three points during the pregnancy/birth/recovery process.

The seven participants were asked questions intended to elicit responses to the following research questions: 1) what are the reasons given for selecting and attending Lamaze classes when interviewed prior to attending; 2) what are the reasons given for selecting and attending Lamaze classes when interviewed after attending one or two classes; 3) what are the patient's perceived role(s) and task(s) during the birth process; 4) how does the perception of role(s) and task(s) change over time; and 5) does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role(s) or task(s) during the birth process. The study data was the audio-taped interviews. Analysis of data was completed using both the computer software, Martin, and manual methods.

Themes noted in response to the first two research questions included information and preparation, control, husband, rite of passage, anxiety/relaxation and socialization. All participants assigned themselves the task of maintaining control, and most believed they needed to assist their husband during the birth process. The self-assigned tasks did not change over time. Three of the participants definitely believed that the classes had assisted them in achieving their goals, one was ambivalent, and

three were equally sure that the classes had not met their needs.

The results of the study were compared to the theoretical concepts of enablement, mastery and role supplementation. Implications for nursing practice and education were offered, and further research areas identified.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

Introduction

The efficacy of health care interventions such as adult patient education is a strong focus in this time of finite fiscal and personal resources. In order to fully illuminate the efficacy of adult patient education, it must be assessed from the viewpoint of all participants. Patient education has long been recognized as an important nursing activity (National League for Nursing Education, 1918, 1937). As a nursing activity it has been mandated both by professional organizations such as the American Nurses Association (American Nurses' Association, 1974, 1985; American Nurses' Association Division of Medical-Surgical Nursing Practice & Association of Rehabilitation Nurses, 1977) and regulatory organizations such as the Joint Commission on Accreditation of Healthcare Organizations (Honan, Krsnak, Peterson & Torkelson, 1988; Joint Commission on Accreditation of Healthcare Organizations, 1992). Thus patient education is an expectation of nurses in all areas of patient care, from acute care to long term care, and from tertiary care centers to community/preventative nursing.

Although patient education is an expectation, it is not clear that all participants in the activity hold the same definition or perception of the activity. Barrett, Doyle, Driscoll, Flaherty and Dombrowski (1990) and Kruger (1991) all found that nurses agreed that patient education was important, although the relative importance differed among various levels of administration, education and staff nurses. Tilley, Gregor and Thiessen (1987) found that patients and nurses held quite differing views on what

constituted patient education.

A cursory examination of the recent nursing literature on the subject of patient education revealed that the literature is categorized most often by curricular content area. Within each single literature review, generally only literature within that content area is deemed applicable by the authors. For the nurse faced with the necessity of offering patient education in a content area not mentioned in recent (or past) literature, there is little in the way of guidelines for possible application or generalizability of the results of the available research.

A search for possible commonalities in process and outcomes within and among the myriad of content areas of patient education was the driving force for this research study. An additional quest was a search for the process of patient education as viewed by the patient and/or significant other(s). For this study, patient education was defined as "lifestyle advice aimed at promoting healthy behaviors and delivered with an individualistic focus" (Latter, Clark, Wilson-Barnett & Maben, 1992)

Although the purpose of the current study was the search for commonalities across patient education content areas, it was necessary to initially focus the research questions in a particular content area. The content area chosen for this initial study was childbirth education, specifically Lamaze classes. The participants in the study thus were the individuals who had chosen to participate in Lamaze childbirth education classes. The rationale for the choice of patient education program is elaborated on further in the report. From the broad literature searches the specific research questions for this study were articulated. They included:

1. What are the reasons given by participants for selecting and attending Lamaze classes when interviewed prior to attending classes?
2. What are the reasons given by participants for selecting and attending Lamaze classes when interviewed after attending one to three classes?
3. What are the patient's perceived role(s) and task(s) during the birth process ?
4. How does the perception of the role(s) or task(s) change across time?
5. Does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role or task during the birth process?

Purpose of the Study

Research in patient education should promote both excellence in clinical practice and the discovery of new knowledge. Therefore, this qualitative study had clinical and theoretical purposes. The clinical purpose was the search for a common process within patient education that could be applied across multiple content areas and patient populations. As the common process is understood and explicated, through this and future studies, the possibilities for measurement of effectiveness of patient education would be enhanced. The theoretical purpose was the testing of a proposition that effective patient education is an example of the nursing function of enablement. Through concept analysis completed by this researcher, enablement was articulated as a process by which the patient is assisted to acquire or expand the 1) means, 2) abilities, and 3) opportunities to complete a task or fulfill a role, to the patient's perceived level of satisfaction. The consideration within this study was

whether or not the patient's perceptions of the patient education would include the three components of enablement.

Significance of the Study

The function of nursing research is theory generation and testing (Fawcett & Downs, 1986). Nursing research on patient education, when examined as a whole body of literature, presented as a turbulent morass of isolated results. The phenomenon of patient education reflected a need for further theory generation, so that the theory could be tested for generalizability and applicability, and used to guide clinical practice. This researcher postulated that the process of enablement was a possible theoretical explanation for the phenomenon of adult patient education. Within the conceptualized process, the subconcepts of means, abilities and opportunities were identified. It was further postulated that all the components of means, abilities and opportunities were necessary and sufficient for the process of enablement to occur.

In addition, researchers needed to examine completed research findings to develop research questions that would move knowledge-seeking forward from what was known to what was not known. There were few examples in patient education literature of research that had been replicated, or that built on previous findings. Fiscal limitations no longer supported isolated studies that were not applicable to more than one situation.

One of the greatest difficulties appears to have been that the researchers did not have a common object or outcome of the search. Further, in designing primarily quantitative studies, nursing researchers had concentrated on "what they thought

should be there" rather than "what was". In nursing research related to patient education, this difficulty was expressed by the fact that the curriculum for the bulk of patient education was planned according to what the "experts" believed the patient needed to know. Although the planned information and activities may have indeed been relevant and helpful to the patients, the patients were rarely asked for input or evaluation except in rigidly controlled instruments. Thus, the research had infrequently ascertained the need from the persons most intimately acquainted with the requirement for and use of the patient education process.

Mulhall (1992) has suggested that studies using qualitative research methodologies give us

> "the potential to discover what precedes specific lived experiences, what can prevent them if that should promote quality of life, or discover what comprises lived experiences so that we can interpret what is needed by people so that the experience becomes tolerable, manageable, or even enhanced" (pg. 261).

Qualitative research in the area of patient education will assist the profession in explicating the phenomenon of adult patient education, and further open the dialogue between health professional and patient.

From the knowledge gained through qualitative studies, nursing researchers will be able to more clearly articulate the conceptual basis for measuring various attributes of effective patient education, and design appropriate measurement instruments to demonstrate the efficacy of the activity. Perceived control has been a concept noted in some of the qualitative literature; there may be more concepts common to the myriad of patient education experiences. As new concepts arise, they can be accommodated

within one or more theories that will help nurse researchers explain the process and outcomes of patient education.

Padilla and Bulcavage (1991) were able to articulate more than ten different theories arising from a number of disciplines that have been used to explain and attempt to predict the results of patient education. One theory that some authors have been able to agree upon is that the principles of adult education/learning should be used (Gessner, 1989; Padberg & Padberg, 1990). One of those principles is that the content must be perceived by the learner as relevant, or it will not be learned. Smith (1989), supported the relevancy issue when she noted that the focus of patient education should be on benefits to the patient. Another principle in adult learning is the notion of using prior learning as a basis for new learning. This principle was supported by Theis (1991), who found that structuring the patient education relative to results of a knowledge pretest enhanced new knowledge gained. All of these results pointed to the fact that a dialogue with the patient relative to his needs, and the role of education in meeting of those needs is required. The literature revealed that such dialogue was conspicuously absent from the bulk of patient education design, implementation, and research.

There were difficulties inherent in designing research in patient education. First, patient education usually takes place after the event, for instance, crutch walking is not taught until there is a need for it. Depending on the biophysical and/or psychological implications of the medical diagnosis that generated the patient teaching, the patient may or may not be a good candidate for indepth study at the time of the

patient education experience. Secondly, the time available for patient education interactions within an acute care institution is becoming increasingly shorter, as the length of stay shortens. The patient may not have time or opportunity to formulate his needs and concerns regarding what he requires, even if he were asked. Research findings on patient initiated phone calls to the hospital following discharge revealed that the majority of the requests were not for specific information, but for assistance in applying the information to the patient's particular situation (White & Holloway, 1990). The success of followup patient education programs suggested that opportunities for patient expressions of needs and reinforcement of learning were indeed factors in the attainment of the goals of the program (Cargill, 1992; Cunningham, Lockwood & Cunningham, 1991).

Theoretically, the concept of enablement appeared to embody much of the common process of patient education. This study was the first effort to test that theoretical stance. Anticipated outcomes of the current project included the explication of common themes and patterns expressed by patients experiencing a common life experience, and a common educational preparation for that life experience. In planning the study, it was recognized that the outcomes might support the theoretical stance, or refute it, and suggest other avenues to explore. Examples of other possible avenues were the concepts of mastery and/or role supplementation. Regardless of the immediate theoretical implications of the results of this study, the outcomes provided this and other researchers with more refined questions for use in subsequent studies with other patient education populations.

The current study represented the first step in a trajectory of research related to patient education. Within the research trajectory, this study will be replicated and expanded in other patient education situations. The anticipated conclusion of the initial efforts was a theoretical explication of the process of patient education that could be tested and possibly applied to the myriad of situations in which nurses effect patient education. With a common process identified, the potential for developing instruments to measure the effectiveness of patient education from the viewpoint of patient satisfaction becomes greater.

Healthy People 2000 (US DHHS, 1990) sets forth health objectives and research priorities for the United States in the 1990's. This study hoped to contribute to the multiple objectives related to patient education.

Review of the Literature

Review of patient education research literature

Nursing literature related to patient education has existed for several decades. Much of the early literature described the attributes of specific patient education programs, and the successes and failures of those programs; more recently, formal research in the area has been published. For the purposes of this study, literature was examined that had been published within the last three years. If a study referred to a previous study in terms of replication and/or expansion, the previous study was also examined.

The following sequence of presentation was used. First, quantitative nursing

research was examined under the headings of content areas, place of delivery of the educational program, type/timing of educational program, method of delivery, and outcomes measured following the delivery of the educational program. Secondly, quantitative research with the outcome of patient perceptions of learning needs and meta analyses was reviewed. Thirdly, qualitative nursing research was presented. Finally, a summary of the current state of nursing research in patient education was presented.

Quantitative Nursing Research

Quantitative research formed the bulk of nursing research in the field of patient education. Although patient education is mandated (American Nurses' Association, 1974, 1985; American Nurses' Association Division of Medical-Surgical Nursing Practice & Association of Rehabilitation Nurses, 1977; Honan, Krsnak, Peterson & Torkelson, 1988; Joint Commission on Accreditation of Healthcare Organizations, 1992), it is not recognized as a valid nursing activity in terms of reimbursement from most third party payers such as insurance or government. Thus one might have predicted that the body of nursing research related to the efficacy of patient education would have been small, in response to subtle inference that the activity, while expected, was not valued. However, there was a significant body of nursing research in the area of patient education. As with many other areas of nursing research, early researchers in patient education chose to follow the empirical route. This section of the review considered published quantitative studies. The results of single studies were reviewed first, then the meta-analyses.

Content areas. Much of the nursing literature written about patient education focused on the particular curricular content of the patient education. While content provided a convenient means of categorizing the literature, it resulted in a large number of categories.

Generally, the content area was labeled according to either the procedure that the patient was to undergo or the medical diagnosis. Examples included patients having cataract surgery (Allen, Knight, Falk & Strang, 1992), or coronary artery bypass graft surgery (Beckie, 1989; Cupples, 1991; Gortner & Jenkins, 1990; Lepczyk, Raleigh, & Rowley, 1990), or patients with osteoarthritis (Bill-Harvey, Kippey, Abeles, Donald, Downing, Ingenito & Pfeiffer, 1989), COPD (Emery, Leatherman, Burker & MacIntyre, 1991; Gift, Moore & Soeken, 1992; Janelli, Scherer & Schmieder, 1991; Kersten, 1990 a & b), cardiac infarction or disease (Chan, 1990; Gulanick, 1991; Peterson, 1991), back injury (Sirles, Brown & Hilyer, 1991) or AIDS (Stephens, Feucht & Roman, 1991). Less frequently the content area label specified the desired outcome, such as breast self-examination (Calnan, Moss & Chamberlin, 1984) or medication or appointment compliance (Buckley, 1990; Cargill, 1992). Even less often, the content of the education was related to new equipment that the patient must learn to use, such as an indwelling urethral catheter (Roe, 1990).

Devine (1992), and Devine and Cook (1983), in a meta-analysis of psychoeducational programs for adult surgical patients, divided the content areas into three main domains. They were: health care relevant information, exercises or skills, and psychosocial support. Yount, Edgell and Jakovek (1990) used Devine's

classification system to design their preoperative educational program. No other authors were found who followed Devine's lead in categorizing. The value of the classification system was that patient education research literature could be considered as a whole, rather than the current fragmented classification system.

In summary, the content of patient education was as varied as the patients it was designed to serve. While the division suggested by Devine would simplify the categorization process, the lack of deliberate application of research findings across patient education content areas supported the notion that patient education literature will continue to be categorized and studied by specific content area for some time to come. Thus, there was an identified need for research that would search for commonalities among the various categories of patient education.

Place of delivery of patient education. Patient education traditionally took place within the health care institution. However, with continuous changes in the health care delivery system related to fiscal and personnel constraints, it was not surprising that patient education delivery, too, was changing. Caldwell (1991), while not reporting on a patient education program per se, noted that with the increasing prevalence of "Not For Admission" (NFA, Day Surgery) surgical procedures, the traditional "night before surgery" hospital preoperative teaching was becoming increasingly rare. The health professional's concerns about this trend were that the patient readiness for learning was not optimal immediately before surgery, or in the rush of admission, the patient education easily could be forgotten. In response to this trend, some patient education planned for preoperative delivery was identified as being

offered in the community (Cupples, 1991) or in the hospital building, but prior to admission (Eddy & Coslow, 1991; Lepczyk et al., 1990).

Followup interactions by telephone, home visit or other interventions after hospital discharge were becoming more prevalent (Cargill, 1992; Gortner & Jenkins, 1990; Gulanick, 1991; White & Holloway, 1990; Wong, Wong, Nolde & Yabsley, 1990). Patient education community or outreach programs for a target population (Bill-Harvey et al., 1989; Cunningham et al., 1991; Janelli et al., 1991; Sirles et al., 1991) were held both inside and outside the health care institution.

None of the authors previously cited believed that the place of delivery of patient education was a strongly influencing factor on the patient education outcomes to warrant testing, or extensive discussion. The most obvious inappropriate site for patient education was any place in which the patient was not physically or psychologically comfortable. An exploration of appropriate sites for patient education was not found in the literature.

Types of educational programs. Although patient education is frequently informal, in order to meet the expected rigor of quantitative nursing research design, these studies focused on formally designed and presented programs. Categorization of the type of program was most clearly represented by the timing of patient education. The most common programs were ones designed for preoperative education (Allen et al., 1992; Brown, 1990; Caldwell, 1991;, Cupples, 1991; Eddy & Coslow, 1991; Hanucharurnkui & Vinya-nguag, 1991; Lepczyk et al., 1990; Meeker, Rodriquez & Johnson, 1992; Murphy, Fishman & Shaw, 1989; and Peterson, 1991). Other types of

programs included postoperative ones (Brown, 1990; Gortner & Jenkins, 1990; Murphy et al., 1989; and Wong et al., 1990), post discharge ones (Beckie, 1989), outpatient programs (Bill-Harvey et al., 1989; Cargill, 1992; Cunningham et al., 1991; Roe, 1990; and Stephens et al., 1991) and programs provided during the hospital admission, but unrelated to a surgical procedure (Buckley, 1990; Kersten, 1990a & b; Pasquarello, 1990;, Pommier, 1992; Thompson, Webster & Meddis, 1990; White & Holloway, 1990; Wong et al., 1990, Wyness, 1990; and Yunker, Flint & Carpenter, 1990). As previously mentioned, these examples included only those programs that were formalized enough to comply with the protocols required for quantitative research design.

Some researchers hypothesized an optimum time for the delivery of a particular patient education program, especially if the outcomes of knowledge and/or compliance with expected behaviors were being sought. Lepczyk et al. (1990) and Cupples (1991) based both their studies on the assumption that lower anxiety levels in the patients would result in greater retention of knowledge, and the corollary that greater knowledge would result in lower anxiety levels post patient education. A further assumption was that anxiety levels in patients would be lower preadmission (one or more weeks) than postadmission, just before surgery. Based on those assumptions, they each compared anxiety and knowledge levels in groups of patients receiving the education prior to admission with groups receiving the education postadmission, but preoperatively. Although findings from both studies supported an hypothesis that knowledge retention would be greater in the group with preadmission education, only

Cupples (1991) reported support for an hypothesis that preoperative anxiety in the patients was lower preadmission than postadmission, and neither found differences in postoperative anxiety levels between the groups. Furthermore, Cupples (1991) noted that early-education participants verbalized appreciation for the opportunity to ask questions after they had been admitted. This raised the question for this researcher of whether it is the amount of time for knowledge assimilation and possible opportunities for patient questions that is the appropriate variable for future research focus.

The notion of the importance of reinforcement was supported by Cargill (1992), who reported that reinforcement of education increased medication compliance outcomes. Beckie (1989) also reported an increase in knowledge and decrease in anxiety in patients who had reinforcement of education post discharge, as compared to patients receiving the standard postoperative hospital program alone. Peterson (1991) further supported the idea that opportunity for interaction and questions was important; her results indicated that there was no difference between a social and an educative interaction in reducing pre-operative anxiety. They were both more effective than no interaction. Buckley's (1990) results indicated that a personal interaction was more valuable than a telephone interaction. Yount et al. (1990), in examining nurses' perceptions of the optimal time for patient preoperative education, found that the majority of nurses believed that the optimal time was after admission, but before surgery. This finding, when contrasted with Lepczyk et al. (1990) and Cupples (1991) represented another example of the possible differences in nurses' and patients' perceptions relative to patient education.

The variety of educational programs represented in the nursing research literature documented that patient education takes place at any time during the patient's interaction with the health care delivery system. Although research findings were beginning to suggest new areas of study, the paucity of replication and/or expansion of existing studies relegated each group of findings to the status of isolated incidents, rather than building blocks for theory generation or testing.

Method of delivery of patient education. Program designs for delivery of patient education programs have followed a variety of styles. Perhaps the most common was one-to-one (health professional and patient), or one-to-two (health professional, patient and significant other) face-to-face contact within or outside of the health care institution (Allen et al., 1992; Buckley, 1990; Cupples, 1991; Eddy & Coslow, 1991; Gulanick, 1991; Murphy et al., 1989; Stephens et al., 1991; Thompson et al., 1990; Warner, Peebles, Miller, Reed, Rodriquez & Martin-Lewis, 1992; Wyness, 1990; and Yunker et al., 1990). Other styles included one-to-one per telephone (Beckie, 1989), group (health professional, patients and/or significant others) within hospital (Kersten, 1990a & b; Lepczyk et al., 1990; Meeker et al., 1992; and Pasquarello, 1990), or group within community (Bill-Harvey et al., 1989; Cunningham et al., 1991; Emery et al., 1991; Janelli et al., 1991; and Sirles et al., 1991). Although many programs contained some elements of self-study (Gift et al., 1992; Schoenbeck, 1992; Wong et al., 1990), no research using a self-study only (no personal contact or reinforcement) educational design was found.

Among the quantitative studies reviewed, only a few studies were found that

compared two or more methods of delivery of the patient education (Gift et al., 1992; Gortner & Jenkins, 1990; Meeker et al., 1992; Peterson, 1991; and Wyness, 1990). Gift et al. (1992) compared the use of a taped relaxation tape with just asking the patient to relax in a quiet room. Wyness (1990) and Meeker et al. (1992) compared structured and unstructured delivery of the same content, and Peterson (1991) compared an educational intervention with a social intervention and a control of no intervention. Gortner and Jenkins (1990) added some additional information and a personal counselling session to their experimental group, in addition to post discharge followup. Although other studies may have added a unique element (telephone or home visit reinforcement, or additional counselling interaction at the time of education) to the experimental groups, as with Wyness (1990) and Meeker et al. (1992), both experimental and control group received the same basic educational program. No theoretical justification or rationale was presented for the choice of method of delivery, other than tradition, convenience, or in some cases, fiscal concerns (e.g. group education is less expensive than one-to-one education).

Outcomes measured. As with many other factors within the design of both the patient education and the research used to test its efficacy, outcomes measured within the research were multitudinous and frequently isolated to one set of authors and/or one patient education program. Outcomes measured within this review of the quantitative literature were loosely grouped into four categories: knowledge, compliance, physiological/functional outcomes and psycho-social outcomes. In each category, the unit of measure was usually the difference between a pretest and a

posttest, or the difference between a control and an experimental group on a particular variable. In most studies, more than one variable was studied. In some cases, single variables such as knowledge or anxiety were measured only as precursors to the desired outcome measure; e.g., patient satisfaction. The single variable results were not part of the completed product, nor was the framework that guided the choice of variables clearly articulated.

Knowledge. Knowledge was a variable that was frequently reported in education literature, and patient education was no different. Most authors (Allen et al., 1992; Bill-Harvey et al., 1989; Cupples, 1991; Eddy & Coslow, 1991; Murphy et al., 1989; Pommier, 1992; Roe, 1990; Wong et al., 1990; and Wyness, 1990) used investigator-developed tests of knowledge. Beckie (1989) and Wolfe and Schirm (1992) used previously developed and psychometrically tested instruments to test knowledge change. In most cases, the content of the educational program, and therefore the focus of the knowledge instrument, was developed through consultation with professional experts and review of health care literature in the particular education content area. The patient was rarely consulted.

Duchin and Brown (1990) found differences in the relative importance of various knowledge items when scored by patients as opposed to various health professionals. The information most valued by the patients involved "survival skills" of disease/lifestyle management rather than pathophysiology (more often valued by the health professionals). Therefore, although changes in knowledge were carefully documented, the applicability of the content to the patient's situation, or the use of that

knowledge by the patient or significant others at an immediate or later date, has not been well studied. Further, no longitudinal studies longer than six months with an outcome of knowledge were found. Even in the longitudinal studies, the majority had no continued educational intervention during the study.

Compliance. Compliance is the ability and actuality of the patient demonstrating a desired behavior. Compliance may be a physical activity, such as exercise, or cognitive, such as selecting appropriate foods from a menu.

Patient education research that specified compliance as an outcome measured compliance with medications (Cargill, 1992; Pasquarello, 1990; Wolfe & Schirm, 1992; and Wyness, 1990), exercise (Wong et al., 1990), reduction of risk behaviors (Cargill, 1992; Stephens et al., 1991), and medical appointments (Buckley, 1990; Pasquarello, 1990). The measurements were often by self-report, but some were also validated by demonstrated functional ability, laboratory reports such as drug levels, and pill counts for medication compliance.

Although most health professionals would agree that compliance is a desirable outcome, the patient's right or privilege to agree or choose to refuse may lead to ethical discussions. Further, is the outcome noncompliance or the patient changing the presented protocol to one that suits his/her lifestyle more adequately? White and Holloway (1990) found that post discharge rehabilitation patients' questions were related more frequently to changing the timing/frequency or method of the desired behavior rather than choosing to refuse altogether. The rigidity of the desired behavior within a research teaching protocol may encourage the patient to refuse to continue a

behavior that does not fit into his lifestyle, or to lie about the results. Either option does not benefit the patient or the research.

Physiological/functional outcomes. While some physiological/functional outcomes were self explanatory, such as vital signs, or exercise tolerance, others were less clearly appointed to this category. Examples of outcomes less obviously a part of this category were amount of medication required, length of stay, or the score on a recovery index.

Physiological/functional outcomes measured included length of stay (Hanucharurnkui & Vinya-nguag, 1990; Pasquarello, 1990), dyspnea, peripheral skin temperature and airway obstruction (Gift et al., 1992), skill tests (Allen et al., 1992), function level (Bill-Harvey et al., 1989; Emery et al., 1991; Wong et al., 1990), activity/exercise level (Bill-Harvey et al., 1989; Gortner & Jenkins, 1990; Gulanick, 1991; Hanucharurnkui & Vinya-nguag, 1990; and Sirles et al., 1991), use of adaptive equipment (Bill-Harvey et al., 1989), recovery inventory (Cupples, 1991; Evans et al., 1991), neurological assessment (Emery et al., 1991), vital signs (Warner et al., 1992), atelectasis (Meeker et al., 1992), complications related to the medical diagnosis (Hanucharurnkui & Vinya-nguag, 1990; Pasquarello, 1990), disposition at discharge (home or extended care facility) (Pasquarello, 1990), metabolic improvement (Dunn, Beeney, Hoskins & Turtle, 1990), and medication required (Hanucharurnkui & Vinya-nguag, 1990; Warner et al., 1992). In most cases the instruments were investigator-developed and specific to the program studied, and often without demonstrated reliability and validities. Thus the possibility of applicability of results to other patient

education research or content areas was reduced.

Although physiological/functional outcomes frequently were assumed to be more objective than other outcome measurements, the plethora of variables measured, lack of continued attention to reliability and validity measures, and lack of applicability suggested that these findings should be questioned. In some cases severity of illness/injury or previous functional level were not known or measured. Since either of those factors could significantly affect the outcome measures (especially with small sample sizes), concerns arose about the confidence another researcher or reader could place in the results, or in the replicability of the study.

Psycho-social outcomes. Psycho-social outcomes measure the effect of the intervention on the individual's psychological or social functioning. They frequently were measured using a pretest-intervention-posttest design, or a single test score compared to a standardized measure.

Although many of the authors used previously designed instruments, some continued to redesign or develop instruments specific to their environment or patient population. The most commonly used previously developed instrument was an anxiety scale. Several authors used either the State Anxiety Inventory, or the Trait Anxiety Inventory, forms of the Spiegelberger Anxiety Scale (Allen et al., 1992, Beckie, 1989; Caldwell, 1991; Cupples, 1991; Gift et al., 1992; Lepczyk et al., 1990, Murphy et al., 1989; Peterson, 1991; Sirles et al., 1991; and Warner et al., 1992), while Brown (1990) used palmar sweat as a measure of anxiety.

Another psycho-social outcome measured was patient satisfaction. Again some

of the authors chose to develop their own instruments (Erwin-Toth & Spencer, 1991; Thompson et al., 1990; and Wyness, 1990), while others chose to use a previously developed instrument (Hanucharurnkui & Vinya-nguag, 1990; Meeker et al., 1992). The patients' perceptions relative to patient satisfaction tended to be asked post hoc. No research was found that elicited patients' perceptions at various times during the educational interventions. However, this might be a sound educational testing variable, as retention of information and patient satisfaction may change over time, and retention of information and behaviors over time might be more important than immediately post intervention.

Still other psycho-social outcomes were measured within the efforts of only one to three studies each. Included in the outcomes were: ways of coping (Caldwell, 1991; Janelli et al., 1991), self-efficacy (Cunningham et al., 1991; Gortner & Jenkins, 1990; Gulanick, 1991), mood state (Cunningham et al., 1991; Gortner & Jenkins, 1990), acceptance of catheter (Roe, 1990), distress (Emery et al., 1991), behavioral style (Peterson, 1991), self-concept (Kersten, 1990a & b), psychological well being, health profile, amount of pain, and depression (Sirles et al., 1991), and multi-dimensional health locus of control and coping by repression (Murphy et al., 1989). As mentioned previously, little attention was given in the published reports to the conceptual framework that guided either the choice of the variable to be studied or the instrument design. Therefore, conceptual consistency within the research design was very difficult to ascertain.

Studies Involving Patient Perceptions. Patient learning needs were beginning to

be recognized as a valid source of study. Bubela, Galloway, McCay, McKibbon, Nagle, Pringle, Ross and Shamian (1990) developed a patient learning needs scale for use at the time of hospital discharge. Beginning psychometric testing was completed. No other studies were found that used the instrument.

Hiromoto and Dungan (1991) used the results of an investigator-developed learning needs assessment instrument to plan individual educational experiences for patients receiving chemotherapy. Other than through self-report following the interventions, no evaluation of the effectiveness of the education was completed.

Only one set of studies was found that specifically attempted to build knowledge based on previous work. Gerard and Peterson (1984) investigated learning needs of patients post-myocardial infarction, and compared the results with the learning needs identified by the nurses. Their findings indicated that although there were many similarities between the patients' and the nurses' perceptions, patients were more interested in the general category of risk factors, while nurses ascribed their primary importance to teaching about medications. Although nurses believed that they were the major source of information for the patients, study findings indicated the patients preferred physicians as the source of their information. From this study came the Cardiac Patient Learning Need Inventory (CPLI). In addition, the Educator Preference Tool was developed from items on the CPLI to test patients' perceptions of nurses as educators. Karlik and Yarcheski (1987) replicated the study and supported the major findings of the Gerard and Peterson (1984) study.

Karlik, Yarcheski, Braun and Wu (1990) extended the study to individuals with

angina, using the a modified CPLI, and the Educator Preference Tool. They found that risk factors was the only category identified as more important by patients than nurses. In addition, patients continued to demonstrate a preference for physicians alone as their source of information. The patients were also sampled after discharge. Patients' perceptions of the importance of some categories of information changed after discharge, supporting the notion that followup education and support is important.

Chan (1990) used Gerard and Peterson (1984), and Karlik and Yarcheski (1987) as the basis for her work, but extended it to examine the patients' perceptions relative to their ability to learn all of the important content in the post myocardial infarction hospitalization period. The CPLI was modified to include the dimension "realistic to learn". While her results relative to the patients' perceptions of the content as important to learn were supportive of the earlier studies, the mean scores on the "realistic to learn" scale were universally lower than the scores on the "important to learn". These findings have implications for both inpatient and followup patient education.

Wingate (1990) also used the CPLI to examine patients' perceptions while in the Coronary Care Unit (CCU), in the Post Coronary Care Unit (PCCU), and 2-4 weeks post discharge. Many of her findings were similar to the original two studies. She offered suggestions for cardiac patient education programs based on the findings.

Review of Meta-Analyses. Three meta-analyses were reviewed. Each reviewed research completed within a particular patient education content area. Devine (1992) made a masterful attempt at organizing within broad categories the type

of content, method and timing of delivery and outcome measures. Devine's choice of education for patients having surgical procedures placed natural limitations on the results reviewed, enhancing her attempts at categorization. Mullen, Mains and Valez (1992) examined controlled trials of cardiac patient education. They did not even attempt to combine the results into broad categories, limiting themselves to listing each study with the relevant information. Shade (1992) questioned whether patient education could assist in patient-controlled analgesia, but did not attempt to discuss the varying results except in relation to patient locus of control, and amount of medication used.

Summary of Quantitative Literature. Examination of the total picture of quantitative research in patient education presented the reader with a multitudinous bits of information that were not conceptually based nor consistent. While the results of the studies might provide information relative to the efficacy of particular patient education programs, students or practitioners find little they can use, unless their patient content area or population exactly fits an existing study. Further, the investigator-developed measurement instruments were specific to the situation being studied, and it is not certain that they are reliable, valid, or applicable to any other situation.

Following an examination of the literature, the researcher searching for a common guideline or process for the activity of patient education could be easily tempted to abandon the task. The researcher could be even more discouraged about attempts to measure the efficacy of the activity, or comparison with other, related

activities. However, recent developments in the literature underscored the possibility that a breakthrough in that search may come from a previously unheard-from area of research. That area is qualitative research.

Qualitative Nursing Research

Qualitative nursing research has more recently become a valued scientific research design. Funding efforts are said to be more difficult when this design is used, demonstrating its continued limited acceptance by the scientific world, and hence, nurse scientists. Few qualitative nursing research studies with a focus of patient education were found.

European and Canadian nurse researchers were at the forefront of the qualitative movement, at least in research in patient education. Beginning research has been completed in the content areas of patient education regarding myocardial infarctions (Johnson & Morse, 1990; Tack & Gilliss, 1990), stoma care (Deeny & McCrea, 1991; Kelly & Henry, 1992), diabetes care (Wikblad, 1991), asthma (Richardson, 1991), pressure sore prevention (Basta, 1991), and surgical care (Breemhaar & van den Borne, 1991). A concept that had surfaced within several of the studies was perceived control by the patient. This concept was inferred also in the quantitative studies in which patients expressed desires for time to absorb the information given, and have an opportunity to ask questions at a later date, or were desirous of adapting the skill or behavior to their particular lifestyle. Although these studies were only a beginning, the unstructured and indepth nature of the research responses offered an opportunity to explore both a common process and outcome to

the activity of patient education.

Summary of the Review of Literature

Historically, nursing research on patient education has been limited to single content areas and/or patient populations. The authors have tended to be concerned with the description of, or research related to, single patient education programs with single patient education interventions, rather than a comparison of multiple programs or interventions, even within exclusive content areas.

Various components of the learning process have been examined by nurse researchers. Factors affecting the learning process have been a fertile area in patient education nursing literature (Lindeman, 1988). Behavioral outcomes specific to the particular educational content area have been examined, but with little theoretical justification of why those particular outcomes were chosen, or indication of potential or actual application of results to other patient education situations. Most frequently, the outcome of patient compliance, from the health professional's view, has been considered the desirable outcome. There have been efforts to compare patient populations that seek patient educational programs, and those who do not (Calnan, Moss & Chamberlin, 1984; Glasgow, Toobert & Hampson, 1991). These efforts represent an indirect measure of the patient's expectations of the patient education experience. More direct measurement of patients' perceptions of learning needs has been completed in the content area of cardiac patient education, but there was no examination of whether the patients perceived the outcomes of the educational experience as meeting their needs.

Several problems exist within the current state of published nursing research on patient education. Methodologically, patient education research has been completed using primarily quantitative methods. While this methodology has resulted in a mass of individual pieces of data, the studies are rarely replicated and/or extended. Therefore, generalizability of the findings is difficult. In addition, little research exists that examines the comparison of the health professional-desired with patient-desired outcomes. This is perhaps because patients are rarely consulted in the design, implementation and/or examination of outcomes of patient education programs.

Nurse researchers have begun to question the present methods and strategies for conducting research in patient education. They were beginning to advocate the use of patient participation in the design and implementation of patient education programs. Qualitative methodologies were being suggested as appropriate, and some research had been completed using this design or approach. However, no research was found that examined the patients' perceptions at multiple points during the educational program of study.

Therefore, this study was designed to meet some of the concerns with previous patient education research. The first decision was the study population. The childbirth education population is self-selected, leading one to speculate that the patient may have some awareness of why she chose to participate. In addition, childbirth education traditionally takes place before the event. Therefore the patient is well aware of the final expected event. While this population was different from some other patient education populations in terms of self-selection, there are other patient

education areas where the patients are self-selected. Examples are diabetic education, breast self-examination, and lifestyle changes resulting from other chronic diseases. Findings from this study may be applicable to these educational areas.

The second advantage to this study in the choice of study populations was the length of the educational process. Childbirth education traditionally continues for a number of weeks. The patient, therefore, has opportunities to examine/refine her expectations, and articulate them to the leaders/teachers in hopes of generating a response that meets her needs. The lengthy educational program allows for multiple opportunities for the researcher and the participant to interact. In addition, an interview following the birth allows the participant to articulate a conclusion following the event for which the education was designed to prepare her, and the researcher to arrive at a greater understanding of the participant's perceptions all through the process.

The themes and patterns identified in this study will assist in further formulating and refining research questions for other areas of patient education, where patient self-selection and lengthy duration of the patient education interactions may not be possible. While it is recognized by this researcher that present knowledge, methodologies and instrumentation do not allow for immediate comparison of patient education programs across diverse content areas, the same basic research design can be expanded in the future to search for a possible common process in several content areas of patient education.

Conceptual Framework

The choice of study topic or clinical problem, approach used, and method of analysis are influenced by the philosophical stance of the researcher. This stance is often expressed in the theoretical rationale or conceptual framework for a research study, and arises from the assumptions and beliefs held by the researcher. For this study, the assumptions and beliefs extended from the work of Peplau, Newman, and Knowles.

Margaret Newman (1986), a nurse theorist, defined health as expanding consciousness. She conceptualized health as a lifelong expansion, incorporating time, space and movement, and encompassing disease and non-disease states alike. This definition required a paradigm shift for the health professional who traditionally planned the health goals for the patient from his/her knowledge base, and carried out direct nursing interventions to achieve those goals. Rather, Newman said, the new paradigm was relational, a partnership between the health professional and the patient. She believed that in the new relationship, all participants "grow and become healthier in the sense of higher levels of consciousness" (Newman, 1986, p. 68). The notion of a partnership strongly implied the presence of a dialogue between the health professional and the patient and/or significant others. Within this dialogue there was mutual assessment, goal-setting, and planning for the achievement of those goals. The health professional may have greater expertise in the suggestion of specific interventions to meet the goals, but the planning, interventions and evaluation of the interventions was envisioned as mutual.

Peplau's (1952) original work, while predating Newman's, has many points of conceptual consistency with Newman. Peplau has been classified as belonging to a group of nurse theorists called interactionists (Meleis, 1991). She believed that the relationship between the patient and the nurse was the central core of the nursing function. Peplau's definition of nursing was "a human relationship between an individual....and a nurse....an educative instrument....that promotes forward movement of the personality in the direction of creative, constructive, productive, personal and community living" (1952, pp. 5, 6, 15). If nursing is the function that assists the patient towards the goal of health, then the definitions of both nursing and health according to Peplau and Newman provide nurse researchers with a framework of mutuality, growth and interaction.

Given that the focus of this study was an examination of adult patient education, adult learning theory also formed a portion of the conceptual framework. Malcolm Knowles (1980) was considered the first American educator to use the term andragogy, and defined it as the art and science of helping adults learn. Andragogy was viewed as different from the educational term pedagogy, or helping children learn. Inherent in the practice of andragogy was the understanding that the adult educator changed from being a dispenser of information that the adult "ought to know", to being a change agent, and having a helping role in assisting the person to achieve full potential. In his book The Modern Practice of Adult Education (1980), Knowles articulated the assumptions that underlie the practice of andragogy. They were:

> A. It is a normal aspect of the process of maturation for a person to move from dependency toward increasing self-directedness, but at

different rates for different people and in different dimensions of life. Teachers have a responsibility to encourage and nurture this movement. Adults have a deep psychological need to be generally self-directing, although they may be dependent in particular temporary situations.

B. As people grow and develop they accumulate an increasing reservoir of experience that becomes an increasingly rich resource for learning- for themselves and for others. Furthermore, people attach more meaning to learnings they gain from experience than those they acquire passively. Accordingly, the primary techniques in education are experiential techniques- laboratory experiments, discussion, problem-solving cases, simulation exercises, field experience, and the like.

C. People become ready to learn something when they experience a need to learn it in order to cope more satisfyingly with real-life tasks or problems. The educator has a responsibility to create conditions and provide tools and procedures for helping learners discover their "needs to know". And learning programs should be organized around life-application categories and sequenced according to the learners' readiness to learn.

D. Learners see education as a process of developing increased competence to achieve their full potential in life. They want to be able to apply whatever knowledge and skill they gain today to living more effectively tomorrow. Accordingly, learning experiences should be organized around competency-development categories. People are performance-centered in their orientation to learning. (Knowles, 1980, pp. 43-44)

Preliminary work by this researcher in the search for a common process to the nursing activity of adult patient education included an analysis of the concept of enablement. Enablement was defined as a process by which the patient is assisted to acquire and/or expand the means, abilities and opportunities to complete a task or fulfill a role, to the patient's perceived level of satisfaction. The three components or subconcepts of means, abilities and opportunities were deemed necessary for the process of enablement to occur. The absence of any one of the three components

ensured that the process could not be completed.

The specific outcomes of enablement have not been completely articulated by the author, and may, in fact, change according to the situation, and the task or role desired by the patient. However, the usage of the concept in literature suggested that if the outcomes are perceived as positive, then the process was perceived as positive. Similarly, if the outcome was perceived as negative, so was the process. Thus, the process may be perceived differently by different members of any interaction.

The components or subconcepts of enablement were defined as follows:

> Means: resources required to complete a task or fulfill a role. They may include (but are not limited to) money, position (including organizational structure), policies and/or procedures, equipment, knowledge, availability of an enabler (teacher), existence of a program of study, time.
>
> Abilities: skills required to complete a task or fulfill a role. They may include (but are not limited to) motor skills, cognitive skills, psychosocial skills, biophysiological skills.
>
> Opportunities: chances to complete the task or fulfill the role. They may be offered through practice, legislation, social mores, or policy/procedures. Inherent within this definition is the belief it is the health professional's responsibility as enabler to ensure the patient's awareness of the opportunities (including current lack of same), but that the choice to exercise or refuse the opportunity is the patient's.

All of these definitions and assumptions coalesced into the belief that it is in the interaction between the nurse and the patient that adult patient education takes place. While other teaching strategies could be and were used, it was through the interaction that the three components of enablement actually occurred, and the desired outcomes were identified and reached.

Statement of the Problem

At the time of the study, health care delivery was being hotly debated in the United States. One of the issues was accountability to the consumer. The effectiveness of patient education needed to be assessed not only from the health professional's viewpoint, but also from the patient's (consumer's) viewpoint (Smith, 1989). Within the reviewed published nursing research, health professionals had no generalizable way of assessing that effectiveness. This study began a trajectory of research to explore the possibility of a common framework for guiding both the implementation and evaluation of patient education across all content areas.

Research Questions

There were five specific research questions for this study. They were:

1. What are the reasons given for selecting and attending Lamaze classes when interviewed prior to attending classes?
2. What are the reasons given for selecting and attending Lamaze classes when interviewed after attending one or two classes?
3. What are the patient's perceived role(s) and task(s) during the birth process ?
4. How does the perception of the role(s) or task(s) change across time?
5. Does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role or task during the birth process?

Each study participant was interviewed three times for the study. A further description of the timing of the interviews appears in the Methodology section. The initial interview with each participant focussed on interview questions related to

Research Questions 1 and 3, while the second interview with each participant focussed on questions related to Research Questions 2 and 3. The third participant interview, completed following the birth, focussed on information related to Research Questions 3 and 5. Research Question 4 was answered by the compilation and comparison of data for each participant from the first two interviews.

Conceptual definitions

Patient education- lifestyle advice aimed at promoting healthy behaviors and delivered with an individualistic focus (Latter, Clark, Wilson-Barnett & Maben, 1992). Given that a significant amount of patient education is presented in group format, e.g., childbirth education, the individualistic focus is dependent on the desire of the instructor to meet the needs of the individual participants, and the participant's desire and ability to make those needs known to the instructor. Within the dialogue and interactions between the instructor and the participant (and/or significant others) the components of enablement are completed.

Patient perceptions- the thoughts, feelings and beliefs of the participant (subject) regarding her roles and tasks during the childbirth experience, and her ability to complete them. These may change or remain the same throughout the prenatal/delivery/postpartum period.

Enablement- to assist the patient to acquire or expand the means, abilities and opportunities to complete a task or fulfill a role, to the patient's perceived level of satisfaction.

CHAPTER TWO

METHODOLOGY

Type of Study

The study was an example of descriptive-exploratory methodology. Descriptive-exploratory is a methodology within the broad category of qualitative research. The methodology has been described as research that "investigates the meaning of a life event for a group of subjects who share a particular experience" (Parse, Coyne & Smith, 1985, p. 91)

The selection of the methodology was guided by the phenomenon of interest and the research questions. The birth experience is a life event that usually marks a change in the lives of the participants. Indeed, it has been described as a maturational rite of passage (Bobak & Jensen, 1991). Individuals preparing for their first birth experience have no personal knowledge to guide them or to compare. These individuals are exposed to a variety of outside influences including informal and formal information sources. An example of an informal source of information is the individual's mother or mother-in-law. An example of a formally structured information source is childbirth education.

Setting

The setting for this study was chosen due to the nature of the patient education involved. The choice of childbirth education as the example of patient education was influenced by three factors. These were: 1) childbirth education is a relatively lengthy

process, incorporating 6-8 weeks of weekly classes; 2) childbirth education is completed before the event of childbirth; and 3) childbirth is generally perceived as a positive event, without the ramifications of a medical diagnosis (e.g., cancer) that could severely curtail the patient's ability to incorporate the learning. All of these factors supported the use of a multi-interview research design to examine the perceptions of women who were enrolled in childbirth classes.

The geographical setting for the study was an urban area in the southern midwest part of United States. The urban area incorporates portions of three counties, as well as three states. The majority of the urban inhabitants were located in one county. According to 1990 census data, this county had a population of 866,228, of which 20% were African-American. Within the urban area there were approximately 20 acute care hospitals. Childbirth education was offered by multiple groups. Many of the groups used the Lamaze curriculum. The classes were not necessarily taught by nurses, and classes were often held in hospitals or community buildings.

The specific setting for the study was the homes of the participants. With the seven participants, there were a total of 21 interviews. Eighteen of the interviews took place in the participant's home. One interview took place in the participant's workplace, and two of the post-birth interviews took place by long distance telephone, as the researcher had moved out of the country by the time of the delivery.

Subjects

All participants were recruited by mail from women who were experiencing the

maturational event of first birth, and who had registered to participate in childbirth education classes. The participants were drawn from women who registered with two organizations. One organization was community based, while the other organization was based within an urban hospital group. Recruitment was essentially the same for each group.

The community group was a non-profit organization designed to educate and support persons during childbearing years. The specific educational program used in the design of this study was the basic Lamaze course.

Pregnant women and their partners took the six week course at some time during their seventh and eighth months of pregnancy, in preparation for the childbirth experience. The weekly classes were 2.5 hours each. Curriculum as described in their brochure included: history of and rationale for Lamaze, the stages of labor and birth, total conscious relaxation, definition of partner's role, body toning exercises, controlled breathing and pushing skills, birth alternatives (medication, anesthesia, Cesarean birth), introduction to hospital procedures and equipment, parent-infant bonding, and Leboyer birth. The administrator of the group indicated that the instructors followed the curriculum as described in the brochure.

The organization offered Lamaze classes to pregnant women who were expected to deliver at two area hospitals, and their partners. In 1992, this organization held Lamaze classes for 364 pregnant women and their partners. During 1992, organizational information indicated that the estimated percentage of participants from minority populations was 5-7%. The age range was 17-42 years. The classes were

provided at a cost of $60.00, which might or might not be covered by health insurance.

The community organization recruited participants through the use of brochures in the physician's offices who delivered babies at two urban hospitals. Mail registration was used by the organization, with a confirmation card subsequently mailed out by the Administrator of the organization. The organization's records indicated that 95% of the registrants completed the course. Those who did not left due to medical reasons.

The hospital based organization offered childbirth education to any woman and her partner scheduled to deliver at one of their institutions, as well as individuals and their partners who were scheduled to deliver elsewhere and wished to take the childbirth programs offered by the hospitals. The specific educational program used in this study was the basic Lamaze course, which has a modified Lamaze curriculum.

Pregnant women and their partners took a single class, called the Early Bird Class, sometime during their third month of pregnancy. This was followed by an eight week course, that the participants scheduled so that the last class was about 1-2 weeks prior to their expected delivery date. The weekly classes were 1.75 hours each.

The hospital organization noted that in 1992 they delivered the basic Lamaze course to approximately 800 women and their partners. The age range for the patients was 16-40, and it was estimated that approximately 5% were minorities. The program's cost might or might not be covered by health insurance.

This organization recruited participants through physicians' offices, when the women came for prenatal care, or in response to participant-initiated phone calls to the department. A woman could register by phone, however, the registration was not confirmed until the fee was received by the hospital.

Women who registered for Lamaze classes through either the community or the hospital based programs, and who met the inclusion criteria were eligible for participation in the study. Following the recruitment procedures outlined in the section on Procedure, potential participants contacted the researcher.

Inclusion criteria for the study included: 1) adult female (18+ years old), 2) English-speaking, and 3) primipara (first birth). Rationale for the inclusion criteria included: 1) adult status so that the selection of participants would be developmentally consistent with the use of adult learning principles in the educational process, 2) English-speaking due to the interview method of data gathering, and 3) primipara so that all participants were entering into the educational and birth experiences with no personal knowledge of the experience.

Recruitment for the study was by self-selection; therefore, the racial and ethnic mix of the participants could not be controlled. There was no exclusion of participants based on race, religion or ethnicity.

Operational Definitions

The operational definitions for this study were as follows:

Patient Education: Lamaze childbirth education classes, delivered by a community or

hospital based organization.

Patient Perceptions: the self-disclosures of the participants in the study, during audiotaped interviews.

Instruments

The instrument for data collection for this study was the researcher's interview. Some demographic variables were elicited orally from the participants. These included: age, educational level, marital status, socioeconomic level (family income by grouping), and presence and identification of a coach or partner. These data were noted on a coded questionnaire (see Appendix A). The presence of a partner was the only piece of demographic data for which the researcher anticipated possible changes during the time frame of the interviews. That datum was validated at each interview.

The research questions formed the basis of the interviews. The researcher used the interview schedule only as a guide (see Appendix B). The interview schedule was designed by the researcher, and was reviewed by advisors, peers, the Institutional Review Boards (IRB) of both the medical center attached to the researcher's educational institution and the hospital based organization, and the board of the community based organization. The interview schedule was also examined by 14 lay (non nurses) women who had been or were pregnant. They were asked to comment on the clarity of the questions and the language used in the questions. Adaptations to the interview schedule following their examination of it included clarifying the word "tasks" by adding the words "or jobs". The lay women noted that all the questions

were understandable, and were not offensive to them. Since the changes suggested by the lay women were minimal, no substantive changes were made.

As per qualitative research methodology, probing questions were used in order to clarify what the participant had said, or to assist in expanding the information from the participant. The flow of description by the participant was unimpeded by the researcher as much as possible.

Brief field notes were written by the researcher following the interviews. These field notes were for descriptive purposes only, and included such information as time of day, place of interview, presence of others, and non-verbal impressions of the participant by the researcher. The field notes were included in the transcripts, and the originals destroyed.

Procedure

Data collection

Recruitment Recruitment of the study sample from both populations was achieved through mail. When the Administrator of the community based organization received a registration card from a participant who met the inclusion criteria, she mailed the individual a study packet in addition to the usual confirmation card. The packet consisted of: 1) a letter from the researcher indicating the purpose of the study, the extent of participation expected from the participant, the reimbursement they would receive, and a telephone number to call for further information (see Appendix C); 2) a letter from P.E.A.C.E. Lamaze indicating knowledge and support of the research (see

Appendix D); and 3) a copy of the consent form (see Appendix E). A reminder letter was sent approximately three weeks after the first package. It contained the reminder letter (see Appendix F) and another copy of the consent form (see Appendix E).

Recruitment of participants who were registered through the hospital based organization was also through the mail. Participants who were registered for the eight week class were sent a study packet. The packet included: 1) a letter from the researcher indicating the purpose of the study, the extent of participation expected from the participant, the reimbursement they would receive, and a telephone number to call for further information (see Appendix F); and 3) a copy of the consent forms (see Appendices E and G). These participants were asked to sign two consent forms, as both the educational and the hospital institutions had some unique clauses in their respective consent forms. No participant expressed concern at signing two consent forms. At the time of the first interview, the consent forms were reviewed, and differences and similarities between the two forms were noted for the participants.

When the prospective participant phoned the researcher in response to the information packet, she was again advised about the requirements, and the consent form(s) were reviewed. The use of audiotaping during the interviews was explained. Upon positive interest, a verbal consent was obtained by the researcher at the time of the phone call, and the time and place of the initial interview was mutually decided. The consent form(s) were signed at the beginning of the initial interview, and the participant was verbally advised of her right to withdraw at any time. In addition, the participant gave verbal consent on the audiotape of each interview, for later

verification.

Sample Size The sample size was 7. No attrition of participants occurred during the study. In no case were any of the participants in the same Lamaze class as another participant, and to the best of the researcher's knowledge, did not have the same instructor. The exception to this was the use of the nutritionist with the hospital based organization, who rotated through all the Lamaze classes. Since each instructor had a core curriculum to follow for the educational program, the multiplicity of instructors was not viewed as a strong limitation to the study design. One of the concerns with qualitative data gathering is premature closure, or the possibility of ceasing to recruit and interview participants too soon, and thereby foregoing possible data. The threat of premature closure to data gathering was mitigated by the frequent use of clinical and research experts as a trial audience for presentation of tentative results (Ammon-Gaberson & Piantanida, 1988).

Interviews Participants were interviewed at three different times. The audiotaped interviews took place: 1) after registration for Lamaze, but before attendance at the first class, 2) after the participant had attended two (community based organization) or three (hospital based organization) Lamaze classes, and 3) between one and seven days after discharge from hospital following the delivery of the infant. All but one of the participants was discharged from hospital with her infant. The interview time for that participant was held within the research protocol time, with the infant still in the hospital, but going to be discharged the following day.

Interview time ranged from seven to forty minutes and was bounded only by

the participant's desire to talk. All interviews were conducted by the researcher for consistency.

The purpose of the first interview was to have participants describe what their perceived roles and tasks would be during the birth process, what their perceived needs were in relation to meeting their self-described roles and tasks, and how each one imagined that Lamaze classes would meet those needs. All of the first interviews were held within the time frame specified by the research protocol.

The purpose of the second interview was to validate the information given in the first interview, and elicit any changes that might have taken place in the participant's perceptions, based on information received during the first two or three Lamaze classes. While the ideal time for the second interview was following the second (community based group) or third (hospital based group) Lamaze class, it was recognized that arriving at a mutually agreeable time might be difficult. Therefore the research design allowed for some leeway. However, this leeway was not needed for the actual study, as all second interviews were held within the time frame specified by the research protocol.

The purpose of the third interview was to elicit information related to the participant's perceptions following the life event of giving birth. The planned time for the third interview was approximately 24 hours after discharge from hospital, but was up to 7 days after discharge. Leeway was again built into the research design to allow for scheduling, and difficulty in anticipating the exact time of birth. Documentation as to length of time from the desired interview point was kept to see if length of time

influenced perceptions. In the case of Participant B, a miscommunication, coupled with a premature delivery, resulted in the third interview not being completed until 17 days post discharge. The third interview with Participant B was the only interview held at a different time than the research protocol stated. Further discussion of this interview is found in the analysis and results section.

At the close of the initial interview, agreement on a time and place for the second interview was reached. The same procedure was followed at the second interview, with discussion related to the timing of the third interview. The participants were requested to contact the researcher at the time of discharge from the hospital, but the researcher also planned an alternate form of communication with the participants. The plan usually included the researcher contacting the participant within 3 days following the expected day of delivery. If subsequent contacts calls were needed due to late delivery, they were made. The plans were shared with the participant at the close of the second interview. The research protocol allowed for the possibility that the after-discharge contact might elicit the information that the birth had resulted in untoward circumstances, such as premature birth and/or complications, or death of the infant. The plan was that in such a case, the participant would be reminded of the option of continuing or not continuing her participation in the study. This possibility was not needed in this study. A $25.00 gift certificate at the store of her choice was given at the end of the third interview as reimbursement for the participants.

Data Analysis

The taped interviews were transcribed in preparation for computer analysis.

Reading one (the first analysis) for all but one of the participants was completed after all the interviews were completed. Initial analysis for that participant was completed after four of the interview sets were completed. Her data were analyzed early to assure researcher familiarity with the computer analysis program.

The computer software Martin had been developed for ease in analysis of qualitative data. Martin allows the researcher to enter each transcript into the computer program (and on to the screen), and then extract words or phrases that are applicable to the research questions from the transcripts. Each selected quote is saved by the program on a 'card', that is represented on the computer screen. At any point during the analysis, the researcher can group the cards together into 'folders'. These folders are also represented on the computer screen, and are identified by the researcher by descriptive names.

For reading one of the data, each set of three interviews (one participant) was analyzed for words, phrases, or paragraphs that related to any one of the five research questions. During reading one, the researcher had no predetermined groupings or categories. Participant's comments that implied or stated negative feelings towards the educational process as well as those that stated or implied positive feelings were included. Each of these selected comments became 'cards' on the computer screen. Then the cards were gathered into descriptive folders, one set for each participant. The results of reading one were printed for future perusal by the researcher. The descriptive names of the folders and the contents of each was perused several times by the researcher.

Reading two was completed at a later date, after reading one had been completed for each participant. Again, each participant's set of three interviews was analyzed using the computer software, Martin. The data were selected from the interview transcripts in the same manner as reading one, that is, both positive and negative comments were included, and any comment that related to any one of the research questions was selected. This time, however, the quotes were grouped into three researcher-predetermined folders. The folders were 1) reasons and expectations for attending classes, 2) roles and tasks for self and others, and 3) outcomes. These folder names were chosen because of their relationship to the research questions. After much deliberation by the researcher, several themes within each folder were identified. Again, a printout of the analysis was obtained.

The next part of the analysis was to combine the data (quotes) from each of the participants in each of the interviews together. It became apparent that the Martin program could not handle the massive data that would result from combining the results of all of the interviews (twenty-one) together. Thus, at that point, the data analysis continued manually. Using the themes identified from the reading two folders as headings, the quotes from each of the analyses were physically placed in a large working area.

First, the quotes for participant A that had been gathered from reading two were cut apart, and each was singly placed under the appropriate heading. Then the quotes from reading one, participant A, were examined to ascertain if there were significant differences in the selection of appropriate data. Any quotes found in

reading one that were not in reading two were included in the physical placement within the working area. Sometimes, it was found that the researcher had included the same quote, but had split one quote into two smaller ones, or vice versa. It was found that there were few deviations between the two readings. The same process was followed for each of the readings for each of the participants (Reading two, Participant B; Reading one, Participant B; Reading two, Participant C; etc.), until all the readings and participants had been completed.

During the above process, the researcher was assisted by a content expert with no previous involvement in the study. A quote could only be placed under a heading if both the researcher and the assistant agreed on the placement. In some cases, a quote was split apart, and the resulting parts placed under different headings. As well, both the researcher and the assistant agreed that the readings (selection of raw data from the transcripts) were essentially comparable.

Following the placement process outlined above, the researcher re-examined each of the transcripts to ascertain the presence of any further data to be included in the placement. No further data were found.

Within the same period of time, another content expert was retained to provide an external audit of one of the participants. Again, this expert had had no previous contact with the study. The expert randomly selected one letter from A-G, corresponding with the code numbers given to the participants. The research questions, transcripts and printouts of both reading one and reading two for that participant were provided to the expert. She was asked to read the transcripts, and

also the readings and ascertain if the quotes selected represented a consistent and complete representation of the perceptions of the participant. She agreed that they were, and that readings one and two were essentially similar. In addition, copies of reading two were provided to a dissertation committee participant for review related to placement within the folders identified in reading two.

In all but one case, the third interview with each participant was held within 7 days of discharge. As a result, the data from this participant were not included in the final analysis until all of the other data had been placed under the thematic headings. The data from this participant were conceptually consistent with the data from the other participants, hence, she was included in the final results.

Risks and Benefits/Human Subjects Protection

Specific points addressed in the protection of human subjects included:

1) The involvement of human subjects in the proposed study was interview only.

2) Sources of research material were the three interviews conducted with each participant. In addition, there was a single questionnaire that addressed demographic data such as age, marital status, educational and socio-economic status.

3) Recruitment of the study sample was achieved through mail. The researcher had no contact with the study population during the initial recruitment. The participants had to indicate their interest by

telephoning the researcher. The consent form was signed at the beginning of the initial interview, and the participant was verbally advised of her right to withdraw at any time. The participants completed an audiotaped consent to each interview.

4) As mentioned in the consent form, there were no anticipated risks from participating in this study.

5) All interviews were audiotaped, and transcribed with codes attached to each to ensure confidentiality. Field notes, and demographic data were also coded, and kept by the researcher. Transcripts and field notes (including demographic data) were available only to the researcher, transcriptionist, and research advisors. Original data (audiotapes, transcripts and other notes) were kept by the researcher for possible future secondary analysis, but were kept in a locked cupboard and were unidentifiable as to participant to protect anonymity. Consent included the right of the researcher to include anecdotal quotes in the written reports of the research, without citation. Should the participants have requested it, a copy of the aggregate data would have been available to them at the close of the research.

The research protocol was reviewed by the Institutional Review Board of an urban university, and received approval of the full board.

CHAPTER THREE

RESULTS OF THE STUDY

This chapter will present the research findings. First, a description of the study participants will be presented. The study data will follow.

The study data will be presented according to the study's five research questions. The research questions were:

1. What are the reasons given by patients for selecting and attending Lamaze classes when interviewed prior to attending classes?
2. What are the reasons given by patients for selecting and attending Lamaze classes when interviewed after two or three classes?
3. What are the patient's perceived role(s) and task(s) during the birth process?
4. How does the perception of role(s) and task(s) change across time?
5. Does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role or task during the birth process?

Each question will be considered in a separate section. Following the restatement of the question, the themes found during the analysis will be stated. The themes will then be considered individually, with supporting anecdotal data from each of the participants. Since this was a descriptive study, all the data will be presented, even those themes that were mentioned by less than the total participant group. In each case, the number of participants expressing the theme is stated, with some discussion. A summary of the response to each question follows.

Description of the Study Participants

The final sample in the study consisted of seven primiparous women, all taking childbirth education classes in preparation for the birth. Three were from the community based organization's study population, and four from the hospital based organization's study population. All of them volunteered by phone in response to being contacted by the organizations with the introduction letter from the researcher.

The age range of the study sample was 24-32. All of the sample participants were Caucasian. All of them were married, and their husbands were serving as their coaches during the classes and subsequent birth. All participants lived within the metro and suburban areas of Cincinnati. Three lived in rented accommodation, three in their own homes, and one was living with her parents while a home was being built.

All of the women had completed some form of post-secondary education. Two had certificates, one in court reporting, and the other in licensed practical nursing. The remaining five had college degrees, two in education, one in human ecology, one in engineering and one in science. None of the participants had graduate degrees.

All of the women worked outside the home, and had health insurance, either from their own or their husband's work. None covered childbirth education.

All of the participants were delivered of healthy children. One participant had had a problem pregnancy, and delivered prematurely, per vaginal delivery. Three other participants delivered vaginally, but some were induced pharmacologically.

There were no forceps deliveries. Three participants were delivered per Cesarian section (C-section). For one, the decision for method of delivery, C-section, was made because of a breech position. The other two were emergency sections, one because the fetal heart beat had suddenly dropped (also a premature labor and delivery), and the other because of meconium-stained amniotic fluid. None of the participants who had C-sections had expected this outcome, greater than 24 hours prior to birth.

Research Question One

Research question one asked: What are the reasons given by patients for selecting and attending Lamaze classes when interviewed prior to attending classes? Only data obtained during the first interview with each participant were included in this section.

During the data analysis, it was recognized by the researcher that while some of the participants were very articulate and reasoned in their answers, others were unable to state concrete reasons. However, those same participants, during the interview, made comments such as..."that's what will happen at these classes", ..."that's what the classes will do for me", etc. In addition, the participants were asked what they hoped to learn or "get out of" the classes. The answers to those questions, together with the comments suggested above, constituted what the researcher has called "expectations" of the classes. Data related to both patient expectations and reasons for attending have been included in this section.

The reasons and expectations of the patients fell into four main themes. They

were reasons and expectations related to: information and preparation, control, the husband, and a rite of passage. Each theme will be presented separately.

Reasons and expectations related to information and preparation

All of the participants stated reasons and expectations of the classes related to information and preparation. Often, they couched their expectations as wanting to be more prepared for whatever was to come.

Participant A noted that "the main reason is because this is something that I have never been through before, and I'm the person who kind of likes to know what to expect". She also stated, "I want to be more prepared". When asked what specifically she hoped to learn, she said, "I want to know what to expect, in terms of how many people are going to be in the room with me, and how long all this is supposed to take...".

Participant B, in contrast, had more specific informational desires. She stated that she wished to "see the tapes that I've heard about, of the childbirth, which I haven't before", because "I think the Lamaze class really will (make it more real), especially with the video, or you know, the movies and stuff." She also wanted to "find out more about episiotomies, and, um, the different types of pain relief." She believed that being pregnant "raises a lot of questions" and wanted to know about "all those, a lot of those things that the hospitals routinely do versus whether you, um, you know, you can have a choice, in what's going on."

Participant C was experiencing a problem pregnancy, and therefore had had significantly more contact with the health care system during her pregnancy than the

other participants. She stated, "...and really I think the biggest thing is being informed of what is going to happen because even if you're...you can read all the books you want but not really understanding what they say is a big part of it and I think that (the classes) will help me to remain calm knowing that you are going to go and this is going to happen and this is going to happen and at least from the delivery onset, since I already know about the labor onset." She also said, "...I think, it's just the information, and I'm really big into knowing what's happening and why it's happening. So, to get a lot of that out of it".

Participant D was a woman of few words. She answered most questions as succinctly as possible. When asked why she wanted to go to Lamaze classes, she replied, "Because this is my first...baby". She also wanted to know "just what I need to do. The mech....I guess, the mechanics part of it".

Participant E was also a woman of few words, especially during the first interview. She stated that she was going to classes "just to be a little bit more prepared", and agreed that knowing the procedures and what is coming also was important to her. She also stated that since it was her first baby, she "didn't have much experience" and that "I'm a little bit unsure about what's going to happen". She stated, "we'll know what to expect..more through these classes".

Participant F wanted to "get an idea....a better picture in my mind of what is going to happen on that day, that's it, the expected things". She observed that "what to expect is the biggest thing, because this our first child." In addition, she noted that "we'll know what to expect....more through these classes". Participant F had been to a

class on breastfeeding that was not part of the childbirth education main series. She noted that "(the instructor) talked about all the changes your body goes through as well as the baby, and you know, they always talk about how good it is for the baby, but she brought up a lot of good points about you, too". The result was "I'm definitely going to try (breastfeeding) now, since I've been to that class". Perhaps she was envisioning the same positive result from the main series of classes.

Participant G was more loquacious, and had obviously thought about the classes a good deal. She stated, "...what I hope to gain out of Lamaze classes is that--you know, they'll learn me, they'll teach me the breathing techniques and just knowing what to expect when I am there giving birth". She also had specific desires, to know "more about breastfeeding, I don't know if they will really go into it a lot" and " I meant to always know more about labor, and you know, childrearing.....at least, you know, until the first year". She had read the information sent to her from the hospital, and already noted that "they sent it very early so that gave me enough time to decide, you know, what you want to do."

In summary, all participants identified that the classes were important to them because they assumed that they would be provided with information related to what to expect during the birth. They identified that this was a new experience for them, and as such they had no personal knowledge prior to the birth. Some of the participants were able to identify specific topics that they wished to include, and one mentioned the videos as a learning tool. Although only one participant stated it as such, it could be inferred that knowing what to expect would include knowing the routines of the

hospital and the expectations that the health care staff would place on the participant.

Reasons and expectations related to control

The researcher, after studying the data, had believed that there might be two subsets of data related to the theme of control. One was control of pain, and the other was control of anxiety/fear. Only one participant clearly stated that she had an expectation that the classes would assist her with pain control. It was participant D, who said "I want to know what it's going to take for me not to hurt...I know it's going to be painful, but I what to know what to be able to control my, all that other stuff". Further, "(the Lamaze classes) will direct my mind away from the pain".

The technique of breathing is frequently presented as a method of controlling the pain of childbirth. None of the participants directly stated that they had expectations of learning to breathe for pain control. Some mentioned pain in passing, such as Participant B "(learning about) different types of pain relief", or Participant G, who stated that she hoped she would learn about breathing in Lamaze classes. In the section of roles of self and others, it will be demonstrated that most of the participants' believed that one of their roles was coping with the pain and anxiety. This may be why specific expectations related to pain control were not readily discernible from the data.

The theme of Lamaze classes contributing to control of anxiety/fear was mentioned by almost all the participants. As Participant A stated, "so hopefully if I can learn from Lamaze how I can control myself, and keep myself relaxed, it will be a better experience". In addition, she said, "...so we're hoping that Lamaze will calm

me down a little bit. I put too much pressure on myself, and I know I do it and I just can't stop it, so I need people who know better than me to tell me, you don't need to do that". Fear of the unknown was expressed by Participant A when she said, "and I'm hoping that what I learn in the class won't fly out the window, that's what I'm kind of afraid will happen, um, I don't know, its, I mean, fear of the unknown." She restated that at another point in the interview, and said, "fear of the unknown is a big deal to me. That's probably the biggest reason (for taking the classes)". A further concern was expressed when she said, "and I hope that Lamaze doesn't make we worse! I was kind of expecting that the breastfeeding class would help me.....and it didn't, I mean, I really felt pretty bad when I left the class..."

Participant B did not express concerns about anxiety/fear per se, however, as mentioned previously, she did talk about wanting to know about the different types of pain relief, therefore the inference could be made that she might be anxious about the pain.

Participant C also identified herself as a tense person, in fact she felt that she needed to "know basically the relaxing and that because I am kind of a tense person and I definitely need somebody to kind of make sure that I'm not going berserk". This participant had had a previous miscarriage of a 10 week fetus. She noted "this time we are more prepared...and I know what the policies are and whatever. So it makes me feel a little more relieved". For her, the connection between knowledge and decreased anxiety/fear was clear.

Participant D, on the other hand, identified her anxiety/fear in much stronger

terms. She not only mentioned pain, but said, "I think (I'm scared) more of the pain and not knowing what is going to actually happen more than anything else. I am not scared about the baby part, just what I gotta do to get it here". She further stated, "....and I am scared to death."

Participant E had a gentle, understated way of speaking, and this was demonstrated when she said, "and so, you know, there's a little bit of, quite a bit of anxiety, I guess". More support was given for anxiety/fear as a reason for attending classes when she said, "(I want to learn) just a bit more what to expect, and so that I could be a little bit more relaxed, cause I understand that if you're more relaxed, it's a little bit easier".

Participant F did not specifically talk about being anxious or fearful about the pain or anything else, except, as mentioned previously, to want to know more about what to expect. Participant G, spoke about hoping "it is not going to be as painful as I would think, and I hope I am not going to be in labor for, you know, hours and hours and hours".

In summary, the theme of control appeared to be closely related to the themes of information and preparation and roles and tasks for self. There may have been an assumption that with the information and preparation would come the control that was sought, and that much of the anxiety/fear was due to fear of the unknown, and again relieved significantly by information and preparation. While one of the participants did not specifically speak about the issue of control, she had definite items of content that she wanted to learn more about. This may have been her way of stating that she

was anxious or fearful about those things.

Reasons and expectations related to the husband

The original list of suggested questions for the first interview did not include a question related to the participant's perception of the feelings of her husband in attending classes. This was because it was unknown if the participants would be married, or who the coach would be. However, after Participant A specifically mentioned that one of her reasons for attending class was so that her husband could learn, the researcher decided to include a question about the husband with each of the married participants. That meant, in this study, that all the participants were asked.

As mentioned, Participant A clearly included her husband in her reasons for attending Lamaze classes. She identified two ways that the classes would be valuable. One was that the classes were "a way to get my husband involved- its all so...surrounding me, you know, everyone talks to me about being pregnant, because they look at me and see me being pregnant, my husband's kind of on the fringes, so that's the way that I think I can get him involved." She also noted that his class attendance might help her anxiety when she said, "so hopefully Lamaze will help me, my hope is it, it'll show me that he's there to be a participant and not to be someone, you know, to give me something to worry about. Cause that's what I have in my mind, and I mean this is his first child, and you know, we're pretty young".

Participant B also wanted her husband to be involved. She said, "I think, I think that'll really help him too, because he doesn't...I've been reading books and stuff, but he, he doesn't really have any idea what's going on, so I think that will

really help him, and then he'll understand, that you know, and then he'll get to hear other people rather than just me being pregnant".

Participant C, on the other hand, identified that her husband was "curious about what is going to happen. I mean obviously, he's just kind of wondering if it's going to finally happen, so, how is it going to happen". Since her problem pregnancy had necessitated her being on bed rest for many weeks, she also identified that "he is into the normal things about pregnancy, too. He's excited about that. He is disappointed about not being able to go out and show me off or whatever per se. So he's thinking he's going to get with all these other pregnant people and at least be able to see that yeah, she is normal".

Participant D did not talk much about her husband, even under direct questioning by the researcher, except to say that he was all excited about going. Participant E acknowledged that "right now he's not real excited about it, he's had some friends who've gone, and it didn't help, and so..I don't think he's really looking forward to it, but I think he'll learn a lot, I think he'll like it when he gets into it, knowing how he thinks".

Participant F noted that "he's excited about going, cause he hasn't really read anything, or, um, you know, I read to him as I'm reading at night, but you know, I think he's really looking forward to learning more about it". Participant G, had several things to say. She noted that "the major factor making me decide (to go to Lamaze classes) was that my husband, I think, needed to know a little bit more about...well he needed to know a lot more about childbirth and raising children". She

identified that he had not had much experience with children, and was nervous with babies. She was "hoping he'll gain, like, more courage going to these classes". She also had expectations for her husband related to breastfeeding. She hoped that her husband gained information about breastfeeding, "not, obviously, how to do it, but to know what I am coming through and um, the whole procedure." She was concerned regarding her husband during the delivery, she noted that "I guess I am really worried about my husband because he, he keeps saying I don't know how I am going to take, you know, with you dealing with pain". It is not known if the classes were to help him or her cope with the pain of delivery.

In summary, prior to going to any of the class sessions, all of the participants had some ideas of how the classes would affect their husbands. Some were able only to identify that their husband was curious and/or excited about going, and some had definite expectations for their husbands related to acquisition of knowledge and understanding. Only one of the participants identified that her husband was not particularly pleased to be going, but believed that his attitude would change during the classes. This might have been wishful thinking on her part. At any rate, each of the women viewed their husbands as part of the educational process.

Reasons and expectations related to rite of passage

For the purposes of this study, the theme of rite of passage was defined as completing the "normal" or "expected" tasks or rituals associated with the event. Therefore, comments that indicated the normalcy of attending Lamaze classes in preparation for childbirth were included in this category. Only three of the

participants made specific comments related to rite of passage. Participant C noted that there were "a lot of downfalls in my pregnancy and that is kind of discouraging...and being able to.. allowed to go to the childbirth classes has been since yesterday like the biggest thing. It's making me feel like I'm going to be normal for at least for that hour and a half or two hour period once a week".

The other two participants were less straightforward. Participant F noted that "several of my friends have all been through it, and enjoyed it", and Participant G stated that "I got all the information sent to me from (organization) so that made it very convenient".

Other participants spoke around the theme of rite of passage. Participant D noted that her preparation for the child included getting the room ready, going to showers, and registering for the classes. As noted before, Participant E observed that her husband didn't want to go because he felt that the classes had not helped his friends, but it is interesting to note that she had registered the two of them anyway. Participant A, while asserting that one of the main reasons for going was to involve her husband, noted that "he was kind of dreading six Mondays in a row", however, she stated that she had paid for the classes, and they were going to go.

First birth has been described as a life event (Bobak & Jensen, 1991). Some life events have particular and/or elaborate rituals associated with them. An example of this would be the Bar Mitzvah for Jewish boys, signaling the movement into adulthood. Since all of the participants were generally similar socio-economically, it could be postulated that they all saw participation in childbirth education as "normal"

and refusal or failure to attend as the "abnormal" action. Since one frequently does not notice or mention those actions that are deemed "normal", failure by some of the participants to include the theme of rite of passage as a reason for attending is quite possible.

In summary, participants in the study were able to identify four main reasons for selecting and attending Lamaze classes in preparation for their first childbirth experience. The reasons or themes were related to information and preparation, control, their spouse and the rite of passage. The theme of rite of passage was the only category not directly or indirectly mentioned by the majority of the participants. Possible explanations for this absence were discussed.

Research Question Two

Research question two asked "what are the reasons given by the patient for selecting and attending Lamaze classes when interviewed after two or three classes?" The participants frequently did not answer this question directly, even when reminded by the researcher of what they had said in the previous interview. However, they did tell the researcher about the classes and their perceptions about and responses to the classes. This allowed the researcher to explore with the participant whether or not the classes themselves were meeting the needs or expectations identified in the first interview.

Responses that related to their ability or inability to meet their own perceived goals and experienced by them prior to the conclusion of the classes were included in

the categories for this question. The assumption was made by the researcher that both positively and negatively perceived educational outcomes could motivate the participant to continue the classes. For instance, the participant with the positive perceptions or reinforcement could continue to go to receive more reinforcement for achieving her educational goals. The participant with the negative perception could continue to go to try to change the perception, or to change the classes to better meet her identified goals.

The data for this question were obtained during the second interview. As with research question one, data that related to reasons and expectations of the participants were included. The data were grouped into five themes. They were reasons and outcomes related to: 1) information and preparation, 2) anxiety/relaxation, 3) control, 4) the husband, and 5) socialization. Each of the themes will now be explored.

Reasons and outcomes related to information and preparation

Participant A was very pleased with the progress of the classes when the researcher interviewed her after the second class. She stated, "I find that I'm learning about things that I had no idea about", and "I'm still looking for the same things, and I think I'm getting them, um...and more". The connection between learning and lessening of anxiety was made when she said, "...so that, I mean, if I hadn't been to those classes, and they bring out these belts and things, I think I'd be a little concerned". She noted that the information "applies a lot better (to me) (than the breastfeeding class), and when it doesn't, she explains it to me why it doesn't". This encouragement to ask questions was important to Participant A. Also, the instructor

was "speaking from experience...its not like she's just this person reading out of a textbook, she's actually been through it and that kind of.... makes you feel like she knows what she is talking about...".

Participant B was also pleased with the classes. She observed that "all the content is good to know, and it has all been reiterated for me and my husband's learning it as well, and that is great".

Participant C was less enchanted with the classes than she expected to be. After three classes, she noted, "I thought by now we'd have all three stages (of labor) done and we could practice them". She did mention that "I don't know if (my concern) is because I already know some of the stuff, which you know, some people may be going in not knowing anything", she felt there was "not as much actual labor and delivery, it's more of this pre stuff". For her, "the major thing is this delivery, and I don't think I know enough about that yet".

Participant D was also less than pleased with her classes, and observed that "I learned more from (the nutritionist) in one day than two days with this other (instructor)". Her comments that "she's gone over the basic pregnancy stuff", and "she has given us a lot of pamphlets and handouts and I have been reading through those" indicated that there was some exchange of information. However, she noted "I don't even know what a contraction's going to feel like". Her most heartfelt comment was, "I thought the classes were going to teach me something and I was going to be able to prepare myself to go into the hospital but now I am just scared to death". In view of her extreme concern, the researcher ensured that she had the name and number of the

director of the educational program she was enrolled in. However, even with all of her concerns, the participant and her husband planned to continue attending the classes.

The second interview with Participant E revealed very little data. This was partially because out of the two possible classes, she had attended one, and her husband had attended none. The second class had been missed because of a violent storm that night. Her statement about learning and expectations for the rest of the classes was that "they haven't really covered..like all the medical procedures and that sort of thing, but I understand that they will, and that's ...I'm kind of looking forward to that so that we will know." She continued to view the classes as a positive preparation for the childbirth experience.

Participant F found the classes informative and interesting. At the second interview she noted, "the nutritionist was neat, um, she came and talked about nutrition for us and for the baby" and "the stages of labor, that we're doing now, and that's been real interesting because I didn't even, you know, I've read about the stages of labor, but you know, she brought last week the props and stuff and showed us exactly how the baby comes out of the birth canal and stuff, so.. you know that was really neat". She identified that she and her husband were "reading a lot of materials that she gives us, and...um, we're really (bad) about practicing our breathing exercises, but we have a little bit, I guess. I'm still reading a lot and I have definitely been eating better since we went and (the nutritionist) told us, you know, the last three months is the time when this and this happens, so..". She was also "looking forward

to seeing the movies cause you know, I've never seen anything like that before". The education had assisted her in being prepared because "from the classes hopefully I'll stay home longer than, I mean, instead of like wanting to run right to the hospital, as soon as it happens, and ...I have a better idea of what the labor rooms are like". However, she still believed that "I don't know really what to ..picture (about the delivery)" and "mostly (was looking for) just general information". She told the researcher that "in a couple of weeks there's a pediatrician coming which, you know, I'm really looking forward to that, and um, the tour".

Participant G also found the classes very helpful. She noted, "they are covering everything and they're going at a good pace. They are not going way too fast or and they're not going real slow, to where you're going "Ok, I know this, hurry up"". She observed that "last night we had the dietician (nutritionist) ...she was dry but she really had a lot of information but she was dry". The tour was appreciated because "I really felt that I learned a lot about what, you know, was going to take place". She observed that "(the teacher) started talking about the early active and the....transition periods of labor. So that's where we are right now. I learned a lot already. Yeah, last night I really learned a lot".

In summary, all of the participants expressed satisfaction with the classes at some level in terms of information and preparation. While Participant C noted that the classes were beginning with information that she already had, the possibility of learning more in future classes was still a positive goal. Participant D was not happy with her instructor, but believed that others (e.g., the nutritionist) could assist her in

meeting her information goals. Therefore she also planned to continue the classes.

Reasons and outcomes related to anxiety/relaxation

Most of the participants appeared to sense a strong connection between anxiety/fear and relaxation. As well, most of them had identified as one of their goals, either for the classes or for the birth, that they needed to know how to relax.

Participant A remarked that "(we) do relaxation and massage, and that's my favorite part! I get to lay on the floor and my husband has to get me relaxed, I like that, makes it worth the money I paid to take that class". However, in contrast, she observed "reality's hitting me, and its making me really nervous". When she compared the Lamaze classes with the breastfeeding class that she had gone to prior to this series, she said "it makes me feel a little less bizarre". She continued to express concerns that she might forget some of the information, "My big hope, um, is that I (deliver) early enough, so that it's like, right after classes are done, I mean, I don't want to (deliver) early, but there's a woman who's due the last night of class, and I think it would be so nice because it's going to be fresh in her mind, I mean, once we get out of class, and you know, she gives us homework, practice relaxation and all of that, but we usually don't get around to it". It was not only about her own learning that this participant was anxious, she noted, "last week (the instructor) asked a question, kind of quizzing the fathers on something we had learned the first week, and my husband didn't raise his hand, and that kind of made me nervous".

Participant B noted that they had done some exercises with the breathing in class, and she found that "the breathing really helped (the pain) and I was surprised by

that." She identified that a new goal for her was to concentrate on the techniques, "trying to avoid pain as much as possible". This participant summed it up by saying, "I think about the pain, and then I think about the excitement and, like I can't wait for it to happen but then I'm still, I'm kind of scared a little, too".

Participant C, perhaps because she observed that the classes were not at her level of informational need, had little to say about how the classes were or were not meeting her anxiety needs. However, she did mention that the breathing techniques were the same that she had used with her 10 week miscarriage, and said, "it kind of made you feel like you actually, even though everything's been wrong, at least something was going ok". As was mentioned in the theme of information and preparation, this participant was very much hoping that the topics of the actual delivery would be covered the next class, "cause that might be my last class" and she was concerned that she wouldn't be prepared. She was anticipating a premature delivery due to her problem pregnancy.

Participant D, was quite vocal about her anxieties surrounding the birth and the classes, "I mean that's why I went to the classes was to find out what I'm going to have to do to try to ignore all this pain I am going to be in and I don't feel like I am getting it. I'm just, I just feel I will be unprepared when I get to the hospital and not know what to do". She stated, "my idea of (the birth) is that it is going to be a panic, cause I'm not goi...I feel like I am not going to know what to do". She obviously believed that the relaxation and breathing exercises were important in meeting her anxiety needs when she said, "when it comes down to the breathing exercises and

relaxation stuff, I think out of two classes we have gotten 15 minutes of just sitting on the floor and closing our eyes. There's nothing else."

Participant E, even though she only attended one class, identified that "we learned a lot of things about how to relax" within that one class. Participant F, noted that one of her goals for the birth had changed. She had decided, after the classes, to have an epidural during delivery because "I'd rather be able to enjoy it more, and you know, see the whole thing, and whereas I think if I was in all that much pain I wouldn't, you know, probably be able to see as much because I'd be worried about other things, other than just the baby coming out..". Another factor in her decision was the fact that a friend had "gone natural" about six weeks previously, and this participant had decided that she did not wish to repeat the friend's experience.

Participant G identified that she was feeling less anxious than during interview one. She noted, "I guess the last time I was picturing (the birth) to be more-- I was a little bit more, I was a lot more nervous, I guess because I didn't know what was going to go on. Now, I know when I get in.....(describes what the health team will do)...I was so much at ease last night when she was explaining everything, and I don't know, it was just, I feel so much more at ease than I did without knowing that". She also identified "what I like about this teacher is that she really makes it easy to ask questions. She does not make you feel like an idiot, like 'why are you asking that question.' You know, but she really makes it easy to ask questions, and you don't feel like an idiot, you can just ask anything".

As was noted in the themes of research question one, the themes of information

and preparation and anxiety/fear/relaxation were closely related, in fact the two were frequently mentioned in the same sentence within the participants' perceptions. The participants who perceived that their informational needs were being met were the same individuals who perceived that they were less anxious.

Reasons and outcomes related to control

Another closely related theme was the theme of control. In some cases the participants were able to identify control as an issue for them during the second interview.

While Participant A had always noted that not being in control was a concern for her, by interview two she had identified some activities that she could do to assist with this. For instance, "my husband will have to sign paperwork (at the hospital) --- well we're going to do it ahead of time". As well, "I think the part about keeping myself in control, I think I'll be a little better at that now, you know, because I'm a little more.. I'm a little more aware of what to expect....and we're going on a tour....and I think that will be helpful to me when I get there, I can say "oh, I've been here before", so it won't get me so freaked out". This participant was ambivalent about using drugs to maintain control. On the one hand, "I was going to get to the hospital and demand drugs". On the other hand, "Now I feel some, going to these classes and reading the material that she gives us, that maybe I could deal a little longer without medication". She summed it up by saying,"I still foresee that it's going to be hard on me, but I think, if I can concentrate on what we learned in class, I maybe can handle it better. And I think now, that I can handle it, which I didn't

before I started".

Participant B believed that "the more you perceive pain to be, the worse you perceive it to be, the worse it will be". She had identified that the techniques she was learning were helping, and noted that assistance as a positive outcome of the classes. Participant C reiterated that for her, control was a goal, and continued by saying that one of the ways she would meet that goal, was to have a drug-free delivery, particularly "I do not want the epidural, cause it looks like it will hurt". When asked what she would do if she could not meet her goal, she said, "I don't think I will be disappointed or anything because I know it will probably be the best".

Participant D did not mention control per se, however, after she had described how frustrated and scared she was because she felt that the classes were not meeting her information and anxiety needs, the researcher asked her if she felt that she would have to depend on the health care team more than she had expected to. The participant replied, "Right", and the researcher continued to ask if it was correct that the participant felt more out of control. Again, the participant quickly agreed.

Participant F, as mentioned previously, had decided to have an epidural. This seemed to give her a sense of control over the action of the delivery. Participant G was going to achieve her sense of control by "concentrat(ing) on, you know, on having a healthy baby and, you know, breathing right, and you know, forgetting about the pain".

In summary, although most of the participants were able to identify actions or decisions that they were planning that would afford them a stronger sense of control,

they did not all identify the issue directly. When the researcher asked a few of them directly, the answer was in the affirmative.

While all of the participants readily noted that they recognized that total control of the situation was impossible, given the nature of labor and delivery. What they seemed to be searching for was what has been identified as perceived control. From the data in this study, perceived control was described by the researcher as the perception by the participants that they were aware of what would generally happen to them, the procedures and policies of the institution, and the decisions that they had control over. They also had the knowledge and information to make those decisions.

Reasons and outcomes related to the husbands

Several of the participants had identified goals or expectations of the classes for their husbands. This was followed up in interview two. All of them had something to say.

Participant A noted that "my goal was for him to learn, I'm hoping he's paying attention, I mean, he finds the beginning part of the class kind of boring, and I don't know if he's listening or he's daydreaming". The action of him not raising his hand when the teacher asked a question continued to bother her, she mentioned it two or three times during the interview. This participant also noted the actions of the other men in the class, and offered opinions on how much help they would be to their wives if they continued to not pay attention!

Participant B felt that "he takes it a lot more seriously than I thought. So um, and I think he is learning a lot. He is asking a lot of questions and stuff, which is

good". Participant C's husband was even more involved. She continued to have contractions at home, and noted that he continued to be "a very big advocate of making sure that I stay home and breathe when I have contractions". He was also active in class, "the videos make me sick and he just looks at them. I cannot watch those things. But he, he's real excited".

Participant D had expressed several concerns about the classes during the second interview. These concerns also included her husband. She said, "he is not going to know what to tell me to do when, even if I knew what to do for myself that I couldn't do it because it was going to hurt so much and he would have to remind me and he's not going to know what to tell me to do". In relation to the instructor, "he is more aggravated that sh..just the same as I am". She noted that "my husband mentioned (our concerns) a couple of times which I don't think she is really listening".

Participant E's concerns related to her husband centered around the fact that he had not yet been to class. She said, " I am anxious for him to be going, too", and "I would have felt better if he would have gone, I think he would have benefitted from it. Some of it I had learned in school, and you know, had read and things like that. I think he would probably have benefitted a little bit more".

Participant F's only mention of her husband in the second interview was to note, "I think he likes it. He, um, he definitely says he's learning a lot". Participant G identified one of the reasons that she was glad her husband was learning in class, "it's different than me just telling him, cause he's hearing it from an expert. So, I mean, that's..this class is great for that reason alone, just for my husband to hear all

that stuff". She also had concrete examples, "I think he liked listening to, just the same as I did, the care of the baby cause, even probably more that I did, cause he didn't realize you know, I didn't realize that, I didn't realize this", he didn't realize like the different tests they run afterwards, PKU test, and all that stuff, but interesting, cause I could hear him telling others, "Well, you know they do this, and they do that"".

In summary, the participants' perceptions of how their husbands were coping with/enjoying classes was strongly colored by their perceptions of the classes for themselves. The exception to this was Participant C, who found the classes not as wonderful as she had expected, but believed, through observing his interest and excitement at the classes and with the "homework", that her husband enjoyed them. The difference she identified could be because she perceived that he had identified attendance at the classes as part of a "normal" rather than "problem" pregnancy.

Reasons and outcomes related to socialization

For the purposes of this study, the theme socialization was given to participants' comments that related to the interaction between the class participants. There were no negative comments related to socialization with other class members, although some participants did not isolate socialization as a positive aspect of the classes. Sometimes the comments were spontaneous, other times they were in response to the question, "is there anything that you would do to change the classes at this time"?

As Participant A said, "It's nice to see other people have the same problems,

you know, all the women coming in and complaining about this is hurting and that's hurting, and it's nice to know I'm not the only one! I know I'm not the only person who's ever pregnant, but I'm the only person in this house who's pregnant, and it's kind of nice to have someone else to commiserate with". Participant B noted that what "I would do in addition I would try and make the um, the couples interact more and in that way maybe um, everybody would get to learn more about everybody else's experiences".

Participant C, who had embraced the classes as a chance to be out among other people, noted that for her, the fact that she had some prior experience (the miscarriage) set her apart from the others in the class. At the same time, she noted that everyone else was very concerned for her with this pregnancy, so the "abnormal" response was still a positive one. She observed that her husband "enjoys being with other couples that are expecting and that kind of makes things nice for him, so...".

Participant D made no comments about socialization, her concerns were with the instructor, and her own anxiety. Participant E, on the other hand, having gone to her single class alone, noted that "there was some time after (the class) when we got together and talked about it among ourselves." She felt "it was helpful to see other people that were kind of going through the same thing". Participant F observed that there were two other couples from their area of town in the class, and that she was glad to have met them, but that was all she mentioned. Participant G did not mention social interaction with the other couples at all during the interview.

In summary, just over one half of the participants identified socialization with

the other class members as a positive outcome of their educational process. It is possible that the participants who did not talk about it had other, more pressing priorities (Participant D) or had other networks of individuals who served the same purpose in their lives.

The themes that emerged from the data in answer to research question two were information and preparation, anxiety, control, husbands, and socialization. In all cases except socialization, the data to support the themes came from at least six of the seven study participants. Information and preparation, anxiety and control were very closely related. Some of the data responses (even single sentence responses) could have been appropriately assigned to more than one theme, making some of the analysis difficult. The general perception was that with greater information and preparation and less anxiety came greater control. The participants' perceptions of the husbands' responses were colored by their own responses to the educational experience. Rite of passage, a theme from the first interviews, was not a theme in the second interviews. However, it was replaced by the theme of socialization. Like rite of passage, socialization was mentioned by the fewest participants of any of the themes for the research question. In one case, the participant was not at all happy with the classes, and in another case, the participant was not as happy as she had expected to be. In both cases, the participants did not indicate that this disenchantment would keep them from continuing with the educational experience.

Research Questions Three and Four

Research question three asked, what are the patient's perceived role(s) and task(s) during the birth process? Research question four asked, how do these perceptions change across time? Since the two questions were so closely related, and in fact, required the researcher to compare the data from interview two to the data from interview one, they are presented together.

Some of the researcher's questions that elicited data related to the roles and tasks were "Tell me about how you picture the birth day? What will be happening? What will you be doing? What will others in the room be doing?" Data for this question were also noted in response to participant's statements of goals for the birth.

The data for this question were presented by participant, using data collected during interviews one and two. Changes in perceptions across time were explored for each participant. Finally, a summary of the data for the group was presented.

Each participant identified for the researcher not only her perceived roles and tasks, but how those differed from the perceived roles and tasks of the other participants. These were grouped into perceived roles and tasks of spouse, and perceived roles and tasks of the health care team. The contrasts and comparisons of the roles and tasks of the other participants (husband, health professionals) in any one birth process are presented with the data on own perceived roles and tasks, by participant.

Participant A had difficulty projecting an image of what the birth day would be like, but she identified two main roles and tasks for herself to assist her in making the

birth "an enjoyable experience". The first one was maintaining control of herself. She observed, "I imagine I'm probably going to be pretty nervous", and "in the delivery room I don't really think I'm going to be in control". She also identified that "I'm a real perfectionist person, and I don't want to do it wrong". When asked what "wrong" would be, she replied, "Losing my cool, crying, ..(my sister) said she just freaked out, and to me, if I did that, I would just feel like I failed, which is so stupid".

The second goal that Participant A identified was to console her husband, or at the very least to put on a brave show for him. She noted that "he's probably going to be more freaked out about this than I am. Partly because it's just an idea to him, and you know I feel the kicking and the moving and go to the doctor all the time, and I have the feeling once the reality hits, he's going to be pretty freaked out". She believed "I've got to put on a brave show so he thinks I'm doing it right!" She arrived at this decision because she thought "he expects it of me, maybe he doesn't, that I need to keep, you know, everything under control, so he hasn't said to me, you know, I'm going to freak out and I need you to help me, but I just, I feel like that's one of those unspoken tasks, like doing the laundry, which I've got to do because I'm the wife."

At the time of the second interview, Participant A identified that her two goals had not changed, in fact the second goal, related to her husband, had received reinforcement. When he failed to raise his hand at the 'quizzing question' that the teacher asked, the participant felt that if he couldn't remember those things, then that was just one more thing that she needed to remember, because he wouldn't. She

believed that there was even more pressure to perform.

Participant A was able to contrast her roles and tasks with those of some of the other people in the delivery room. At the first interview, she did not specifically identify a task for her husband, perhaps because she had no expectations of him. She did visualize "my doctor telling me what to do, and I'm going to lay there and do what I'm told! Hopefully without too much hysteria on my part!" During the second interview, this participant identified that the biggest role for her husband was that "I don't want him to leave me, I'm just so afraid that I'm going to freak out, and I want him to sit and say, you know, calm down and relax...".

In summary, Participant A's goals remained maintaining control and assisting her husband. She strongly desired comfort and support from her husband, but was unsure if she could trust that it would happen. Other than guidance, she was unable to identify roles and tasks for health care team members.

Participant B was similarly unable to give a strong picture of what the birth day would be like, and her roles and tasks involved. Her goal was that "I'd really like to be able to go natural", but "I don't want to get myself set up for disappointment if I can't". When directly asked what she thought the birth day would be like, she replied, "I see me trying to, um ... I don't know, but it'll be really neat once the baby gets here". By the second interview, she had not really changed the picture in her mind, but noted, "what I'm getting from the classes is that you need to stay in control, control of yourself like, um, the more you perceive pain to be, the worse you perceive it to be, the worse it will be and so, um, I think that is going to be a main, my main

goal initially. That is what I see right now. I am trying to stay in control and just listening to my instructions and trying to do my best".

Participant B did note that she was "worried about my husband, cause he's pretty queasy, so I'm afraid he'll pass out on me". She had identified that "I think my husband and the doctors and the other people, I guess they all try to (help you bear) down and relax, whereas I (try to use) what I've learned, and try and follow that". By the second interview, she was able to identify a more specific role for her husband on the birth day. She said, "I mainly see him as being just a supportive role, well, that's not necessarily true, he has to tell me how to breathe and all that. So... very encouraging".

Participant C, since she had been through the 10 week miscarriage, believed that she had a clear image of what the birth day would be like. She noted that the day would "kind of be a relief, I think. Probably the biggest thing is just knowing that I have worked for this for many weeks at keeping a healthy baby, and now I'm actually going to be able to deliver it. So I think it will be a big relief, still anxious.... but there will be a lot of excitement and a lot of relief basically, hoping that everything comes out ok".

She identified that "my number one task is to remain calm", and expanded on that theme by stating, "(I will be) trying to breathe and trying to tell myself that everything is going to be okay this time and reassuring myself that if something doesn't happen right it is not my fault, and that I shouldn't feel guilty about it, cause that's be a definitely big factor in what happens". If "things go wrong" she had

particular tasks in mind, "because we don't want to go into the hospital and have..... something happen and have things told.... like what's going to happen. We're going to tell them what our preferences are".

This participant recognized that she wanted to "strive toward a drug free pregnancy" but also realized that since she had been on several medications throughout her pregnancy, this would be a difficult task to meet. The theme of drug-free delivery continued into interview two, "even more so. I do not want the epidural cause it looks like it will hurt...I think I am more into it because now I think that it's not as...it looks like it is painful but it is not as difficult as I think a lot of people go into it thinking, so I'm kind of....seeing I have already gone through all this stuff, I can handle it....it's kind of even grown more, it's my goal, is to do it drug-free".

By interview two, she had a few more specifics related to tasks and roles. She noted that "its going to be painful and bloody, and I can't handle that. I'll keep my eyes closed". She wanted to "hold off as long as I can, and just probably just barely make it to the hospital, which will be fine". She noted that if she needed pharmacological assistance to remain calm, "Demeral and Staydall usually just give you a more calming effect than anything else". She identified that taking those drugs would interfere with her goal of remaining drug-free, but said, "I don't think I would be disappointed or anything just...I know that's what has to be done and it has to be done". However, "I won't have an epidural, that's for sure".

Participant C did not identify tasks for her husband on the birth day that were different from what he had been doing during the entire pregnancy. She noted that he

was very supportive at all times, even encouraging her when she really didn't want to be encouraged! When asked how her roles and tasks differed from others' in the room at the time of the birth, she said, "everybody else kind of knows what is going on besides my husband but he is getting used to it these days". She was continually being monitored at home during the pregnancy, she originally had stated that she would know when to go to the hospital because "they are going to tell me I had 22 contractions and they'll send me to the hospital". She was socialized into the role of the recipient who does what the health professionals tell her. She indicated that all of this was worth it to have a healthy baby at the end of it all.

Participant D strongly believed "(my job is) getting the baby here". She identified that "I've got the biggest job". Her other task was related to her husband, since "knowing my husband, it is going to be panicky for him", "I am more or less going to have to baby-sit him....until we get to the hospital..". By interview two the task had not changed, but the self-expectations had. Now, "I should go (to the hospital) and at least know something" had become important. Although she believed that one of her tasks was assisting her husband, he also had tasks. She noted that "my husband is just, I guess, is just to yell at me to get me to push". She stated that in order to do that, her husband was going to have to know what was going on, so that the information was also important for him. At the first interview, she identified that "the nurse, I don't know really what the nurse does in the delivery room, but the doctor is there to make sure it comes out all right, I guess". By the second interview, she expanded this to "I will be going through every contraction.... they (the nurses)

can tell me just, they can run in the door and tell me something and then run out." Clearly she did not expect much support in her tasks from anyone else.

At the time of the first interview, Participant E was able only to identify that her job was "just to help as much as I can, with the delivery". During interview two, she was able to say, "I think it helped me to say, well you know, I am really going to have to go through this rather than put it off and say, well this happens to somebody else or something like that. It's so powerfully, you know, to realize it a little bit more realistically that you really are going to have to do work". However more realistic she believed she was, when asked what she thought her jobs would be during the delivery, she replied, "I'm not exactly...I'm not sure, I guess. You don't know until you have gone through it....I'm not sure how to answer the question". She did offer that she needed "to probably relax and to, you know, participate as much as I can to make the whole process easier". She observed that "the doctors and nurses would actually be doing a lot more, on the medical side of things". Her husband "would be just there for support, and maybe to remind me of what I need to do". By the second interview, her expectations of her husband were that "(he) more than me will know what to expect", presumably so that he could give her support.

Participant F had only one two-part self-expectation in interview one. It was "remaining calm... trying to enjoy (the birth) as much as possible". She reiterated that she saw herself as "hopefully calm" during another part of the interview. By interview two she had a few more ideas. She stated that "I'm not real sure (what will happen on the birth day)", but noted that "at first I always thought that one of my goals would

be to go natural, and try to do it without, you know, but I, I've pretty much decided that's not what I want, I'd rather be able to enjoy it more and you know, see the whole thing, and whereas, I think, if I was in all that much pain, I wouldn't, you know, probably be able to see as much, because I'd be worried about other things, other than just the baby coming out." However, now, "I've pretty much decided that I'm not going to go natural, so..you know, I'm going to have an epidural". She believed that accepting the medication would assist her in remaining calm, and trying to enjoy the experience, her two main self-expectations.

At the first interview, this participant identified the nurse "just coming in and out and checking" and the doctor "coming in when it's going to happen, you know, not coming in till the very last minute". However, she identified her "husband, poor guy, having to do everything else!" This also identified where she believed her support for meeting her goals would come.

Participant G identified that her primary tasks were "the pushing and the breathing". She observed that she had "a lot of stamina", and she would "be able to get through it just fine". By interview two, while her basic job had remained the breathing, she had more self-expectations. She noted that "it's got to be mind over matter, I've got to totally relax and just take each contraction as it comes, don't worry about the next one. I mean, you know, concentrate on that one and just, you know, put your mind in a state of relaxation".

This participant identified that she "needed to know that I can rely on my husband to..if, you know, cause I will be in a state of.. whether its pain or excitement,

or you know, it's probably'll be very easy to forget or you know, get so nervous, so at least I have him there to lean on and everything". During interview two, she identified that the coach's (husband) job was also the breathing.

At interview one, this participant indicated that the nurses and the doctors were there for "instructing me to do what I need to do..breathing and pushing and, you know, how much further do I have, how dilated I am or stuff like that". As well, she noted that "I think the doctors and the nurses, I guess, just basically because I am not going to know like if something goes wrong, I am relying on them to, you know, be on top of everything if something goes wrong". When asked at interview two how she saw her tasks differing from others in the delivery room, she said, "I think their's is more from a medical standpoint, they're...let me see. I wouldn't know personally, how many centimeters I'm dilated, and the part I know is how the pain is and how I am feeling and how many seconds or how many minutes they are apart and how many seconds they go for. They're more, I would think they're more responsible for anything medically that goes wrong that I have no, that I really have no control over because they tell you "don't really think about that". (The instructor) was telling us last night, you know, this room is equipped, the nurses are well equipped, they're very knowledgeable and all this". She was the participant who most clearly laid out exclusive tasks for all the persons in the delivery room.

In summary, the participants perceived several commonalities in delineating their roles and tasks. The most common role identified was remaining in control. This role remained constant throughout both interview one and interview two for each

participant. The participants identified various strategies/tasks for remaining in control. One was to get more information, so that they would feel/be more prepared. Another was to make decisions related to medications prior to the birth experience, so that at the proper time they could just implement the decisions. Some saw relaxation as a means to a less painful end, while others identified their role as enjoying the birth experience, and identified that a relaxed birth was an enjoyable birth. Most of them indicated on some level that losing control would also mean a certain measure of failure to attain their own role expectations.

Another role and/or task that the participants perceived was related to their husband. While some of the participants identified that they needed to console, assist or support their husbands, the underlying message seemed to be that they wished someone would support them in the manner they were anticipating needing to support their husbands. For some of the participants, the underlying message was quite clearly articulated. The tasks related to the husbands were also frequently consistently identified across time. In some cases during the second interview, there was the feeling that more support for the husband would be needed, and in some cases, the later perception was that the husband would be more support to them than previously identified.

None of the participants were able to state exactly what they thought would happen on the birth day. This was an expected result, given that the sample was drawn from primiparous women. Even Participant C, who had had a previous miscarriage at ten weeks, was really unsure of exactly what would happen at the birth

of a term or premature baby. A few of the participants recognized that one could not really comprehend or understand the situation until one had progressed through it. However, it was also clear that they did not identify the health professionals as providing support during this unknown time. Rather, they saw the health professionals giving direction, and themselves as the more emotionally passive recipient, striving to be the good patient, and do what she is told.

When tasks for nurses and physicians were identified, the nurses were the ones who came in and out of the room during the labor process, checking that things were progressing appropriately. With only one exception, physicians were identified as individuals who showed up in the nick of time to deliver the child. The participants did note that the all the health professionals were there to assist if anything went wrong. This realization produced an underlying sense of relief that the women would not need to concern themselves with identifying those kinds of situations.

Research Question Five

Research question five asked, "does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role or task during the birth process"? In responding to the question, a review of the theoretical concept of enablement is required.

Enablement was previously defined as "to assist the patient to acquire or expand the means, abilities and opportunities to complete a task or fulfill a role, to the patient's perceived level of satisfaction". The subconcepts or components of means,

abilities and opportunities were further defined. Means were defined as the resources required, abilities were the skills required and opportunities were chances to complete the task or fulfill the role. It was noted that although it was presently impossible to quantify the components required to complete the concept, it was understood that elements of all three components were necessary to complete the enabling process. The outcome criterion, as specified by the definition, was the patient's perceived level of satisfaction.

The data for the response to this question were gathered from the third interview with the participants. Questions that were asked included "tell me about the birth of your child", and "if you could design a Lamaze class that would have been perfect for you, and met all your needs, what would it be like". Data were included that indicated that the participants believed that they had met their goals or not met them.

As previously mentioned, all the participants successfully delivered a healthy infant. Since the participants were not really sure what to expect during the birth experience, it was assumed by the researcher that their level of satisfaction would be colored by their perceptions of their own success or failure during that experience. The data indicated that although all were pleased with the end result of a healthy infant, there were varying levels of satisfaction with the birth experience itself. The same was true of the perceived and identified satisfaction with Lamaze classes in preparing them for the experience.

Since the stated goal of childbirth education was to prepare the individual for

the experience, it was assumed by the researcher that participants with generally positive perceptions to relate would be those who were most satisfied with the experience, and believed that they had, in fact met their self-imposed goals/expectations. This assumption was supported by the outcome criterion within the definition of enablement, which states "patient's perceived level of satisfaction". All the participants related some positive perceptions to the questions in the third interview. There were four participants who also indicated definite negative responses. However, even the participants who had some negative perceptions had some positive perceptions as well.

With the assumption mentioned in the previous paragraph in mind, the data are presented, by each participant's responses rather than as a whole. After reporting each participant's data, the analysis of the participant's perceived level of satisfaction both with the birth experience and the classes in preparing her for the experience is presented. The summary of the responses in light of the theoretical concept of enablement follows.

Participant A

Participant A had identified two main roles for herself. One was maintaining control, and the other was assisting her husband. She had identified that the physician would tell her what to do, and she would do it. Participant A had an unexpected result to her pregnancy in that, at the last moment, her baby's position was identified as breech, with the result that she had a C-section the next day. She therefore had one day to contemplate what was going to happen.

When asked about the decision to have a C-section, she observed that she hadn't been expecting the decision at all. "But I mean, I was so worried about labor. So worried that I wasn't going to perform well, that it was kind of nice that I didn't have to do anything." She related that she "did use the calming breathing when they were giving me the spinal, cause I was really, I mean, you know, I couldn't see what they were doing".

Later in the interview, when asked about the goal of controlling herself, Participant A noted that "I did (lose control). Well, I, I could have been worse. I expected that I was going to be a lot worse than I was". She identified the point at which she had the most problems as "I was okay until they separated us (my husband and me)..... I felt better when he was there, and I thought he was going to make me worse, but he really didn't". "I was concerned that (my husband) was going to be bad, and he helped me more than anything". Other individuals in the delivery room were also identified as having assisted her in meeting her goals, specifically the anesthesiologist and the nurses.

Participant A's positive statements were overshadowed by her negative statements. She noted that the C-section was "not what I was ready for". For instance, "the spinal kind of bothered me. I wasn't prepared, I mean, in class we learned what the little instruments looked like, but I was not really ready for what was going to hurt and the spinal, it was hurt...it hurt for maybe five seconds but it was pretty painful to get that medicine in there and it hits immediately, I mean suddenly you are immediately numb from your collar bone down to your toes, and that was

kind of, it was unexpected, because I didn't think it was going to be that quick". She noted that she had used the breathing with the spinal insertion, but "when I was having the surgery, the breathing and all that, that was the last thing that I was thinking about, you know, and I was getting myself pretty crazy." During the C-section, "I wasn't in control and you know how that is...I don't like that. I could feel them you know, moving my body, but I could not feel any actual cutting. It was a very weird situation. And it was kind of...it got to me. I have to say it got to me".

In class, "there was one evening that they devoted to C-section, and they had a movie. But the week before they had a movie of vaginal births and it really bothered me a lot. So I chose to not watch the Caesarean movie". She went on to say, "(the classes were) not helpful for my situation. And maybe if I had watched, you know, the C-section film I would feel differently. But they didn't really focus much on it. It was more, you know preparing you for what contractions are going..you know, and what you do when you have them. I never had any labor. I never had anything." "I felt like even thought I all along felt prepared for all this, suddenly I felt very unprepared ....it kind of overwhelmed me at the last minute". "If they spend a little more time on, on other options other than the normal, you know vaginal birth because that's not what everybody has. And um, even one of the other girls in the class .... she had to have a forceps delivery, and she, you know it was awful and she didn't know. They never even talked about it really." "I mean, if I had gone vaginally the classes were great. I really felt prepared for that even though it scared me. They were very, you know, good detail about the breathing and pushing and all that".

This participant seemed to vacillate between being very angry about the lack of preparation and blaming herself for it. For instance, "I would have been more prepared had I watched the film. Even though they talked more about, actually they talked more about epidural and I chose to have a spinal instead....But I just wasn't, wasn't quite prepared and that's my own fault, cause it was offered to me....But I'm sure that the, it, from what the people who was it told me it showed the procedures and I really had no idea what was coming up".

Finally, the classes seemed to make Participant A focus on the pregnancy more than she wanted. "And we talked about it and we did the breathing, and they gave us all kinds of literature and it was almost like I was sick of hearing about it. And you know it made the last couple of months seem so...long.....It was almost like my pregnancy went quicker when I was in the early stages and I didn't think about it".

In summary, Participant A found that she experienced great difficulty in meeting her role of maintaining control, but her role of assisting her husband was not needed, indeed, he provided strong support to her. She was somewhat ambivalent about the classes. On the one hand, "we kept teasing, "we wasted our money"". On the other hand, "I was glad we went cause it got (husband) involved". Participant A did not express a high level of satisfaction with the birth experience, or meeting her goals, therefore she was not enabled.

Participant B

Participant B had identified two goals. One was to "go natural", and the other was to remain in control. She believed the goal of control was heightened by what

she had learned in class.

Participant B also had an unexpected C-section. However, hers was even more unexpected in that the decision was made in the midst of premature labor. She had previously identified that staying in control was important for her, as well as "going natural". She had also previously identified that she didn't want to set herself up for disappointment if she was unable to meet the second goal.

Positive responses by Participant B focused on her husband's response, her own preparation, and the use of a spinal block. She was pleasantly surprised with her husband's response to the birth. The labor had begun at home, and "he was all prepared, and he was very calm going in, well pretty much calm going into the hospital, because he had all day to think about it". And, "my husband did great. He, I told him not to look because if I saw any fear in his eyes I would be really..I'd get sick". This participant found that "the breathing helped, and the relaxation techniques you can use for any time. So that was great..." She also noted that "I think I'll be prepared for the next time if I, you know, if I can have a vaginal delivery next time". The spinal block was helpful to her because "then I could see (the infant). I could see him once he was born and I had a little, I was a little more involved that way".

Negative responses by Participant B focused on her goal of maintaining control, and the actual C-section. One of the activities she was looking forward to in the classes was the videotapes. "I was prepared for a C-section in that, I, I saw the tapes.... everyone said "Oh, that's not so bad" I said, "That's terrible, look at that gaping hole in her stomach"". She noted that "(the video) was helpful, but it made me

fearful.... a lot of the reading that I did (helped).... I even remember reading don't be disappointed if you have to have a C-section because the baby, you know having the baby come out healthy is more important than, you know, having a vaginal delivery". "I was worried about the episiotomy on the way going to the hospital. "I hope I don't have to have an episiotomy", and meanwhile, I had to have the C-section". Regarding the fact that she did not deliver vaginally, she said, "at the time it didn't matter. At the time I, I just really wanted everything to be ok. I was really worried about him. So, that didn't matter. But afterwards I was a little disappointed that it, it, you know, that I didn't give birth. They took the baby out".

The thing that bothered this participant the most was the lack of control relative to the C-section decision. The labor had been progressing nicely, and then the heartbeat dropped. "And all of a sudden the room was swarming with anesthesiologists, and doctors and everything, and it was really scary. They were getting me prepped for general anesthesia ..... and then they left my husband behind, who I, you know, I had planned to have there helping me the whole time, and I had no control over anything that was going on. .....I was in a good mood until that, the one nurse looked at the other nurse and I saw that, you know, something was wrong." At that point the heart rate rose again, and so it was finally decided to do a C-section with a spinal anesthesia, "then they let my husband come back". She continued, "I had no, I really had no control. Even after the baby came, I couldn't see him for three hours until I could wiggle my toes".

Therefore, even though this participant was pleased with the final outcome, and

most of the activities once the spinal anesthesia had been decided on, she definitely was not happy with the lack of control, and the powerlessness in making decisions related to the C-section, or having her husband, her main support, not present during those decisions. She also was not able to participate in the birth to the extent that she had wanted and anticipated, therefore contributing to a generally low perceived level of satisfaction. Therefore the outcome criterion of enablement was not met for this participant.

Participant C

Participant C had identified two main goals for the delivery, a drug-free delivery and a healthy baby. Due to her problem pregnancy, a premature delivery was not a surprise to her. She identified that the delivery fulfilled her quest to be a "normal pregnant couple" because "we went through all the pain". She had previously noted that she had wanted more information on the delivery itself, and was concerned that with the premature delivery she would miss the classes where that was taught. However, the "final stage of labor that our instructor stayed with us later that night to go through it with us, so that we could at least have some idea of what was going on...that was real helpful".

She also found the breathing to be very helpful, "and the Lamaze breathing and that, really it does work if your labor isn't 24 hours long, in my opinion, I mean. I could have gotten through it, I think without it, without the medication, if it had been a lot shorter, if I would have got to the hospital and was dilated".

She identified that she met one of her goals in that she had a healthy baby.

After eighteen hours of labor, she consented to an epidural, and was most delighted to find that it made the delivery much easier. She justified her decision as "I think I made the right decision, and I did, I made it 18 hours really without taking anything but Staydal, I went into labor knowing I'd probably have to take something to at least calm me, or whatever. But it made a lot of sense, and it was smart". She also noted that "without (my husband) there, I don't, I would not have made it at all", since "he was right there by my side, and kept me calm". She summed up her reactions to the length of the labor by saying, "I will never say I am going natural again".

Participant C was less than pleased with the conduct of the labor experience, in fact her answer to the question: tell me about the birth of your child was "It...was...awful". Due to the use of the term contractions during the entire time that she was being monitored, she had thought she was prepared for the contractions of the actual labor experience. She was not expecting a 24 hour ordeal. She had had as her goal a drug-free delivery, but after many hours of labor, "(the doctor) told me he was starting the Pitocin which is worse than any other thing, so at that point I gave in and got the epidural". While she was able to justify her decision, as noted in the previous paragraph, it obviously bothered her.

After the birth, she noted that she felt very incompetent in the care of both herself and her infant. "Maybe they could, and I think that that's what the focus is the last couple of parts, is baby care, which I'm not positive, but I'm sure that's, I'm hoping that's part of the end of the class, cause that's, I mean, I'm baffled, I don't know what to do all the time, I kind of sit here, twiddling my thumbs, thinking "Now

how do I give her a bath? How do I wash her hair?".

In summary, Participant C was unable to complete the goal of drug-free delivery. She had entered the hospital believing that she was prepared, due to both her prior admissions due to high levels of contractions, and due to the classes. However, she found she was not prepared for the reality, and even meeting the goal of the longed-for healthy infant had not erased her sense of frustration. She also was frustrated with what to do now that the delivery was over, and the infant was here. Since she did not meet a self-expected level of satisfaction with the birth experience, by definition, she was not enabled.

Participant D

Participant D was the third participant to have a C-section delivery. The decision for this action was made when it was found in the midst of her labor that the amniotic fluid was quite green. She had previously identified that her goal was "getting the baby here" and "knowing something when she got to the hospital". She also felt that she would need to assist her husband. She now stated, "I was prepared for the labor part, I was prepared for the pain, and I got through them with my breathing instructions, and .....yeah, overall, I guess (I met my goals), because I got through the part where I needed to breathe and I got through the pain".

This participant had always concentrated on the tasks of the birth. In frustration after the first classes, when she had considered herself incompetent in terms of being prepared, she had phoned the director of the educational department, and had acquired a videotape from her. The participant observed that "It gave me, actually it

told me more than my teacher told me, because she didn't go into real depth into anything about the breathing part". Further, "it gave me a chance to sit down and practice what they were doing on the tape". She identified that the breathing part was the most helpful, because "it helped me get through the labor pains". This participant was the only one to not directly mention her husband except to say that she had been afraid that they would send him away during the C-section, and she was glad that they didn't, and that he had brought the infant for her to see as soon as it was delivered.

Participant D also had several negative comments related to the delivery and her preparation for it. First of all, she noted that the contractions "were explained like they were a hard period cramp, and they were maybe a monster period cramp". When pressed about the decision for a C-section, she maintained that no further explanation had been given her at the time, other than the "green water". This lack of further information had bothered her.

She, too, had problems with the C-section videotape, because "it kind of scared me more than anything else. I mean, seeing that tape, and thinking that I might have to go through it, and then I actually did, and knowing what was going to happen. After I saw it on the tape kind of unsettled me". She noted that "I was scared when I went into the C-section room", and "I wasn't real sure that (husband) was going to be able to go in there". She stated that "there was no explanation (with the C-section video), just "here's the movie, go ahead and watch it"", and felt that "knowing that he (husband) could come in and those kinds of things would have been helpful". This participant was somewhat obese, and stated that during the C-section she was

continually afraid that she was going to fall off of the operating table.

In summary, Participant D believed herself fairly prepared for a "normal" delivery, but unprepared and unsupported by staff for what actually happened to her. She had had to go beyond the actual classes to get the information and practice she so desired. She also felt that the class preparation had lacked explanations that would have helped her later, during the delivery. Although she had met her goals, it was her own efforts, and not the classes that had enabled her, and contributed to her positive level of satisfaction with her preparation. Her level of satisfaction with the actual birth experience was low, hence, by definition, she was not enabled.

Participant E

Participant E had probably the most passive and unformed goals and expectations of all of the participants. Her only goal was to assist in the labor, and her only strategy was to try to relax. Her labor was very short- "only three hours of active labor...so I didn't go through the trauma that other people go through". She found the birth "a little more amazing than I thought, you know. I just really didn't know what to expect before the time, but it was just a really incredible experience". She and her husband had only managed to make it to two classes together. However, "the two that we went to were very helpful, especially the film... and the things they gave him in addition to that class, they were real helpful, so he was glad, because he just didn't know what to expect, he was pretty calm through the whole thing, having been, you know, even though he only went to a couple, so you know, he had the information". For herself, she considered that she went to "the ones on breathing and

the film and the actual birth and just, you know, the ones that prepared you". She believed that "I knew basically what to do, and (the nurse) just kind of reminded me". She had missed the tour of the hospital, but didn't mind, because she had been there previously to be monitored for hypertension, and so she observed that she knew the setting, and what to expect.

Perhaps because her perceived roles and tasks were so vague, this participant had less difficulty in meeting them. As well, the absence of complications and swift delivery had contributed to her feeling of euphoria following the birth. Therefore her level of satisfaction with the birth experience was high, and she perceived that the classes had enabled that level of satisfaction.

Participant F

Participant F had as her main goal, to remain calm, and try to make the birth an enjoyable experience. She was delivered vaginally, and after it was over, it was discovered that the epidural catheter had not been in place, thus rendering any medication administration totally useless. However, she observed, "overall, I mean, even not having the medicine, it, it wasn't as bad as I thought it would be, painwise". She considered herself prepared for most of the things that happened, for instance with the insertion of the epidural catheter, "(the instructor) brought the package in and showed it to us and explained exactly what they were doing...I think that helped a lot because there was a lot of pressure when they were putting the epidural in, but it wasn't, you know, I knew that there was going to be because we talked about it and she showed it to us and that kind of stuff". She noted that she used the "breathing,

and that definitely helped, when the epidural didn't work".

She noted that her husband "knew what to expect when it happened" and therefore "did a lot more than I thought he would ....I just wasn't sure how it would go, and it went great". Her physician didn't make it for the actual birth, and a resident was called, "but I, you know, it was like, at that point, I knew somebody was there, doing what they were supposed to be doing, and I wasn't, it didn't bother me, I mean I didn't get upset about it, I just knew that somebody was there..". This participant summed up the experience by saying, "I'm very happy with the way it turned out... it was, I was real calm and real, you know, I enjoyed it".

Participant F had noted that during the delivery she considered herself very prepared, however, when she anticipated going home, she did not believe herself to be nearly so competent. Her infant required PKU injections, and so this participant solved her information problem in a most creative way. She insisted on going home before the second PKU injection had been given. In this way, the system (hospital) was forced to send a nurse to her home to give the injection. The participant had already created a list of questions to ask when the nurse came the following day. Therefore the participant displayed an ability to identify her needs, and ensure that they were met. It was not surprising that she believed that she had met her goals. She also believed that the classes had enabled the preparation required to achieve a high level of satisfaction.

Participant G

Participant G was the participant with the most prosaic self-imposed tasks. She

had identified her tasks as the pushing and the breathing. She had previously also noted that she gathered information and then made up her mind about things. While she stated that she needed to know she could rely on her husband, she had not assigned him any particular tasks, other than assisting her with the breathing.

This participant was most pleased with her birth experience. Her statement was "you know what...I think I did really good". She was pleased that the classes had ended just before she was due, because if it had been earlier "I probably would have forgot. Not forgot, but it wouldn't have been right there fresh in my mind".

She identified that her husband "was a huge, huge help" in fact, "my husband did more than (the nurse) did", "he's a very calm guy, but he just had everything under control". The information that they had learned during the classes seemed to help in the experience. She noted that "they taught us how to read the sheet of paper that comes out of the external monitoring, with the contractions and the baby, and so he was reading .....all that cause he learned it in class". She talked about the fact that "we have a little, it's kind of like a little cheat sheet, which has like, you know, early labor or active labor, transition and all that stuff, so he, anything I'd day, he'd be like "OK, let me look it up"". She summed it up by saying, "I think he's glad he went now for the same reasons, he knew what to expect when it happened".

There were other class-time activities that this participant identified as influencing the positive feelings following the birth. She noted that they read all the handouts from class, and that "we did about 10-15 minutes of breathing at the end of every class". She felt that she did learn about both the birth and about child care, and

noted that "it was nice to get all that information and make our mind what we wanted to do". She observed that during the teaching in the hospital following the birth, "they didn't do a hands-on kind of thing, like you would in Lamaze class" and "(the Lamaze instructor) really had hands-on experience".

In summary this participant was pleased both with her performance during the delivery, and her preparation for it. She believed that the classes had enabled her to meet her goals for the birth of her first child.

Summary

Of the seven participants, four had expressed negative perceptions related to the birth experience, and all seven had expressed some positive perceptions related to the birth experience. Although the participants with negative perceptions did note positive perceptions, the overall feeling was one of a certain sense of failure. In most cases, there was the feeling that "I was not prepared", and "I was not in control".

Within the theoretical concept of enablement, the researcher has stated that all of the components of means, abilities and opportunities needed to be present for enablement to occur. In addition, the outcome criterion measure is the "patient's perceived level of satisfaction". Using this outcome criteria, Participants A, B, and D were definitely not satisfied, and Participant C was marginally satisfied. Therefore, theoretically, Participants A, B, C and D were not enabled to meet their own goals for the birth of their first child.

All the participants identified that maintaining control was very important.

Participant B even stated that "from the classes" she had gathered that maintaining control was a very important task. From the data, one can infer that they believed that with increased knowledge and preparation came decreased anxiety/fear. Decreased anxiety/fear resulted in greater control.

Participants A, B, and D were the three participants who had unexpected C-sections. It could be said that they had the least physical control over what actually happened during the birth experience. Certainly they experienced the least perceived control. They each expressed that they were prepared for a vaginal delivery, albeit with varying amounts of fear. However, that was not what happened, and they identified a certain sense of betrayal that what they had prepared for so carefully was not the reality.

When the perceptions of the participants are examined in light of the components of enablement, patterns begin to emerge. All of the participants believed that they had sufficient information and preparation until the unexpected happened. While Participant A noted that she understood the need for the C-section, the other two participants did not believe that the need for the surgery had been sufficiently explained. As well, the fear of 'was the baby all right' was very strong. This fear was made stronger by the lack of explanation.

The participants responded to the situation by focusing on the details in the picture. Participant A focused on not being able to see or feel what they were doing and the sensations of the spinal, whereas Participant B believed that the spinal helped her to be more involved in the birth, and focused on the "the gaping hole" in her

stomach, the removal of her husband, and the absence of participating in the decision, or even understanding the decisions related to the choice of anesthesia. Participant C was very angry about the length of the labor, but focused on her body's failure to dilate quickly, and the use of pitocin following a prolonged labor. Participant D focused on the feeling that she was going to fall off of the operating table, and not knowing if her husband could be present during the surgery. Perhaps the participants were unable to take in the whole picture. Perhaps by focusing in on the details, in some sort of order, each could then put the entirety into perspective.

Participant B was the individual who was interviewed significantly later following the birth than any other participant. She was able to focus more on the sensation of not having any control of the situation. It is unknown if she omitted any details during the interview that she had processed prior to the interview.

Conclusions of the analysis are that with each of the participants who noted strong negative perceptions, and low levels of satisfaction with the birth experience, a portion of one of the components of enablement was missing. With Participant A, information about the activities during a C-section was missing (means). Participant B noted some information (means) was missing, but the greatest lack was a sense of control relative to the C-section decision, part of the component of opportunities. Participant C had believed herself to be prepared for almost anything, but it was evident later that what she thought were contractions were only precursors to the real thing. She was totally unprepared for the length of time labor might take, again, a lack of information (means). Participant D had acquired the information she believed

she needed, but did not have the information as to why the section occurred, and was lacking information (means) related to hospital policies in the operating room, e.g., could her husband be there. Although only Participant B directly talked about it, the opportunity of completing the ultimate task of the laboring woman, that of delivering an infant, had been missed by the three participants who had C-sections.

In contrast are the participants who expressed positive perceptions and high levels of satisfaction with the birth experience. Even when some things went not as planned, the unplanned incidents were deemed sufficiently unimportant that they were mentioned only in passing. Examples are that Participant F had such precipitous labor that she required a large number of stitches, and it was only then noted that the epidural catheter had not been in place, ensuring that she had "gone natural". She focused on how much the local anesthesia had helped for the repair of the tissues. During the birth, Participant G's baby experienced a fractured clavicle, but what the mother focused on was that the infant was able to move it more than she thought she could.

Clearly, these participants believed that they had had all of the components of enablement: means, abilities and opportunities. They had sufficient information to make decisions, and skills to cope with whatever happened. They believed that they had the opportunity to make necessary decisions, or at least contribute to the decision-making process.

When there were concerns related to one of the components, e.g., Participant F wanting more child care information, they believed themselves empowered to make

decisions that would ensure that the needs were met. In contrast, Participant C, with the same concerns, had not yet been able to make plans to assist herself.

The factors that were most evident in the data from this study that contributed to the classes being an enabling factor in the birth experience were:

-feeling prepared (means and abilities),

-knowing what to expect (means),

-practicing (abilities and opportunities),

-knowing the rules (means and opportunities),

-knowing the procedures (means and opportunities), and

-the freedom to ask questions and receive explanations (opportunities).

It was during the unexpected that these participants had greater need for further intervention from the health professionals.

In summary, from this small sample, the participants who met their perceived expectations/goals and expressed high levels of satisfaction with the birth experience also expressed data that demonstrated the presence of each of the three components of enabling. Those participants who described an inability to meet their perceived expectations/goals, and expressed low levels of satisfaction with the birth experience, expressed perceptions that illustrated that one or more of the components of enablement was missing.

CHAPTER FOUR

DISCUSSION

In this chapter, the results of the study are discussed in relation to the theoretical concept of enablement, and secondarily in relation to the theoretical concepts of mastery and role supplementation. In each discussion the original theoretical presentation of the concept was used as the basis of the conceptualization. The limitations of the study are noted.

Theoretical concept of enablement

Enablement has been defined as "to assist the patient to acquire or expand the means, abilities and opportunities to complete a task or fulfill a role, to the patient's perceived level of satisfaction". The components of enablement were identified as means, abilities and opportunities. Means were described as the resources required to complete the task or fulfill the role, abilities were described as the skills required to complete the task or fulfill the role, and opportunities were described as chances to complete the task or fulfill the role. Within the component of opportunities, the notions of power, permission and practicing were embedded.

Enablement was described as a process. All three components were necessary for the process to be completed. The outcome was described as "being enabled", and an outcome criterion was the patient's perceived level of satisfaction. A further articulation of the outcome of the process had not been completed at the time of beginning this study.

It is difficult to ascertain whether one can ever be truly satisfied with one's performance in an unknown, painful process such as first birth. However, within this study, participants expressed both low (negative) and high (positive) levels of satisfaction with the birth process.

As noted in the previous chapter, it was found, for the participants who perceived negative outcomes of the birth process in relation to their own tasks and roles, that at least one of the components of the concept of enablement was missing. Thus, they were not enabled. In contrast, the participants who expressed a high level of satisfaction with the preparation and completion of their childbirth experience, displayed evidence of all three components of the concept of enablement. Theoretically, and in actuality, they were enabled to complete what they wanted to do.

As also noted in the previous chapter, there is and presently can be no attempt to quantify the components of enablement. For each participant there were differing goals. Therefore, there were differing roles and tasks needed to achieve each goal. Although several of the participants, and in some cases all of them, had common goals, and perceived common roles and tasks, the amount and type of each component needed by each participant differed. Yet, whenever one of the components was identified as missing, the process did not occur.

The data for this study suggested that the component most frequently identified as missing was means, especially in the form of information and preparation. This component became especially important when the unexpected happened during the birth experience. Such a result was somewhat unexpected. The researcher, when

developing the concept as a possible framework for patient education, had believed that the component of opportunity would be the component most frequently identified as missing within patient education. However, for this sample, and this content area, means was the component most frequently identified as missing.

The common goal of control, or perceived control, could be viewed as an outcome of enablement. From the data there was a clear link between several of the themes. Increased information --> increased knowledge of what was expected --> decreased anxiety/fear of the unknown --> increased sense of perceived control. The linkage that emerged suggested perceived control as a possible outcome or end point. This is not to suggest a causal relationship, but rather a possible path of influence.

The results of this study also support the notion that enablement is a dynamic process. The process has some clearly defined beginnings, but more diffuse endings. Lamaze classes were the beginning of an enablement process leading to the birth of the infant. However, the process did not end with the end of the classes, at least in the mind of the participants. Rather, it was a process that continued with some different players, and expanded to include the hospital staff during the labor and delivery.

The framework of enablement allows for group interaction, but recognizes that the assessment of individual patient goals and perceived roles and tasks is also mandatory for successful completion of the process. The act of assessment, as well as further interventions to meet the individual goals also helps to create a milieu where the patient feels empowered to bring his concerns to the facilitator, and has a

reasonable expectation that the concerns will be heard and addressed.

Theoretical concept of mastery

Younger (1991) defined mastery as "a human response to difficult or stressful circumstances in which competency, control and dominion have been gained over an experience of stress (p. 76). The philosophical underpinnings of her theory arose from stoicism. The goal of the theory was the explanation of the human responses.

Younger (1991) presented the related concepts of coping, adjustment, efficacy, resilience, hardiness and control, and described how they differed from mastery. In particular, she noted that control lacked "the focus on outcome and growth" (p. 80). This idea was given much attention by this researcher, in light of Neuman's definition of health as "expanding consciousness". The outcome of mastery is achieved through "having developed new capabilities, having changed the environment and/or reorganized the self so that there is a meaning and purpose in living that transcends the difficulty of the experience" (p. 81). It was noted by this researcher that although competency, control and dominion are articulated within Younger's (1991) definition of mastery as components of the outcome of mastery, they have not been defined within the original work.

The defining characteristics of mastery include "1) the achieved sense of control, perceived or actual, over a situation that created a sense of vulnerability and over one's life, 2) having an answer to the question, 'how can I keep this or a similar event from happening again', when that is appropriate to the circumstances, 3) having

recovered self-esteem, feeling good about oneself again, and having a competent self-image, and 4) having found alternative sources of satisfaction for what is lost" (p. 81). Younger distinguished among the various possibilities of mastery in terms of the outcomes achieved; full mastery, some mastery and absence of mastery, and how they might impact on the human responses.

Four elements of mastery were identified by Younger (1991). They were certainty, change, acceptance and growth. Certainty was defined as "a state of having adopted a particular view that is free from troublesome doubts" (p. 82). The view is the "product of an internal model that incorporates previous life events and self-perceptions but has been revised in the face of new realities pertaining to the event and to changes in self, in others, and in the relationship between self and environment" (p. 82). "To change is to directly affect the demands or resources of the objective environment and thus to reduce the impact of the stressor" (p. 84). Younger defined acceptance as acknowledging "events as true and normal and to agree to the terms of a situation" (p. 85). Growth was defined as "a state in which the individual has attained new competencies and feels stronger, more purposeful, and more efficacious than before the event" (p. 86).

Younger stated that certainty was necessary for the movement towards change or acceptance, and that both change and acceptance were necessary for growth. Each of the elements is described as a process within mastery. Mastery is used both as a noun and a verb, both as the all encompassing process and as the outcome.

Using the data from this study, and the conceptual framework just presented,

this researcher discerned a possible linkage between the concept of enablement and the concept of mastery. Perceived control was potentially identified as a desired outcome of enablement. However, upon further examination of the concept of mastery, the suggestion that control does not focus on outcome and growth was well noted.

The data suggested that the components described by the researcher in the conceptualization of enablement were indeed necessary for the participant to perceive resolution and a certain closure of the birth experience. The components of enablement may indeed provide the stimulus to begin and continue the processes identified by Younger that result in growth and mastery. The components of enablement may therefore have provided the framework for planning, implementing and evaluating nursing interventions designed to stimulate certainty, change, acceptance and growth.

Theoretical concept of role supplementation

In 1975 Meleis published a conceptual framework of role insufficiency and role supplementation. She identified the purpose of this conceptualization as "providing a systemic framework for nursing diagnosis and intervention" (p. 264). In searching for a framework to guide the process of patient education, the researcher had considered the concept of role supplementation. A brief description of the conceptualization follows.

Meleis based her understanding of role theory on symbolic interactionalism as developed by George Herbert Mead. She noted that all human beings participate in

different roles during the life cycle, and postulated that "roles chosen by the patient are validated by the acceptance of his significant others such as the nurse and members of his family" (1975, p. 265).

Meleis identified that a change in roles, or role transition, "denotes a change in role relationships, expectations or abilities" (1975, p. 265). When the individual is forced by circumstances to create a new role, he is frequently required to "acquire new knowledge, alter his behavior, and thus change his definition of himself in his social context" (1975, p. 265). Common transitions include developmental, situational, and health-illness transitions. Nursing is most frequently involved in health-illness transitions.

Meleis defined role insufficiency as "any difficulty in the cognizance and/or performance of a role or of the sentiments and goals associated with the role behavior as perceived by the self or significant others" (1975, p. 266). She further stated that role insufficiency could result from "poor role definition, the inner dynamics of role behaviors, or simply from lack of knowledge of role behaviors, sentiments and goals" (1975, p. 266). Meleis suggested the nursing intervention of role supplementation to assist in the amelioration of role insufficiency.

Role supplementation was defined as "any deliberate process whereby role insufficiency or potential role insufficiency is identified by the role incumbent and significant others, and the conditions or strategies of role clarification and role taking are used to develop a preventative or therapeutic intervention to decrease, ameliorate or prevent role insufficiency" (1975, p. 267). It was noted that within her conceptual

framework, the nurse becomes a significant other for the patient.

Pregnancy and childbirth are developmental and health-illness situations where significant role transition takes place. Under Meleis's definitions, childbirth education could be seen as either a preventative role supplementation intervention, when completed pre-delivery, or therapeutic role supplementation, when completed during the delivery.

Meleis suggested two components of role supplementation: role clarification and role taking. Strategies for achieving role taking included role modeling, role rehearsal, and reference (peer) group communication and interaction. She presented a schematic diagram of the postulated relationships between the components and strategies, and suggested role mastery and adaptable role transition as the desired outcomes.

Using Meleis's framework, and the content area of this study, childbirth education, one must first consider whether the time of labor or childbirth is truly a role, or merely part of the physical-psychosocial transition from the role of pregnant woman to the role of new mother. In other words, is childbirth education preparing the woman for a new role, or the transition between roles? This researcher would suggest, using role theory as outlined by Meleis, that childbirth, or the laboring client, is a transition time between the roles. Thus, it could be argued that childbirth education could not be considered role supplementation intervention because there is no role as an end product or outcome.

The summative purpose for the research trajectory, of which this study was the

beginning, was the search for a common framework for patient education, regardless of the content area. Although there may be other patient education content areas where the framework for role supplementation can be used effectively, it was reluctantly decided by the researcher that the role supplementation framework could not be used in the present patient education example.

While the proposed outcomes, mastery (Younger, 1991) and role mastery (Meleis, 1975), appear very similar, role supplementation could be used only in patient education content areas where a clear role and therefore a clear role transition was present. Examples might be diabetic care, ostomy care, post-myocardial infarction (MI) education and parenting.

Limitations of the study

As with any research study, there were limitations. This study involved self-selection, rather than purposive or random sampling. The participants were much more similar than they were different. Previous research has suggested that childbirth expectations may be quite different among individuals of strongly differing socio-economic strata (Stanton, 1992), and the participants in this study came from similar socio-economic and educational strata. However, the reality is that participation in many facets of patient education is voluntary. Hence, this study reflected the reality.

An anticipated limitation did not occur. Not one of the participants withdrew from the study, even though participation involved a lengthy protocol time. The participants who volunteered were most interested that a nurse wanted to hear what

they had to say, and were generous in offering their perceptions.

Within the purpose and methodology sections of this report, the choice of childbirth education patients as the study population was described as a benefit. The choice was beneficial due to the length of the education experience, the general sense of joy associated with the awaiting of a child, and the fact that the educational experience took place prior to the event of birth. However, those same attributes that made the choice of population contribute positively to the research design contributed equally negatively to the possibility of generalizability of the themes to other educational populations. Generalizability could only be achieved after replications with several study populations experiencing other patient education in other content areas. However, generalizability was not the purpose of this study. The purpose was to explore the possible utility of the concept of enablement as a framework for patient education planning and intervention.

In summary, the benefits of the rich data source, and the repeated interview opportunities outweighed the limitations noted in this section. From the descriptive data and thematic results, this and other nurse researchers have the possibility of refining the research and interview questions for use in other patient education content areas, with other types of patients.

Conclusions

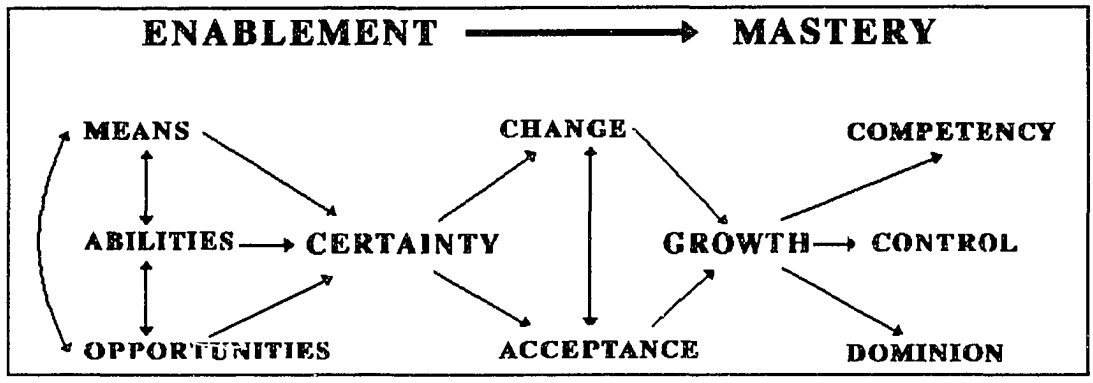
The results of this study support the notion that the concept and components of enablement may provide a framework for the assessment, planning, implementation and evaluation of patient education. While there were definite limitations to the study,

there were also strong indications that the proposed framework could be useful.

Further examination of the concepts of mastery and role supplementation in relation to the study data were completed. Role supplementation was reluctantly rejected at this time as an explanation for the perceptions of the participants. It was recognized that the difficulty may be with the specific patient education experiences chosen for the study, and the concept may assist in explaining the process in other patient education content areas.

The concept of mastery was the other conceptualization studied. The concept of mastery provided a greater potential explanation of the perceptions of the participants. Secondary analysis of the study data would be required to ascertain if the elements of certainty, change, acceptance and growth were present in the participants' perceptions. It is not known if the interview schedule for this study would have elicited the data required for such an analysis.

This researcher now proposes a revised conceptualization of the process of patient education. The revised conceptualization is a combination of the concept of enablement and the concept of mastery. A possible schematic of the revised conceptualization follows.



Within the revised conceptualization, it is proposed that the components of enablement provide the framework for assessing, planning, implementing and evaluating nursing interventions related to patient education. It was recognized that all three components continue to be necessary and sufficient to begin the process of certainty that moves towards change and acceptance and thence to growth. In addition, elements of the components may also be required at other times during the four processes articulated by Younger. For instance, some means may be required to achieve certainty, but more and different means may be required to continue on to change.

Younger's definition of mastery outcomes as "competency, control and dominion over the experience of stress" (1991, p. 76), encompasses the endpoint within the definition of enablement. Enablement had specified the "patient's perceived level of satisfaction" as the end point. Continued research would test this researcher's assumption that the individual who perceived him/herself as having competency, control and dominion over the experience of stress would also perceive him/herself as satisfied with the situation.

Implications of the study for nursing practice

This study was intended only as the beginning of a research trajectory. However, implications for nursing practice may still be drawn from the results of this study. The overall implication is the imperative requirement that nursing personnel create a milieu in which the patient perceives the freedom to ask questions and express concerns, and has a reasonable expectation that explanations will be provided as

requested.

Other implications are presented in reference to childbirth education, nursing practice during labor and delivery, and post birth. The implications or suggestions for childbirth education are: 1) the encouragement of increased socialization between patients within the classes of childbirth education; 2) the encouragement of spoken or written goals by each patient (these may be anonymous) so that some classes (or parts) can be tailored to their specific requests; 3) the accompaniment of videos with discussion and explanation of what has been seen; 4) the inclusion of potentially anticipated feelings/responses of the patients to participation in various procedures encountered in the delivery room within the classroom curriculum.

Implications for the labor and delivery staff include: 1) continuing to reinforce learning, recognizing that some learning may not be perceived as needed until the time of the delivery; 2) asking the patient what is most important for her (and her spouse/coach) during the birth experience; and 3) providing continuous and repeated explanations of the decisions and procedures being carried out, especially in the event of an unexpected experience (e.g. C-section).

Third-party insurers have mandated that following a "normal" birth, the expected hospitalization time be approximately 24 hours. This mandate puts post-delivery patient education into severe jeopardy. The study data suggest that patients identify learning needs related to both self-care and child care following the birth. Knowles (1980) would assert that those learning needs might not be recognized by the patient until they are needed, after the delivery of the infant. Therefore, nurses may

need to seek creative strategies to meet those needs. Public health nurses have historically made postpartum visits. However, they have little or no prior knowledge of what has happened with any one patient. Thus, while they can provide information on childcare and self-care, they have difficulty assisting the patient who has unresolved concerns surrounding the delivery, and the transition between roles. Perhaps a better plan would be to utilize obstetrics nurses from the institution where the individual delivered to make these home visits. Research would have to be completed to ascertain the benefits of same, for either third-party insurers, or other health care plans.

Implications of the study for nursing education

Implications for nursing education are centered on the education of nurses rather than the education of patients. The researcher believes that the concept of enablement has utility within the education of nursing students, with the recognition that such utility will only come after several replications of this study.

The researcher has demonstrated the strong mandate from several sources related to the nursing function of patient education. In order to fulfill the mandate, nursing students must be taught how to complete patient education. This researcher believes that with a clearer framework for this activity, nursing students will be assisted to integrate patient education, both formal and informal, into their activities of daily nursing.

Similarly, nursing educators could use such a framework to guide their teaching

activities, especially within the clinical practice component of nursing education. All nursing students would agree that clinical practice qualifies as a stressful event. Perhaps clearly providing the elements of means, abilities and opportunities related to learning rather than evaluation would assist in contributing to the growth of the student nurse and the mastery of clinical judgement.

CHAPTER FIVE

SUMMARY AND RECOMMENDATIONS

Summary

Patient education continues to be an accepted and mandated part of nursing's role and function (Honan, Krsnak, Peterson & Torkelson, 1988), both in the professional expectations as demonstrated by the Standards of Nursing Practice (American Nurses Association, 1974, 1985; American Nurses Association and Association of Rehabilitation Nurses, 1977) and in legislated expectations as demonstrated by Joint Commission on Accreditation of Healthcare Organizations Standards (Accreditation Manual for Hospitals, Patient and Family Education, 1993, pp 1-5).

Historically, nursing research on patient education has been limited to single content areas and/or patient populations. The authors have tended to be concerned with the description of or research related to single patient education programs with individualized education interventions (Cawley & Gerdts, 1988; Thompson et al., 1990), rather than a comparison of multiple programs or interventions, even within exclusive content areas (Cargill, 1992; Emery et al., 1991).

Various components of the learning process have been examined by nurse researchers. Factors affecting the learning process have been a fertile area in patient education nursing literature (Cargill, 1992; Lindeman, 1988; Murphy et al., 1989; Pommier, 1992). As well, behavioral outcomes specific to the particular educational content area have been examined, but with little theoretical justification of why those

particular outcomes were chosen, or indication of potential or actual application of results to other patient education arenas (Allen et al., 1992; Pasquerello, 1990; Stephens et al., 1991; Warner et al., 1992; Wong et al., 1990). Most frequently, the outcome of patient compliance, from the health professional's view, has been considered the desirable outcome (Cargill, 1992; Dunn et al., 1990; Rankin & Stallings, 1988; Wyness, 1990; Yunker et al., 1990). There have been efforts to compare patient populations that seek patient educational programs, and those who do not (Calnan et al., 1984; Glasgow et al., 1991). These efforts represent an indirect measure of the patient's expectations of the patient education experience.

Several problems existed within the current state of published nursing research on patient education. Methodologically, patient education research was completed using primarily quantitative methods. While this methodology had resulted in a mass of individual pieces of data, the studies were rarely replicated and/or extended. Therefore, generalizability of the findings was difficult. In addition, little research existed that examined the comparison of the health professional-desired outcomes with patient-desired outcomes (Latter et al., 1992; Tilley et al., 1987). This was perhaps because patients were rarely consulted in the design, implementation and/or examination of outcomes of patient education program.

Nurse researchers had begun to question the present methods and strategies for conducting research in patient education. They were beginning to advocate the use of patient participation in the design and implementation of patient education programs (Duchin & Brown, 1990; Kelly & Henry, 1992). Qualitative methodologies have been

suggested as appropriate, and some research has been completed using qualitative methodology (Breemhaar & ven den Borne, 1991; Deeney & McCrea, 1991; Johnson & Morse, 1990; Richardson, 1991; Wikblad, 1991). However, no research was found that examined the patients' perceptions at multiple points during the education process.

This qualitative study had clinical and theoretical purposes. The clinical purpose was the search for a common process within patient education that could be applied across multiple content areas and patient populations. It was believed by this researcher that as the common process was understood and explicated, possibilities for measurement of effectiveness of patient education would be enhanced. The theoretical purpose was the testing of a proposition that effective patient education was an example of the nursing task of enablement.

Enablement was conceptualized by this researcher as a process by which the patient is assisted to acquire or expand the 1) means, 2) abilities, and 3) permission/authority to complete a task or fulfil a role, to the patient's perceived level of satisfaction. The consideration within this study was whether or not the patient's perceptions of the patient education would include the three components of enablement.

The study population chosen for this study was primiparous women taking Lamaze classes in preparation for the birth of their child. There were several reasons for the choice of this study population. First, the childbirth education population was self-selected, leading one to speculate that the patient may have had some awareness of why she chose to participate. In addition, childbirth education traditionally took

place before the event, and, in fact continues for a number of weeks. The patient, therefore, had opportunities to refine her expectations, and articulate them to the leaders in hopes of generating a response that met her needs. Finally, the research design allowed the participant to articulate a conclusion following the event for which the education was designed to prepare her, namely, the birth of the child.

There were five specific research questions.

1. What are the reasons given for selecting and attending Lamaze classes when interviewed prior to attending classes?

2. What are the reasons given for selecting and attending Lamaze classes when interviewed after attending one or two classes?

3. What are the patient's perceived role(s) and task(s) during the birth process ?

4. How does the perception of the role(s) or task(s) change across time?

5. Does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role or task during the birth process?

Inclusion criteria for the study included: 1) adult female (18+ years old), 2) English-speaking, and 3) primipara (first birth). Patient perceptions were elicited at three points during the pregnancy/childbirth continuum. Semi-structured interviews were used at each interaction. The questions in the interviews were driven by the research questions.

The study sample consisted of seven women. All of the participants completed the protocol of three interviews. Data for the study consisted of the transcripts of the interviews, and demographic data collected at the beginning of the first interview.

The data were analyzed using the computer software, Martin. Theoretical saturation was demonstrated by the fact that all but two of the themes identified by the researcher were articulated by at least six of the seven participants. Credibility of the results was supported by an audit trail completed on the data of one of the participants, and the use of another content expert to corroborate the placement of pieces of data within the identified themes.

Four themes were identified from the data from the first interviews with each participant, and five were identified from the data from the second interviews. The themes that answered the question "What are the reasons given by the participants for selecting and attending Lamaze classes when interviewed prior to attending classes" were information and preparation, control, husband, and rite of passage. The themes that answered the question "What are the reasons given by the participants for selecting and attending Lamaze classes when interviewed after attending 2 or 3 Lamaze classes" were information and preparation, anxiety/relaxation, control, husband, and socialization. Rite of passage and socialization were the only two themes that were not articulated by six of the seven participants.

In answer to the research questions, "What are the patients perceived role(s) and task(s) during the birth process" and "How do these perceptions change across time", participants identified one very common role, that of remaining calm. The participants identified various strategies for achieving this role. A secondary role included assisting their husbands.

Several of the participants were able to identify tasks for others involved in the

birth process. Husbands were seen as hopefully offering support, while health professionals were identified almost exclusively as being there to ensure that the birth proceeded safely for all concerned, and as a source of information.

Research question five asked "Does the patient perceive Lamaze classes as an enabling or non-enabling factor in fulfilling their perceived role(s) or task(s) during the birth process". Three of the participants definitely believed that the classes had assisted them in achieving their goals, one was ambivalent, and three were equally sure that the classes had not met their needs, and they themselves were unable to fulfil their self-expectations. The participants who believed themselves not to be enabled were also the participants who had the most unexpected experiences during the birth process, and who believed themselves to be unprepared for these unexpected experiences. The participants who believed themselves enabled, while also having some unexpected experiences during the birth process, were empowered to make decisions related to concerns identified post birth. Those that were not enabled continued to focus on the problems during the birth.

The data from the study, with resulting themes and conclusions, were compared to the theoretical concepts of enablement, mastery and role supplementation. It was found that the data supported the contention that the three subconcepts or components (means, abilities and opportunities) of enablement were necessary for the process to be completed. The participants who did not believe themselves to be prepared or enabled identified at least one of the components as missing. Perceived control was identified as a potential endpoint to the process of enablement.

The concept of mastery as articulated by Younger (1991) was next compared to the data and results of this study. It was found that the components of enablement were potentially necessary to begin the four processes identified as embedded within the larger process of mastery. Thus, means, abilities and opportunities were necessary for the processes of certainty, change, acceptance and growth. Younger (1991) articulated competency, control and dominion as possible endpoints of the process of mastery in terms of her definition of the process. This researcher believes that Younger's definition and endpoints embody the defined endpoint of enablement, that of the patient's perceived satisfaction.

The concept of role supplementation (Meleis, 1975) was also compared to the data and results of this study. It was decided that since childbirth education is preparing the woman for the biopsychosocial transition period between the pregnant woman and the new mother, there was no role change involved within the context of the patient education experience. Therefore, using Meleis's definition and descriptions (1975), role supplementation interventions would be inappropriate. It was recognized that role supplementation may be an appropriate conceptual framework for other patient education content areas.

Final conclusions of this study included the proposal of a schematic that incorporated the components of both enablement and mastery. It was postulated that the components of enablement are necessary not only to begin the process of mastery, but also may be necessary at other times within the four smaller processes. This notion needs to be further researched. The components of enablement may provide

the framework for the assessment, planning, implementation and evaluation of patient education programs, both formal and informal.

Recommendations of the study for future nursing research

Recommendations of the study for nursing research are presented as a series of research questions.

1. Is enablement a process in itself or a description of the elements described by Younger (1991) to achieve mastery?

2. Is mastery as described by Younger (1991) the outcome of enablement?

3. Do the components of enablement provide necessary and sufficient impetus to begin the processes of certainty, change, acceptance and growth?

4. Do the components of enablement provide necessary impetus to continue the process of mastery within the four inner processes of certainty, change, acceptance and growth, or will the processes continue in the face of non-enablement (the absence of means, abilities and opportunities)?

5. Will the theoretical processes described hold true when tested in a variety of patient education content areas?

6. Do the components of enablement provide a framework for assessing, planning, implementing and evaluating formal and informal patient education?

7. Is the mastery of stress instrument (Younger, 1993) a reliable and valid instrument for evaluating the efficacy of patient education programs across content areas?

8. Do the scores for the mastery of stress instrument, when used to evaluate the efficacy of patient education programs, correlate with the patient's perceptions of the patient education experience?

9. Can the concepts/processes of enablement and mastery be used as frameworks for the assessment, planning, implementation and evaluation of other learning activities, most particularly, the clinical practice of student nurses?

10. Is the mastery of stress instrument a valid and reliable instrument when used to evaluate the efficacy of teaching strategies used with nursing students in clinical practice situations?

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APPENDIX A

Demographic Questionnaire

Name_____ Code Number_____

Address_____ Phone Number_____

Age_____ First Pregnancy?_____ EDD _____

Starting Lamaze classes _____

Education Level_____

Marital Status _____ Birth Partner?_____ Who?_____

Socioeconomic Status __ Under $10,000. family income

__ $10,000. - $50,000. family income

__ Over $50,000 family income

Payment for Lamaze classes __ Health Insurance

__ Own payment

APPENDIX B

Interview schedule

Interview 1

Purpose:

To have participants describe what their roles and tasks will be during the birth process, what their needs are in relation to meeting their self-described roles and tasks, and how each one imagines that Lamaze classes will meet those needs.

Common Questions

1. Tell me about the reasons you have for choosing to go to Lamaze classes.
2. Please describe for me what you imagine will happen during the birth process.
3. What do you imagine your tasks will be during the birth process?
4. How will your role differ from the other persons in the room during the birth process?
5. What do you hope to learn from Lamaze classes?
6. How will Lamaze classes help you prepare for the birth process?

Interview 2

Purpose:

To confirm the researcher's understanding of the results of the first interview, and to explore whether or not the participant's perceptions have changed since attending one or two (or three) Lamaze classes.

Common Questions

1. Tell me about the reasons you have for choosing to go to Lamaze classes. (If some reasons given in the first interview are not mentioned, ask- "In the first interview, you mentioned _____as reasons for attending Lamaze classes, are those reasons still correct?")

2. Please describe for me how you now imagine the birth process will proceed.

3. What do you imagine your tasks will be during the birth process?

4. In the first interview, you indicated that you hoped to learn _____ from Lamaze classes. Have those hopes been fulfilled? Do you have any other hopes for Lamaze classes that we have not discussed?

5. Now that you have attended _____ Lamaze class(es), is there anything that you would change about them? Have you felt comfortable discussing your ideas with the staff?

Interview 3

Purpose:

To elicit the mother's account of the birth process, and her ability or inability to meet her self expectations relative to roles and tasks during the birth. In addition, the mother's perceptions of Lamaze classes as being a help or a hindrance to her ability to meet her self-expectations are sought.

Common Questions

(Note- these are suggested questions, assuming the birth of a healthy child with no complications. In the event of an interview following an unexpected birth result, eg., death of the infant, the researcher will attempt to follow the guide, but will be guided by the participant.)

1. Tell me about the birth of your child.

2. In the first two interviews you indicated that you had _____ tasks to complete during the birth process. Did what you imagine would happen indeed happen? Were you able to complete those tasks?

3. In the first interview, you indicated that you imagined your role during the birth process to be different from others in the room in _____way. Was your actual role what you imagined it would be? How was it different?

4. In the first two interviews you indicated that you hoped you would learn _____ in your classes. Did you learn that? Did it help during the birth process?

5. In what way were the Lamaze classes helpful to you in preparing for the birth? In what ways were they not helpful?

6. If you could go back and change anything about the classes or the birth experience, what would you change?

APPENDIX C

Recruitment Letter

Dear Lamaze Class Participant,

This letter is to introduce you to a nursing research study, and to ask you to participate in the study. You have been chosen to receive this packet because of your registration for classes with P.E.A.C.E. Lamaze, but I have not received any names or addresses.

I am a Ph.D. student in nursing at the University of Cincinnati, College of Nursing and Health. The purpose of the study is to examine your thoughts and feelings about taking Lamaze classes, and how the classes will help you. The information that you share will assist in the planning of future classes, as well as help student and graduate nurses understand more about patient education. I am interested in talking with women who are 18+ years old, speak English, and are in the midst of their first pregnancy.

Participation in the study means that I will interview you three times. The first time will be as soon as possible, before you start Lamaze classes. The second interview will be after you have completed one or two Lamaze classes. The third interview will take place between 1-7 days after discharge from hospital following the birth of your baby. All interviews will be audiotaped, but will be coded to ensure your security. Each interview is expected to last 1/2-1 hour, but can be longer if you wish. In addition, I will ask you some information such as your age, education level, marital status, and expected delivery date. At the end of the third interview, you will receive a $25.00 gift certificate.

The interviews will take place at a mutually agreeable place. The timing of the interviews will also be mutually agreed upon.

If you meet the criteria listed above, and are interested in participating in the study, please call me at [redacted]. If I am not in, please leave a message on the machine, and I will return your call. I have enclosed a copy of the consent form which you will be asked to sign. Please note that your participation in this study does not change your relationship with P.E.A.C.E. Lamaze in any way, and you have the option to withdraw at any time.

I look forward to hearing from you!

Sincerely,

Lynnette Leeseberg Stamler, R. N.

APPENDIX D

P.E.A.C.E. Lamaze Letter to Participants

P.E.A.C.E.
Parents Exploring the Adventure of the Childbirth Experience
P.E.A.C.E Lamaze • P.O. Box 62593 • Cincinnati, Ohio • 45262 • 513/861-9368

Dear Lamaze Class Participant:

Thank you for registering for your childbirth class through P.E.A.C.E. Lamaze. Our goal is to help make your childbirth a satisfying and meaningful growth experience.

Enclosed is your confirmation card listing the dates and times of the class(es) you registered for. Also enclosed is a letter from Lynnette Stamler outlining a research study she is conducting. Please read the enclosed information and consider taking part in the study. The results of the study will be shared with P.E.A.C.E. which will help us to continue our long history of providing high quality childbirth classes to the Cincinnati area.

Thank you!

P.E.A.C.E. Lamaze

Kimberly Longi
Administrator

APPENDIX E

UNIVERSITY OF CINCINNATI MEDICAL CENTER

PATIENTS' PERCEPTIONS OF PATIENT EDUCATION AS ENABLEMENT

CONSENT FORM

I. INTRODUCTORY PARAGRAPH

Before agreeing to participate in this study, it is important that the following explanation of the proposed procedures be read and understood. It describes the purpose, procedures, benefits, risks, discomforts and precautions of the study. It also describes alternative procedures available and the right to withdraw from the study at any time. It is important to understand that no guarantee or assurance can be made as to the results. It is also understood that refusal to participate in this study will not influence standard treatment for the subject.

II. OBJECTIVES OF THE STUDY

I, _____, agree to participate in a research study, the purpose of which is to examine patients' perceptions of patient education as enabling or non-enabling related to their personal expectations during the pregnancy/birth/recovery experience. Enablement is conceptualized by the researcher as a process by which a patient is assisted to acquire or expand the means, abilities, and permission or authority to complete a task or fulfill a role, to the patient's perceived satisfaction.

III. PROCEDURES

I agree to be interviewed by the researcher, Lynnette Stamler, a graduate nurse, regarding my thoughts and perceptions at three intervals during the pregnancy/birth/recovery time period. The interviews will be audiotaped, and the researcher will also take notes. I understand that the benefits from this study are to expand the knowledge available to nursing students and graduate nurses about patient teaching.
I will be participating in the protocol for approximately 1/2-1 hours during each interview, however I may talk to the researcher as long as I like. If there is a significant variance from the stated time period, I will be notified. I understand that I will receive a $25.00 gift certificate at the end of the third interview.

IV. RISKS

I understand that the anticipated personal risks to me are minimal, and not greater than those generally encountered in daily life.
I understand that participation in the study may also involve risks which are currently unforeseeable.

V. PREGNANCY

If I am a woman, and I am or should become pregnant, there is no risk to me or my fetus by participation in this study.

VI. CONFIDENTIALITY OF RECORDS

I understand that as a participant in this study my confidentiality will be maintained. I will be given an identification number, and all information obtained will be coded to maintain my anonymity. Quotes from the data may be used in written results, but will only be identified by participant identification number. The original audiotapes, transcripts, and notes will be kept, but will be kept in a locked cupboard, and will be coded to maintain anonymity.

VII. AVAILABILITY OF INFORMATION

Any questions that I may have concerning any aspect of this investigation will be answered by Lynnette Stamler, R.N., 431-6804, or Madeleine T. Martin, R.N., EdD., [redacted]

VIII. COMPENSATION

The University of Cincinnati Medical Center follows a policy of making all decisions concerning compensation and medical treatment for injuries occurring during or caused by participation in biomedical or behavioral research on an individual basis. If I believe I have been injured as a result of research, I will contact Lynnette Stamler, R.N., [redacted], or John Vester, M.D., Chairperson of the Institutional Review Board, [redacted]

IX. FISCAL RESPONSIBILITY

Funds are not available to cover the costs of any on-going medical care and I remain responsible for the cost of non-research related care. Tests, procedures or other costs incurred solely for the purposes of research will not be my financial responsibility. If I have questions about my medical bill relative to research participation, I may contact Lynnette Stamler, R.N., or Madeleine T. Martin, R.N., Ed.D..

X. THE RIGHT TO WITHDRAW

I am free to withdraw from this investigation at any time. Should I wish to withdraw, I have been assured that standard therapy for my condition will remain available to me. I have been informed of the probable consequences of my withdrawal from the study.

XI. IS THE PARTICIPANT CURRENTLY PARTICIPATING IN ANOTHER STUDY?

[ ] Yes. If yes, please provide the Principal Investigator's name and title of the study.
[ ] No.

XII. WITNESSING AND SIGNATURES

_____

Participant's signature Date

[ ] CHECK BOX IF VERBAL ASSENT OBTAINED BY INVESTIGATOR.

_____ _____

Investigator (Date) Witness (Date)

[ ] Check here if witness verification from taped consent.

APPENDIX F

Second Recruitment Letter

Dear Lamaze Class Participant,

A couple of weeks ago, you received a letter introducing you to nursing research study, and asking you to participate in the study. This letter is a reminder of the first letter, and a request for further participants.

As I stated in the last letter, I am a Ph.D. student in nursing at the University of Cincinnati, College of Nursing and Health. The purpose of the study is to examine your thoughts and feelings about taking Lamaze classes, and how the classes will help you. The information that you share will assist in the planning of future classes, as well as help student and graduate nurses understand more about patient education. I am interested in talking with women who are 18+ years old, speak English, and are in the midst of their first pregnancy.

Participation in the study means that I will interview you three times. The first time will be as soon as possible, before you start Lamaze classes. The second interview will be after you have completed one or two Lamaze classes. The third interview will take place between 1-7 days after discharge from hospital following the birth of your baby. All interviews will be audiotaped, but will be coded to ensure your anonymity. Each interview is expected to last 1/2-1 hour, but can be longer if you wish. In addition, I will ask you some information such as your age, education level, marital status, and expected delivery date. At the end of the third interview, you will receive a $25.00 gift certificate.

The interviews will take place at a mutually agreeable place. The timing of the interviews will also be mutually agreed upon.

If you meet the criteria listed above, and are interested in participating in the study, please call me at [redacted]. If I am not in, please leave a message on the machine, and I will return your call. Although P.E.A.C.E. Lamaze is aware of and supports the study, and is sending these letters for me, please note that your participation in this study does not change your relationship with P.E.A.C.E. Lamaze in any way, and you have the option to withdraw at any time.

I look forward to hearing from you!

Sincerely,

Lynnette Leeseberg Stamler, R. N.

APPENDIX G

Recruitment Letter for Bethesda Participants

Dear Lamaze Class Participant,

This letter is to introduce you to a nursing research study, and to ask you to participate in the study. You have been chosen to receive this packet because of your registration for classes with Bethesda Childbirth Education Department, but I have not received any names or addresses.

I am a Ph.D. student in nursing at the University of Cincinnati, College of Nursing and Health. The purpose of the study is to examine your thoughts and feelings about taking Lamaze classes, and how the classes will help you. The information that you share will assist in the planning of future classes, as well as help student and graduate nurses understand more about patient education. I am interested in talking with women who are 18+ years old, speak English, and are in the midst of their first pregnancy.

Participation in the study means that I will interview you three times. The first time will be as soon as possible, before you start Lamaze classes. The second interview will be after you have completed two or three Lamaze classes. The third interview will take place between 1-7 days after discharge from hospital following the birth of your baby. All interviews will be audiotaped, but will be coded to ensure your security. Each interview is expected to last 1/2-1 hour, but can be longer if you wish. In addition, I will ask you some information such as your age, education level, marital status, and expected delivery date. At the end of the third interview, you will receive a $25.00 gift certificate.

The interviews will take place at a mutually agreeable place. The timing of the interviews will also be mutually agreed upon.

If you meet the criteria listed above, and are interested in participating in the study, please call me at [redacted] If I am not in, please leave a message on the machine, and I will return your call. I have enclosed a copy of the consent form which you will be asked to sign. Please note that your participation in this study does not change your relationship with Bethesda Childbirth Education in any way, and you have the option to withdraw at any time.

I look forward to hearing from you!

Sincerely,

Lynnette Leeseberg Stamler, R. N.

APPENDIX H
BETHESDA HOSPITAL

PATIENTS' PERCEPTIONS OF PATIENT EDUCATION AS ENABLEMENT

CONSENT FORM

I. INTRODUCTORY PARAGRAPH

Before agreeing to participate in this study, it is important that the following explanation of the proposed procedures be read and understood. It describes the purpose, procedures, benefits, risks, discomforts and precautions of the study. It also describes appropriate alternative procedures available and the right to withdraw from the study at any time. It is important to understand that no guarantee or assurance can be made as to the results. It is also understood that refusal to participate in this study will not influence standard treatment for the subject.

II. OBJECTIVES OF THE STUDY

I, _____, agree to participate in a research study, the purpose of which is to examine patients' perceptions of patient education as enabling or non-enabling related to their personal expectations during the pregnancy/birth/recovery experience. Enablement is conceptualized by the researcher as a process by which a patient is assisted to acquire or expand the means, abilities, and opportunities to complete a task or fulfill a role, to the patient's perceived satisfaction.

III. PROCEDURES

I agree to be interviewed by the researcher, Lynnette Stamler, a graduate nurse, regarding my thoughts and perceptions at three intervals during the pregnancy/birth/recovery time period. The interviews will be audiotaped, and the researcher will also take notes.
I will be participating in the protocol for approximately 1/2-1 hours during each interview, however I may talk to the researcher as long as I like. If there is a significant variance from the stated time period, I will be notified. I understand that I will receive a $25.00 gift certificate at the end of the third interview.

IV. RISKS

I understand that the anticipated personal risks to me are minimal, and not greater than those generally encountered in daily life.
I understand that participation in the study may also involve risks which are currently unforeseeable.

V. BENEFITS

I understand that the benefits from this study are to expand the knowledge available to nursing students and graduate nurses about patient education.

VI. CONFIDENTIALITY OF RECORDS

I understand that as a participant in this study my confidentiality will be maintained. I will be given an identification number, and all information obtained will be coded to maintain my anonymity. Quotes from the data may be used in written results, but will only be identified by participant identification number. The original audiotapes, transcripts, and notes will be kept, but will be kept in a locked cupboard, and will be coded to maintain anonymity.

VII. ALTERNATIVE MEDICAL TREATMENT PROCEDURES

I understand that participation in this study will not affect or change any of the medical treatment that I receive during my pregnancy/delivery.

VIII. AVAILABILITY OF INFORMATION

Any questions that I may have concerning any aspect of this investigation will be answered by Lynnette Stamler, R.N., [redacted] or Madeleine T. Martin, R.N., EdD., [redacted]

IX. COMPENSATION STATEMENT

I have been provided with an explanation as to whether or not medical treatment is available if physical injury occurs as a result of my participation in this research and that further information can be obtained from Lynnette Stamler, R.N., [redacted]. I understand that I will not receive from Bethesda Hospital, Inc. any payment for such injury. I understand that I should contact Lynnette Stamler R.N. [redacted] or Madeleine T. Martin, R.N., EdD., [redacted] in the event I believe I have suffered any injury as a result of participation in this research.

X. THE RIGHT TO WITHDRAW

I have read the preceding description of this investigation and I freely give my consent to participate. I understand that I have the right to ask questions at any time and that all such questions will be answered to the best of my physician's ability. I understand that I may withdraw from the study at any time I so desire without any prejudice to my continued medical care. I further understand that any significant new findings developed during the course of the study which may relate to my willingness to continue participation in the study will be provided to me.

XI. WITNESSING AND SIGNATURES

_____

Participant's signature Date

[ ] CHECK BOX IF VERBAL ASSENT OBTAINED BY INVESTIGATOR.

_____ _____

Investigator (Date) Witness (Date)

[ ] Check here if witness verification is from taped consent.

This consent form includes no language through which the subject is made to waive any of his/her legal rights, and to release the institution or investigator from liability or negligence.