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Emerging Adults' Lived Prenatal Care Experiences as First-Time Mothers: An Interpretive Phenomenological Study

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Walden University

College of Social and Behavioral Sciences

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Linda McClerklin

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Walden University
2022

Abstract

Emerging Adults' Lived Prenatal Care Experiences as First-Time Mothers:
An Interpretive Phenomenological Study

by

Linda McClerklin

MA, Washington University, 1990

BA, University of Central Florida, 1982

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Social Work/Policy Practice Specialization

Walden University
February 2022

Abstract

Prenatal care is fundamental in the lives of expectant mothers. Studies have highlighted the prenatal care experiences of mothers ranging from adolescents to older women, which included the experiences of emerging adults. However, emerging adults bring particular social, emotional, and developmental concerns to pregnancy experiences that are distinct from those of their counterparts. This study explored these experiences to answer the question of what are emerging adults' lived prenatal care experiences are as first-time mothers. Interpretive phenomenology and assumptions from critical race, feminist, communication, and intersectionality theories helped frame the study. Through purposive and snowball sampling, nine participants were selected to represent18- to 22-year-old first-time mothers who were in their third trimester or had a child up to 2 years of age and lived in the greater Chicago, Illinois area. Data from audio-recorded semi structured interviews were subjected to interpretive phenomenological analysis. Two significant themes, (a) prenatal care/pregnancy knowledge and (b) provider/participant interactions, and one subtheme, (c) effective communication, helped in uncovering the essence of prenatal care experiences for this population. Findings revealed that emerging adults as first-time mothers expect to be educated and informed throughout the prenatal care process and prefer to interact with respectful, supportive, and caring providers in settings void of discriminatory behaviors. Additionally, mutually respectful exchange of information is essential for effective communication for this group. These findings add to the body of knowledge that may equip social workers and providers to build supportive and nurturing environments and recognize this population's strengths and challenges during prenatal care experiences.

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Dedication

This dissertation is dedicated to my God, family (husband, three special sisters, children, mother, father, sisters, brothers), and social work family, respectively.

Acknowledgements

I began this journey as a life-long learner to educate myself, learn more things about myself, and continue to change. Engaging in this work has been one of my life long goals for as long as I can remember. I started with the end in mind and set limits before the process began. I never missed one family gathering or event or let the process control my everyday life. I enjoyed every moment because it led me to a better me. I am thankful.

I acknowledge my family, friends, peers, and colleagues, who provided encouragement, guidance, and constructive criticism and helped me fulfill this monumental task in ways they know not. I acknowledge the hard work and expertise that my chair, Dr. Jeanna Jacobsen, put forth in helping me understand, articulate, and complete this project. Her insights and demands for excellence helped me pass through all the major review milestones in the first rounds. I am thankful.

I acknowledge my co-chair, Dr. Alisha Powell, for adding her expertise and insights and asking questions that encouraged reflections in my research. I acknowledge all the academic advisors, instructors, and supporting staff that played various roles during this work from the start of my program in 2016 to now. The structure and processes of Walden University's Social Work program are designed for success. I followed them to the letter. I am thankful.

Last but not least, without mental, emotional, intellectual, and physical strength, nothing would be possible in my life. For that, I acknowledge the presence of something greater than myself, my God. I am thankful.

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Chapter 1: Introduction to the Study

Introduction

This research study provided an understanding of prenatal care and the experiences that women encounter within it. Specific attention was given to the unique and distinct lived prenatal care experiences of emerging adults as first-time expectant mothers. Health care providers highly advise and advocate for prenatal care services to protect the well-being of mothers and unborn children during pregnancy. Given most circumstances, women comply by beginning prenatal care services as early as possible or later during their pregnancies. Exploring these experiences gave women opportunities to share firsthand stories about their prenatal care. In turn, their voices and insights may help social workers and health care professionals understand the meaning assigned to these events. Subsequently, their input has the potential to shape practices and policies that further enrich prenatal care experiences.

Chapter 1 establishes the gap in the literature that this study addressed which was the lack of data about prenatal care experiences of emerging adult expectant mothers between the ages of 18 to 22. Without this perspective, prenatal care providers offer services at diminished capacities as emerging adults present with social, emotional, and developmental concerns that are different from those of their younger and older pregnant peers. After presenting this gap, I present the research question and additional components such as the conceptual framework, which consisted of critical race, feminist, communication, and intersectionality theories. Essential definitions, assumptions, scope and delimitations, and limitations of the study are addressed. Finally, the chapter ends with a discussion of significant contributions and social policy implications that resulted from this study.

Background

Prenatal care, the period of medical care from conception to delivery, is the hallmark of care for pregnant women in the United States. It is one of the most used medical industry services, with reports of 18 million prenatal care visits in 2015 (Osterman & Martin, 2018). These appointments include intakes, tests, assessments, and education that guide medical attention and care to expectant mothers throughout their 9 months of pregnancy (American College of Obstetricians and Gynecologists [ACOG], 2016; Damiano & Theiler, 2018; National Institutes of Health [NIH], 2017; Pflugeisen et al., 2016). Obtaining adequate prenatal care through these visits minimizes maternal and infant mortality (Mitra et al., 2017). Following standard guidelines of care increases the chances of positive birth outcomes; results in the identification of early signs of disease, abnormalities, and stressors; and offers preventative measures for pregnant women (ACOG, 2016; D’Angelo et al., 2016; Guerra-Hayes & Hamilton, 2017; Hunter et al., 2019; Wernham et al., 2016; Zong et al., 2018). Consequently, doctors highly recommend that expectant mothers engage in and experience prenatal care as the foundation of healthy birth outcomes. However, barriers infringe upon these experiences.

Expectant women face obstacles that shape their prenatal care experiences. Lack of finances; language and cultural differences; inadequate, inaccessible, or absent insurance coverage; improper care; and transportation problems are reasons that expectant mothers’ fail to meet or engage in recommended levels of prenatal care (Carter et al., 2016; Daws & Sommers, 2018; Heaman et al., 2015; Kentoffio et al., 2016;

Roozbeh et al., 2016). Additionally, the quality of care and how women perceived their relationships with their doctors impacted the meaningfulness and essence of their prenatal care experiences (Coley et al., 2018; Dahlem et al., 2015; Hunter et al., 2019; Rowland et al., 2017). Expectant women who perceived their doctors as caring and sensitive reported positive perceptions of their experiences and were more likely to remain involved in prenatal care (Coley et al., 2018). Conversely, mothers who viewed their doctors as disrespectful or dismissive, or as showing signs of biases or prejudices, interpreted their prenatal care experiences less favorably (Coley et al., 2018). Overcoming financial, social, cultural, institutional, and individual barriers increases the chances of optimal prenatal care experiences for expectant mothers.

Literature is plentiful concerning experiences of prenatal care for adult women and adolescents (Adkins et al., 2017; Aparicio et al., 2019; Ayers et al., 2018; Backstrom et al., 2017; Badakhsh et al., 2020; Carter et al., 2016; Centers for Disease Control & Prevention [CDC], 2020a; Coley et al., 2018; D'Angelo et al., 2016: Dahlberg & Berg, 2020; Dencker et al., 2019; Ely et al., 2017; Gennaro & Melnyk, 2016; Guerra-Reyes & Hamilton, 2017; Heaman et al., 2015; Liu et al., 2017; Mazzoni & Carter, 2017; Tills et al., 2015). However, a shortage of data exists on women between the ages of 18 and 22 emerging adults that speaks to their unique prenatal care experiences (Torres, 2016). Researchers mix this group with their younger and older counterparts and do not consider the individual needs and characteristics that shape emerging adults’ prenatal care experiences (Sawyer et al., 2018; Syed & McLean, 2018; Torres, 2016). They face transitions from lives of supervision to emotional, mental, financial, and social independence that leads to uncertain decision making and risk-taking behaviors (Torres, 2016; Woods et al., 2017).

Immaturity and constant changes are indicative of emerging adults' choices, as they lack life experiences (Woods et al., 2017). Schroeder (2017) found that pregnant women between the ages of 18 to 25 have higher rates of substance abuse disorders than their peers under 18 and over 25. Stanley (2016) reported in his study of 18 to 25-year-old emerging adults that there were significant increases in drinking, roadway injuries and deaths, abortions, sexual partners, mental health issues, and other risky behaviors. As it seems, emerging adults can pose distinctive concerns that warrant social workers' attention and focus on acknowledging, identifying, and assessing for nuances that can shape and create meaningful encounters during prenatal care experiences. Therefore, this study explored these rich and distinctive lived prenatal care experiences of emerging adults ages 18 to 22 to acknowledge and understand their prenatal care experiences.

Problem Statement

Although health care providers strongly suggest prenatal care during pregnancies, little is known of the distinct experiences of emerging adults, particularly as first-time expectant mothers. However, the literature has revealed experiences for other groups of pregnant women. Even as a unique "surveillance system" (Carter et al., 2016, p. 3), optimal experiences are generally not guaranteed for expectant mothers. How pregnant mothers identify with and feel about their prenatal care experiences determines the quality of those experiences (Coley et al., 2018). In their study, Mitra et al. (2017) focused on the prenatal care experiences of women with disabilities. They found that

40.3% of 126 expectant mothers felt and believed that doctors who were not knowledgeable about their specific disabilities while pregnant neglected their care needs.

Ayers et al. (2018) and Coley et al. (2018) noted that women of color experienced increased negative prenatal care experiences when they met doctors who lacked compassion, effective communication skills, and cultural sensitivity. This dissatisfaction worsened with changing providers and interruption in the continuity of their care (Ayers et al., 2018; Coley et al., 2018). Coley et al. pointed out that expectant mothers who experienced racism or biased individuals or practices during prenatal care were more likely to report negative experiences and changes in their prenatal care regimen. Correspondingly, Liu et al. (2017) discovered that having fewer choices, less engagement in decision making, and encountering poor communication shaped marginalized women's prenatal care experiences. Although prenatal care is a structured system of care, the experiences that pregnant women encountered were not always favorable, but improvement is possible with increased knowledge and understanding of these experiences.

D’Angelo et al. (2016) found notable disparities between prenatal care experiences among women of color compared to their white peers. The authors highlighted that delayed or no prenatal care contributed to premature births, low birth weight infants, and maternal or infant deaths. Cunningham et al. (2017) found that these disparities and other risky behaviors contributed to 38% of infant deaths, $38 million in medical costs, and physical, medical, psychological, and neurological disabilities of infants. Similarly, additional studies supported the connection between inadequate prenatal care experiences to poor pregnancy outcomes, especially amongst minority pregnant women, mothers with multiple births, and teen mothers (Ayers et al., 2018; CDC, 2019; Dahlem et al., 2015; D'Angelo et al., 2016; Illinois Department, 2018; Liu et al., 2017; Roman et al., 2017; Till et al., 2015; Torres, 2016). Similar concerns are related to the lived prenatal care experiences of emerging adults (Torres, 2016). However, there is insufficient research and evidence for this population.

Addressing this gap in the literature concerning emerging adult expectant mothers may aid social workers in playing vital roles in making connections between providers and these mothers. Such interventions are necessary to relieve stressors and demands that prenatal care systems place on expectant mothers (Schroeder, 2017). Consequently, it is important for social workers and providers, minimally, to understand and address the unique nuances of pregnant women, especially emerging adults, to lessen disparities.

Purpose Statement

The purpose of this interpretive phenomenological study was to explore emerging adults' lived prenatal care experiences as first-time mothers. To obtain deep rich narratives of their prenatal care experiences, interviews were conducted with nine mothers who delivered infants between the ages of 18 to 22 and lived in the Chicago, Illinois westside community of Austin (Chicago Atlas, 2018). Prenatal care was defined as the period of medical care during pregnancy. During this encounter, emerging adult mothers bring distinct emotional, mental, psychological, and developmental nuances that shape their pregnancy experiences. However, their unique perspectives are obscured when researchers and doctors group their prenatal care experiences with those of adolescents and older expectant mothers. Therefore, social workers and researchers must capture these unique and distinctive experiences to help health care professionals create sensitive and supportive environments that can lead to meaningful prenatal care experiences.

Research Question

The push toward the use of prenatal care services for pregnant women is widespread. Services that are so pervasive make it most pressing to capture and understand the mothers' voices and perspectives. These expressions were examined within the conceptual framework of race, gender, communication, and intersectionality, factors that infringe both positively and negatively upon prenatal care experiences. Therefore, this study's research question shaped the conversation toward exploring and capturing the essence of these experiences firsthand. The research question posed was the following: "What are emerging adults' lived prenatal care experiences as first-time mothers?"

Conceptual Framework for the Study

The conceptual framework used to examine emerging adults' lived prenatal care experiences as first-time mothers included critical race, feminist, communication, and intersectionality theories. Developed by Kimberly Crenshaw, critical race theory (CRT) addresses deep-rooted racism in American societies that is held in place through legal institutions (Bridges, 2017; Crenshaw, 2017; Delgado & Stefanic, 1998, 2017; Reese, 2019). It provides insights into how power imbalances, racism, and prejudices impact the prenatal care experiences of expectant mothers. General feminist theoretical principles focus on the oppression of women in American patriarchal institutions and the fight for gender equality in all aspects of societies (Bell, 2016; Gillberg & Jones, 2019; Gordon, 2016). In this study, a feminist perspective highlighted concerns that expectant mothers encountered as they navigated choices, decision-making, and personal expressions in medical environments of experts. Applying the seminal works of Shannon and Weaver's model of communication (Lundheim, 2002; Shannon, 1948; Shannon & Weaver, 1963; Verdu, 1998) addressed the importance of effective two-way dialogue (Awasthi et al., 2017; Hogan, 2018; McCrorie et al., 2016; Ruben, 2016; Smith, 1972; Weaver et al., 2017) and communication between expectant mothers and their prenatal care providers (Kozhimannil et al., 2015).

Intersectionality theory, first used by Crenshaw in 1989 (Al-Faham et al., 2019; Atewologun, 2018; Bright et al., 2016; Ferree, 2018), accounts for the interconnection of social, political, religious, ethnic, and demographic factors and the roles that they play in injustices toward minorities or disadvantaged populations. The theory provides an understanding that these collective factors influence individuals' experiences in the United States. In this study, the intersectionality of race, gender (Deliovsky, 2017; Gillborn, 2015), and communication merged to shape and inform prenatal care experiences. Consequently, this conceptual framework provides broader insights into emerging adults' lived prenatal care experiences as first-time mothers.

Gaining in-depth insights into emerging adults' lived prenatal experiences as first-time mothers can be daunting; however, this conceptual framework offered parameters when examining this phenomenon. Additionally, this framework allowed flexibility in using a qualitative phenomenological approach that made exploring various experiences and the consequent meaning that adult pregnant women assigned to prenatal care possible. A more detailed explanation of the application of this conceptual framework is presented in Chapter 2.

Nature of the Study

The nature of this study was interpretive phenomenology, which emerged from the philosophical teachings of Martin Heidegger, a former student of Edmund Husserl who was renowned as the father of phenomenology (Guerrero-Castañeda et al., 2019; Horrigan-Kelly, 2016; Noon, 2018; Nunez & Celis, 2017; Wheeler, 2018). This approach provided opportunities to examine lived experiences in greater detail and explore the deeper meaning of collective life experiences in context or as "being in the world" (Horrigan-Kelly et al., 2016, para. 6). In states of being and interacting with and in their worlds, individuals' race, gender, culture, historical backgrounds, past and current experiences, ethnicity, and other factors shape and impact their experiences (Horrigan-Kelly et al., 2016; Wheeler, 2018). Through these lenses, individuals interpret, give meaning to, and make sense of their experiences. Therefore, this approach was fitting to explore emerging adults' lived prenatal care experiences as first-time mothers.

Prenatal care is a necessary and vital service for the health and well-being of mothers and their unborn children (ACOG, 2016; Aparico et al. 2016; Carter et al., 2016: Torres, 2016). Understanding the unique encounters that emerging adults experience during prenatal care is crucial to improving services for this population. The literature has shown that this population's prenatal care experiences differ from those of their younger and older counterparts; these differences are further discussed in Chapter 2. To examine the unique lived prenatal care experiences of emerging adults 18 to 22 -years of age, purposive and snowball sampling was used to gain access to this subgroup of mothers. Data saturation was met with nine participants in the sampling size. Data were collected via audio-recorded interviews with two separate recording devices used to offset any technical issues.

For data analysis, interpretive phenomenological analysis (IPA) was used to analyze further and understand the individual and collective stories of the mothers. This method helped in addressing the assumption that individuals experience and make meaning of phenomena in unique, personal, and contextual ways (Horrigan-Kelly et al., 2016; Smith & Osborn, 2015). Additionally, this approach made it possible to obtain data through open-ended and probing questions (Patton, 2015; Rubin & Rubin, 2016) and continually reviewing the data (hermeneutic circle; Mantzavinos, 2020) revealed deeper meaning or the essence of lived experiences. Applying the hermeneutic circle allows researchers more of an active part in the interpretation of these experiences as they examine phenomena from perspectives of their biases, culture, worldviews, race, and gender.

Definitions

Structured health care guidelines for prenatal care are crucial to the well-being of expectant mothers, and doctors strongly encourage adherence to them. The term prenatal care refers to the timeframe of medical treatment and management for expectant mothers that occur once doctors establish conception or pregnancy and up to birth. At regularly scheduled visits, health care providers help identify and assess for problems, provide prenatal education, monitor pregnancy milestones, and advise mothers based on medical histories, physical exams, tests, nutritional and dietary counseling, and fetal monitoring until the end of their pregnancies (Ayers et al., 2018; Coley et al., 2018; D’Angelo et al., 2016; Heaman et al., 2015; Liu et al., 2017; Magriples et al., 2015; Mazzoni et al., 2017;

Osterman & Martin, 2018; Sajitha et al., 2018; Torres, 2016; U.S. Department of Health & Human Services, 2019; Vekved et al., 2017).

Expectant or pregnant individuals are women who have a "developing embryo, fetus, or unborn offspring within the body" (Merriam-Webster, n.d.). Medical protocol involves the expectation that unborn children will remain within their mothers' bodies until at least 40 weeks or for three trimesters. As a medical standard, physicians consider 1 to 12 weeks as the first trimester, 12 to 24 weeks as the second trimester, and 24 to 40 weeks as the third trimester (Butt & Lim, 2019; Office of Disease Prevention and Health Promotion, 2020). Within each trimester, doctors assess fetal development and changes in mothers' bodies, and they ensure that both mothers and fetuses are reaching standard developmental benchmarks (Gennaro & Melnyk, 2016; Iltis, 2016; Piper, 2016). Additionally, doctors assess for and identify possible complications such as preterm labor, preeclampsia, high blood pressure, under or overdevelopment of fetuses, abnormal bleeding or discharges, and many other factors that put mothers and their fetuses at-risk for complications or even death (Reilly et al., 2018).

Lastly, *first-time expectant mothers*, unlike their more experienced counterparts, are unaware of the expectations of motherhood during initial conception or pregnancy. They lack previous personal knowledge or experiences with pregnancy behaviors, processes, practices, and establishing connections to their unborn (Cohen-Yatziv et al., 2018; Torres, 2016). These uncertainties contribute to feelings of powerlessness, fear, and mixed emotions that can lead to poor health outcomes without adequate medical, financial, emotional, and protective support during their pregnancies (Bäckström et al., 2017). Preis et al. (2019) found that first-time expectant mothers' beliefs and expectations about pregnancy and childbirth were not consistent with the realities of pregnancy and motherhood.

Assumptions

Theofanidis and Fountouki (2018) posited that researchers must acknowledge, contend with, and address the numerous assumptions, limitations, and delimitations of their research. The authors continued and noted that failure to do so compromises the integrity of studies and findings and does not allow readers to decide whether the research is convincing enough for their purposes. In this study, one primary assumption posed was that emerging adult expectant mothers' lived prenatal care experiences were unique and distinct from those of their younger and older counterparts. This issue was addressed as the data revealed evidence in support of or challenge to this assumption.

Another assumption involved the elements of inequalities and power imbalances because of race, gender, communication, and intersectionality as influencers of the emerging adults' lived prenatal care experiences. This assumption was attended to by focusing on Heidegger's interpretive phenomenology (Horrigan-Kelly et al., 2016; Nunez & Celis, 2017; Wheeler, 2018), which concludes that the meanings that individuals give to lived experiences occur within their worlds and in historical, social, and cultural contexts. Conversely, peer review of the data and data analysis were used to ensure that equal attention was paid to both sides of the argument. Additionally, the interview questions were structured to explore the prenatal care experiences as they are or were and not crafted to be suggestive of the conceptual elements. Lastly, peer review was used to ensure that my biases related to these elements did not prevail during data collection or analysis.

Scope and Delimitations

The focus of this study was exploring emerging adults' lived prenatal care experiences as first-time mothers. Participants were between the ages of 18 and 22, were in a first-time pregnancy delivered within 6 months of the study or currently in their third trimester, were English speaking, resided in the designated zip code areas, and were willing to discuss their prenatal care experiences. The study excluded mothers younger than 18 years of age, mothers over the age of 22, and mothers who had multiple pregnancies to help isolate the unique experiences of emerging adults as first-time mothers experiencing prenatal care. Further inclusion and exclusion criteria are reviewed in Chapter 3. Mothers selected to participate in the study were provided documents for informed consent. Expectant mothers outside of the scope of this study can be a topic for future research. Participants were recruited in one of Chicago's 77 communities, the Austin community located on the west side of the city. This community consisted of four neighborhoods: The Gale, The Island, North, and South Austin which the population was 81% African Americans, 13% Hispanics, and 4.6% Whites (Community Data Snapshots, 2019; Greater Austin Development Association, n.d.).

As is typical in qualitative studies, smaller sample sizes impeded the transferability of the outcomes. A more detailed discussion of transferability is included in Chapter 3. Discussions of the limitations of the data helped decrease the chances of overgeneralizations. Correspondingly, detailed descriptions of the samples added to the rich and thick data of this study. In this context, sufficient information was provided to allow other researchers to construct their conclusions without inheriting biases.

Limitations

Limitations of this study existed. For one, small sample sizes are a standard in qualitative research, generally, and phenomenology specifically. Therefore, transferability to other populations or settings was diminished (Babbie, 2017; Creswell & Creswell, 2018; Patton, 2016; Schloemer & Schroder-Back, 2018). Two, there are studies that extend the age range of emerging adults up to 29 (Darling, 2018; Hochberg & Konner, 2020; Torres, 2016; Wood et al., 2018). With increasing life experiences and maturity, older emerging adults' (Darling, 2018; Hochberg & Konner, 2020; Wood et al., 2018), pregnancy experiences can differ from those of younger emerging adults between the ages of 18 and 22. Consequently, transferability to the broader population of emerging adult pregnant women may be questionable. Exploration of prenatal care experiences for emerging adults after age 22 up to 29 years of age is a topic for future research.

Three, limiting recruitment to the Austin community on the west side of Chicago, Illinois, which is predominately African American, narrowed the diversity of pregnant women who met the inclusion criteria. As of 2018, Chicago's population was 97,611 (Chicago Health, 2018; U.S. Census Bureau, n.d.). Of that number, the African American population was 79,651, the Hispanic population was 12,299, and the White population was 4,392. This data showed that the ethnic makeup of Austin is consistent with Chicago as a whole. Therefore, the prospects for recruiting African American pregnant women were more prevailing. However, future research may expand the study to encompass more diverse communities and populations.

In this interpretive phenomenological research study, certain conditions negatively influenced the data collection phase. Data collected during interviews were subjective reports (Heath et al., 2018; Oltman, 2016) of expectant mothers' prenatal care experiences. These narratives were unique; it was challenging to confirm their validity, authenticity, or truthfulness, and there were problems of recalling or remembering events as they were.

Significance

This study is relevant because it focused on the unique lived prenatal care experiences of emerging adults as first-time mothers. Studies have emphasized distinct characteristics of emerging adults and their journey navigating transitions from teenage to adult life (CDC, 2017; Torres, 2016; Wood et al., 2018). Adding the complications of pregnancies into the lives of emerging adults intensifies challenges, uncertainty, stressors, and emotional and mental chaos. Because prenatal care plays a vital role in pregnant women's health and well-being, this study helped social workers understand the emerging adults' experiences when providing care, treatment, and support.

Policy Implications

For policy implications, this study adds to the body of knowledge about emerging adults, 18 to 22 years of age, as first-time mothers and can shape future medical and public policies. With this added information, social workers and health care providers will be able to broaden their understanding of this unique population and discriminate their prenatal care needs from those of adolescents or older adult pregnant women. Additionally, social workers and prenatal care providers can begin to discuss policies and protocols that address the emotional, social, cognitive, physical, psychological, and maturity aspects of pregnant emerging adults. Although these steps may require more time and resources, policies can ensure that these resources (extra staff, funding) are in place to secure appropriate services. With protocols in place, emerging adult expectant mothers can receive extra supportive, sensitive, and attentive services that can create meaningful prenatal care environments.

Social Change

Prenatal care continues as a major medical service. Inclusivity of the prenatal care experiences of emerging adult expectant mothers will challenge the status quo. However, these mothers' stories are obscured and not part of the narrative that makes up the prenatal care system. Therefore, it is essential for women to feel like they have central roles and voices in their care. Positive social change becomes possible as social workers and prenatal care professionals acknowledge the separateness of emerging adult expectant mothers from their contemporaries.

Optimal prenatal care experiences can be realities as emerging adult expectant mothers' voices become essential to the process. Social workers can advocate for these mothers to ensure that their voices, feelings, thoughts, and insights become significant and beneficial for improving their prenatal care services. Incorporating pregnant emerging adults' prenatal care experiences into the body of literature for social workers and health care providers acknowledges their presence and vulnerabilities. Additionally, this awareness increases social workers' sensitivity to biases and prejudices that these mothers experience and provides social workers with opportunities to become facilitators in reshaping meaningful prenatal care experiences for emerging adult expectant mothers.

Summary

In conclusion, prenatal care remains a necessary medical service for pregnant women. The literature shows detailed attention to younger and older adult women and their prenatal care experiences while excluding the same attention to the prenatal care experiences of emerging adult expectant mothers, between the ages of 18 and 22. Consequently, their prenatal care experiences are not as well-known and documented. Therefore, this study explored the lived prenatal care experiences of emerging adults as first-time mothers.

Chapter 1 included the research question, foundational elements, and the reason for this study. Chapter 2 contains an extensive review of literature on prenatal care, which emerged from midwifery into the standardized system it is today. Also included in Chapter 2 is a detailed discussion of the conceptual framework, which comprised elements from critical race, feminism, communication, and intersectionality theories as a lens for understanding the lived prenatal care experiences of emerging adult expectant mothers. Chapter 3 covers the research design and methods section and deals with trustworthiness and ethical issues. Chapter 4 focuses on reporting results of the study, while Chapter 5 concludes with a thorough discussion and interpretation of the results and implications for social and policy changes.

Chapter 2: Literature Review

Introduction

Prenatal care is the standard medical approach for the care and treatment of pregnant women. To help readers gain greater understanding of these prenatal care experiences, Chapter 2 offers a discussion of a conceptual framework that combined aspects of four theories as lens into prenatal care experiences of expectant mothers. CRT explains the role that race plays in the quality of prenatal care experiences when evidence of racial injustices, biases, discrimination, and prejudices exists. Feminist theory focuses on the roles of males and females in prenatal care systems and the power imbalances that are present between providers and expectant mothers. Intersectionality theory informed this study as it explains how race, gender, and communication shapes the meaning that pregnant women report about their prenatal care experiences. Lastly, proper channels of health information exchange are crucial to the provider-mother relationship as communication theory describes.

The literature review in Chapter 2 yields the historical evolution of prenatal care out of the practice of female midwifery and the experiences that expectant mothers faced during prenatal care and treatment over time. During this evolutionary period, males became a part of prenatal care by developing tools and inventions that assisted in childbirth and care. They also established, organized, and medicalized health care systems, including prenatal care, and legitimized their efforts through legislations. Chapter 2 also outlines models of prenatal care that exist to improve experiences for pregnant women and includes barriers to quality care.

Chapter 2 also includes the exploration of the developmental aspects of the emerging adult and how these characteristics call for differing encounters with prenatal care providers. However, the literature revealed the lack of discrimination that providers demonstrated when providing care to adult and adolescent mothers versus emerging adult pregnant mothers between the ages of 18 and 22. Similarly, the literature abounded with studies related to the prenatal care experiences of adult and adolescent mothers. However, the literature lacked information about expectant mothers who were emerging adults and their prenatal care experiences. This group presented to health care systems with unique needs, challenges, and concerns that impacted their prenatal care experiences differently than their adult and adolescent equivalents.

Literature Search Strategy

There were several strategies used to search and locate relevant information and data for this study. Electronic peer-reviewed sources included SocINDEX, PsycINFO, SAGE Knowledge, Thoreau, Directory of Open Access Journals, Science Direct, Elsevier, Social Work Abstract, Nexis, EBSCO, ERIC, Cochrane Library Database, ProQuest Central, CINAHL, Communication & Mass Media Complete, Science Direct, Social Sciences Citation Index, and Complimentary Index. For hard-to-locate articles and those unavailable electronically, the Richton Park library and Governor State University libraries proved resourceful. Primary key search words used were *prenatal*, *prenatal care*, *pregnant women*, *expectant mothers*, *health care*, *health care systems*, *obstetrics*, *obstetric care*, *midwife*, *midwives*, *midwifery*, *infant and maternal mortality*, *postnatal care*, *barriers to prenatal care*, *health care with minorities/women of color*, *African American*, *Latino*, *at-risk pregnancies*, and many combinations of these words using

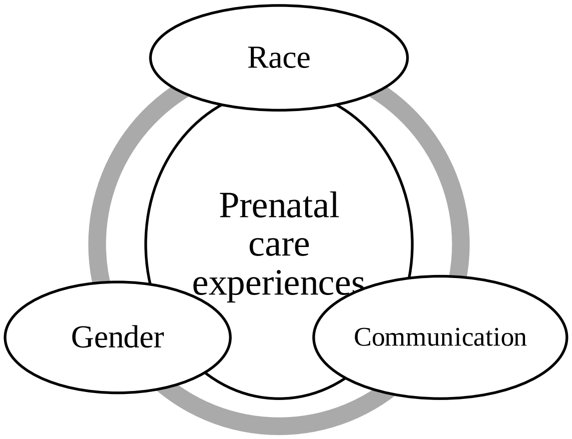
AND or OR in the databases. Other times, using synonyms, related words and phrases in articles, and keywords to search the internet led to useful articles. Additionally, references and citations within articles were checked and reviewed for relevant seminal or current works. Data in the study were primarily within the last 5 years; however, earlier years were used in some cases to explore historical timelines and seminal studies.

Conceptual Framework

The conceptual framework for this study included a combination of theoretical components from critical race, feminist, communication, and intersectionality theories (Figure 1). Many factors influence and shape the lived experiences of expectant mothers as they engage in prenatal care. Differences in race, socioeconomic status, religion, gender, and ethnicity are additional factors that lead to discrimination, prejudices, biases, and exploitation. They can determine the quality of experiences (Ayers et al., 2018; Crenshaw, 2017; Gennaro & Melnyk, 2016; Guerra-Reyes & Hamilton, 2017; Sweeney et al., 2016; Torres, 2016). Therefore, it is imperative to look at this phenomenon from multiple perspectives, in whole or in part, to gain a deeper and richer understanding of how it relates to prenatal care experiences of expectant mothers.

Figure 1

Conceptual Framework Model



Note. Conceptual framework of the intersectionality of race, gender, and communication in prenatal care experiences.

As an overview, CRT suggests that White elitists use race as a social construct to separate themselves as a group and go one step further to use legal systems and processes to sustain this separation (Crenshaw, 2017; Reese, 2019). Feminist theory highlights power imbalances and inequalities of females in patriarchal societies and advocates for women’s rights and their incorporation into all facets of society (Keedle et al., 2019; Mick, 2019). Intersectionality theory shows how race, gender, ethnicity, and other factors merge to create discrimination and prejudices (Al-Faham et al., 2019; Bright et al., 2016; Gillborn, 2015). Equally important, communication theory explains how written, verbal, and nonverbal language shapes the quality of experiences (Eley et al., 2017). Individually, these theories are useful in explaining situations. However, combined as a conceptual framework, they provided a wider perspective that detailed how the social constructs of race, gender, and communication intersected to create the experiences that expectant mothers encountered during their prenatal care.

Critical Race Theory

To begin, the foundation of CRT emerged from critical theory and critical legal studies (Crenshaw, 2017; Delgado & Stefanic, 2017). In the late 1930s, Max Horkheimer in the Frankfurt School framed the idea of critical theory, in which there are two core tenets: (a) societies should be critiqued and examined, and (b) through the knowledge of the social sciences and humanities, one can know and understand societies and their cultures (Delgado & Stefanic, 2017). Stated another way, he surmised that if one observed experiences of oppressed individuals, then one could scrutinize the societies in which these conditions occurred (Delgado & Stefanic, 2017). This self-critical analysis not only highlighted inequalities and discriminatory conditions of the oppressed; it also showed ways that societies questioned and confronted existing power structures that were responsible for oppression.

Correspondingly, critical legal studies which emerged in the 1970s with a connection to critical theory, claims a relationship between law and power (Delgado & Stefanic, 1998, 2017). This theory has several elements. In societies, laws help to preserve, enforce, and protect power structures and the status quo while reinforcing racism and prejudices toward disenfranchised populations (Crenshaw, 2017; Delgado & Stefanic, 1998, 2017). As individuals engage societies’ rules, institutions, policies, and practices, they face racism, oppression, and discrimination. Thus, proponents of CRT champion addressing the realities and negative impact of race and racism upon marginalized groups through the same legal channels that created these environments.

Because no one escapes laws, understanding the application of CRT highlights possible experiences that minority pregnant women face once they enter prenatal care settings where institutional racism exists.

Crenshaw (2017), one of the founding theorists of CRT, attempted to articulate and explain the many reasons why individuals confront and experience issues with race and racism daily. She surmised that the institution of law was the vehicle by which racial constructs were defined, sheltered, and instituted to protect the power interest of White elitists. Similarly, her predecessor in CRT, Derrick Bell, noted that American laws and their interpretations created realities beneficial for Whites to ensure their continuous power and favored status over all other groups (Delgado & Stefanic, 1998). Bell further suggested that this same elitist group determined who appropriately fit into their hierarchy (Delgado & Stefanic, 2017). Resultingly, White elitists continuously redefined legal definitions and structures as society changed to secure their positions of power (Crenshaw, 2017; Delgado & Stefanic, 2017). Within this setting, the issue of race, as a social construct, would be maintained and sustained via legal policies. This legal system supported unbalanced and unchecked racial inequalities that altered lived experiences.

Gillborn (2015) noted that proponents of CRT use race and racism as prisms to understand the life and life experiences of marginalized individuals. The author refuted any biological reasoning for race or racism and contended that dominant Whites in positions of power defined, structured, and maintained this abstract concept. Gillborn claimed that racism is permanently affixed and evidenced in the legal, social, economic, medical, financial, political, and educational institutions in societies. Gillborn further stated that racism takes on subtle forms that individuals perceive as normal, typical, everpresent, and a way of life that often go undetected and unchallenged. So, it appears that when racism became the status quo, the lived experiences of oppressed and disenfranchised groups became fashioned by their oppression and not by their design or expectations.

Additionally, Liao et al. (2016) found that Caucasians who identified as being superior to other groups had tendencies to see their actions construed as subtle racism such as inappropriate remarks based on race to be acceptable and justifiable. However, people who Whites saw as inferior, generally African Americans, defined the same actions as racist and unacceptable. Liao et al. remarked that individuals who saw themselves as part of the accepted class believed that their actions were legitimate. Conversely, blatant forms of racism such as violence against oppressed individuals occurred less frequently but revealed the problematic nature of racism and racist behaviors that individuals sought to change (Gillborn, 2015; Liao et al., 2016). Consequently, these racial constructs, positions of power, and the institutionalism of White dominance have played central roles in maintaining systems of racial injustices, inequalities, and imbalances.

Researchers have applied CRT in various settings and demonstrated the impact of racist or discriminatory practices on the experiences of marginalized persons. In the area of health sciences, Bridges et al. (2017) found medical staff readily identified marginalized groups to be predisposed to predictable health behaviors, diseases, medical treatments, and health outcomes merely based on physical or mental attributes. They identified structural racial tendencies, assumptions, and policies in medicine, medical research, and genetic testing that contributed to health disparities of disenfranchised populations and their experiences in health settings. Alongside their premises, Hicken et al. 2018) noted in their application of CRT in health settings that the experiences of marginalized individuals stemmed more from cultural and structural issues than personal biases and prejudices within these systems. They concluded that medical and public health systems should consider more macro holistic views of how racism occurred as opposed to racist interactions or practices between disadvantaged groups and their providers.

The use of CRT provides insights and a context for the biases, racism, and prejudices that oppressed groups experience as they interact within any institutions of societies (Bridges et al., 2017; Delgado & Stefanic, 2017; Reese, 2019). Specifically, the prenatal care system is an institution with standards, policies, and regulations that dictate hallmark standards of prenatal care for expectant mothers (ACOG, 2016; Carter et al., 2016; Osterman & Martin, 2018). White elitist organizations like the ACOG are among the leading premier organizations that informed such standards for all expectant mothers (ACOG, 2016; Williams, 2019). Medical staff follow through on and maintain these policies and standards by encouraging adherence while labeling pregnant mothers as noncompliant even when these standards clash with, differ from, or disregard cultural, personal, or socioeconomic differences amongst these women (Ayers et al., 2018; Dahlem et al., 2015; Reese, 2019; Romans et al., 2017). Therefore, the formula for racial biases and prejudices within the prenatal care system appears fixed and unavoidable as proponents of CRT surmised.

Studies presented in this paper showed that researchers have applied CRT in health care settings. Therefore, this theory was appropriately used as part of a lens to examine the lived experiences of pregnant women as they engaged in prenatal care systems. It provided insights into the role of race and racism that diverse groups encountered and how these forces shaped their experiences. Additionally, CRT helped in exploring why women of disadvantaged groups reported more negative experiences when they interfaced with prenatal care providers and their institutional policies and practices that made it easy to foster racial inequalities and discrimination (Reese, 2019). Ayers et al. (2018), Coley et al. (2017), D'Angelo et al. (2016), and Torres (2016) agreeably noted that race played a part in these encounters and that racial inequalities and discrimination occurred within health care settings for expectant mothers. As part of a conceptual framework, CRT also provided a way to understand the experiences and meaning that racially diverse expectant mothers gave to their prenatal care experiences, even amid racial differences in their prenatal care providers. However, a critique of applying CRT is that it does not explain racism that occurs within groups, such as African American expectant mothers who are divided by the same constructs of skin color, socioeconomic status, or geographic location. Moving forward, adding aspects of other theories may expand understanding of forces that shape expectant mothers' lived prenatal care experiences.

Feminist Theory

Feminist theory emerged out of feminist movements whose platform advocated for women's equality with their male counterparts in every aspect of life. There are spectrums of feminist theories that range from liberalists (Hague, 2016), who sought to create gender equality through their decisions and choices to socialists (Gordon, 2016) who aimed to give women more freedom to choose what they wanted to do even under capitalism. Additionally, other feminist groups strived to eradicate all forms of gender inequalities (Hirudayaraj et al., 2019). Despite their differences, feminist theorists collectively want to create societies where women experience opportunities without hindrances from gendered social constructs imposed by the powers that be (Bell, 2016; Ferguson, 2017; Sharma, 2019). Without these perspectives, the oppression of females, their voices, presence, and lived experiences would continue to exist.

Although diverse, feminist theories share a few underlying assumptions that define their core values. There may be biological differences between males and females (Winter, 2015); however, these distinguishing traits are not reasons for one group to have power over the other. Using gender differences and the separation of roles between the sexes is socially constructed and leads to oppression and discrimination against women (Crenshaw, 2017). Because society places greater emphasis on the male gender, this patriarchal focus has devalued, minimized, and discounted the presence, voices, and decision-making abilities of the female gender (Burton, 2016; Rowland et al., 2017). Understanding these realities of lived experiences of females is essential, as it accounts for those unique experiences and viewpoints that male-dominated lenses cannot accurately depict (Burton, 2016). Therefore, allowing women platforms to discuss their perspectives and to stand up for their rights, manifests opportunities to show the value of female experiences. In turn, these actions create shifts in patriarchal powers and structures and lessen the impact of discrimination and oppression toward this group.

There are other avenues to make these changes happen. Individuals who advocated for feminist rights kept their desires, agendas, and social change efforts at the forefront of societies to eradicate inequalities between the sexes. More so, they (a) fought for more equal opportunities for women in male-dominated areas of society, (b) fought laws and institutions that limited choices for women, (c) fought for sexual and reproductive freedom, and (e) fought to end sexually related violence toward women (Ferguson, 2017; Hirudayaraj et al., 2019; Vickery, 2018). From a feminist viewpoint, females' demand for social justice and equality became part of the social realities in societies. In turn, these efforts impacted and influenced females' lived experiences and the meaning that they gave to life events. These are hopeful aspirations embedded into feminist theory that, when applied, change the structure of societies.

Sharma (2019) addressed the influence of feminist theory in medical education. She found that universities educated doctors within male-dominant environments and cultures that defined and shaped medical policies and practices. Sharma discussed how the influence of these policies and practices became visible and dominant as doctors' mindsets established in medical classrooms showed up in their interactions with patients, resulted that were life-altering health experiences for women. Sharma also added doctors possessed knowledge about the body, how it works, how to treat and heal it. This expertise gave them unparalleled power and influence in their encounters with patients that appeared normal and acceptable. Applying feminist theory to understand the experiences females encountered in such settings revealed and created awareness of discrimination and power imbalances. More importantly, this female-gendered focus provided opportunities to challenge the injustices of such power systems to create better and more meaningful health care experiences for women. This information helped examine the diverse lived experiences prenatal mothers had as they engaged health care systems.

Intersectionality Theory

Intersectionality theory, a concept first introduced by Kimberle' Crenshaw in 1989, noted that white females faced racist and discriminatory practices and policies in America that they fought against (Crenshaw, 2017). However, their fight excluded the experiences and dialogue of African American females and their voices. Crenshaw noted that the black females' experiences varied from their white peers. The legal system in America had to consider the intersection of race and gender as discriminatory factors in interpreting its laws. Atewologun (2018) and Crenshaw noted evidence of power imbalances, oppression, and biases that existed not only between white males and females but also between white and black females. This environment offered reasons why women of color experienced negative interactions in prenatal care systems (Keedle et al., 2019). The interplay between race and gender is crucial in understanding disparities in lived experiences.

Race and gender alone failed to help understand the lived experiences of expectant mothers during prenatal care. Therefore, it is vital to understand this phenomenon by looking at how these characteristics intersect. Individuals encountered events and experiences that shaped, controlled, and influenced their identities (Al-Faham et al., 2019; Bright et al., 2016; Crenshaw, 2017; Gillborn, 2015; Harrison, 2017). Groups with power and status contributed to these experiences when they constructed ways to define and categorize others who were not like them. As a result, oppression, discrimination, and prejudices became evident in the experiences of others. Intersectionality, as part of a theoretical framework, provided some rationale for this phenomenon. Crenshaw's (2017) position on intersectionality noted that elitists must subjugate individuals using race, gender, class, or other socially constructed physical and mental attributes to create and sustain their biases, prejudices, and oppression. These constructs are interconnected and inseparable.

Similarly, Bright et al., (2016) stated that intersectionality theory explained how multiple aspects of individuals such as class, race, gender, sexual orientation, religion, culture, or disabilities further shaped and defined their experiences as marginalized groups. These authors surmised these variables intertwined, connected, and noted one could not determine the realities of lived experiences based on one without considering how they all shaped and impacted the others. To view one without the other is a one-dimensional perspective. Moreover, these social constructs became criteria used to measure one's abilities, advancements, social standings, and treatment that separated one group from another (Bright et al., 2016). Even acknowledging these discrepancies still did not eradicate the negative impact of using race, gender, or other human, social, or political characteristics in the oppression of people.

Interestingly, Ferree (2018) recounted that during the 1980s, the idea of intersectionality did not exist and scholars saw issues of race, class, and gender as very distinct and separate aspects of life. Because of this viewpoint, the idea of inequalities was justifiable through social processes. The author noted that the "contingent, connected, and conflictual" (p. 127) nature of race, gender, or class, appeared much later in the 1980s which was consistent with the time Crenshaw announced her intersectionality theory in legal circles (Crenshaw, 2017). Meanwhile, Al-Faham et al. (2019) expressed that the intersectionality of race, gender, and class not only existed between dominant and disenfranchised groups but also between and amongst the same groups and how their lived experiences were radically different. Social workers and researchers cannot fully understand the lived experiences of groups unless they consider various attributes of that group but not in ways that perpetuate oppression, inequalities, biases, and prejudices.

In further explanation of the intersectionality theory, Harrison (2017) applied the notion to explore the racial identities of African American adolescent females. She noted researchers generally claimed these females demonstrate unstable mental, physical, and emotional development that impacted how they experienced the world. She concluded that their race and other connecting attributes like age, gender, religion, and class shaped and formed their racial identities. The interrelationship between these variables reinforced, defined, and created meaning in their experiences as marginalized groups in a world where the socially constructed concept of race was dominant. Harrison’s study of African American adolescents applied to this research to show how the intersectionality of race, age, gender, or class influenced the lived experiences of prenatal experiences of emerging adults since both groups shared similar characteristics. Consequently, the racial identities of African American mothers, in tandem with other factors, determined the quality and meaning of their encounters.

Communication Theory

Communication is vital to interactions; understanding it is essential. Communication theory attempted to explain underlying assumptions of productive dialogue. Emerging from the telecommunication industry, Shannon and Weaver’s communication model, established in 1948, set the foundation for all other communication theories and models. It is referred to as the mother of all models, information theory, and Shannon’s Theory (Kim et al., 2017; Lundheim, 2002; Salek et al., 2019; Shannon, 1948; Shannon & Weaver, 1963; Verdu, 1998). A simplified version of Shannon and Weaver’s model suggested communication involved individuals creating, encoding, decoding, and receiving information that is influenced by their values, perceptions, culture, attitudes, education, mental, and social realities (Salek et al., 2019; Shannon, 1948; Shannon & Weaver, 1963). Both senders and receivers bring these dynamics to their encounters (Salek et al., 2019). Additionally, internal and external distractions interfered with this process that influenced the sending and receiving of information (Kim et al., 2017). However, the model has its limitations.

Although one of the most influential theoretical models of its time, its application had advantages and disadvantages (Kim et al., 2017; Lundheim, 2002; Salek et al., 2019). Collectively, these authors found the model showed an over-simplistic version of the process of how communication can be effective and where and how breakdowns occur. However, the process is very mathematical and complex. It also displays a linear understanding of how the communication process worked even though critics of the model argued that communication is circular rather than linear or one-way. In response to this criticism, Weaver added a seventh component to the model that added a way for receivers to respond or give feedback to the senders of the original messages. The model has universal application but it did not consider communication from one sender to large groups of people. Lastly, the model excluded an explanation of communication breakdown when power imbalances and control over others entered the communication process. Nevertheless, the model applies to understand communication factors between health care providers and expectant mothers during prenatal care. Many issues contributed to the quality of communication between expectant mothers and their providers in prenatal care systems. This dialogue determined the quality of the mothers' experiences (Eley et al., 2017). However, race and gender combined altered these encounters mainly when racial biases and prejudices were present and providers believed mothers of color were uncomfortable or incapable of communicating with them (Roman et al., 2017). Coley et al. (2017) found that women of color reported more negative communication experiences during their prenatal care with racially different providers and demonstrated cultural insensitivity. Other studies revealed communication concerns arose during prenatal care when there were conflicting or inaccurate information, misunderstandings, language barriers, cultural insensitivity, and dismissive attitudes between providers and expectant mothers (D'Angelo et al., 2016; Eley et al., 2017; Liu et al., 2017, Mitra et al., 2017; Till et al., 2015). In contrast, successful communication occurred when expectant mothers felt their health care providers listened, provided explanations, and engaged in meaningful dialogues (Wright et al., 2017).

Ruben (2016) suggested communication theory in health care settings shed light on similar principles and implications that impacted patients' experiences. He proposed that a primary assumption of communication theory in health care is that communication between providers and patients is essential. The author also noted, in health care settings, one-sided conversations with little feedback from patients are the norm since the health care team are considered the expert and authority in medical matters. Ruben suggested patients who interacted with health care providers were not comfortable when given opportunities to engage in meaningful conversations. He added effective communication involved both parties' awareness of their ideas, values, and perspectives. These elements impacted what they said, how they said it, and how people responded. He concluded that patients must see themselves as active and not passive members in the communication process. However, patients' fears, uncertainties, or feelings of intimidation limited their interaction in creating a two-way dialogue with providers. Similarly, patients refused to question or dialogue with providers particularly in life and death medical situations. These same views may apply to expectant mothers in prenatal care settings.

Goodman et al. (2017) found the theory of communication applied in their study of verbal and visual messaging in health care settings. They noted common amongst disadvantaged populations, culturally relevant messaging between providers and patients was crucial to understanding medical instructions. They contended that communication should reflect those served and, subsequently, indicated with this population, verbal messaging should be clear, simple, and endearing with positive tones. Correspondingly, visual messaging should incorporate colors, sensitivity, positive images, and be relatable. With appropriate communication, the meaning and value of the information individuals received in their lived health care experiences increased (Goodman et al., 2017). In other words, receiving quality communication from health care providers was more likely to impact health care experiences positively. As a note, this mode of communication appeared one-sided, linear, and assumed all groups of underserved or disadvantaged groups were similar in their understandings and interpretations of health messages received from their providers. It did not address the feedback from patients and how that feedback impacted providers or the consistency with their intended messages. Nevertheless, communication theory remained helpful in understanding how creating meaning in communications with health care providers shaped the lived experiences of prenatal mothers.

Methodology

Phenomenology

A phenomenological approach is appropriate and advantageous in exploring emerging adults' lived prenatal care experiences. Phenomenology is a best practice approach used in qualitative studies to obtain data about individuals' ordinary experiences or phenomena (Babbie, 2017; Creswell, 2009; Creswell & Creswell, 2018; Patton, 2015). Patton cited one advantage of applying phenomenology in qualitative studies included opportunities for researchers to examine first-firsthand accounts of the meaning individuals give to events in their lives. Additionally, Patton noted, phenomenology aided researchers in understanding experiences and what they mean to individuals (Patton, 2015). This methodology emerged from two primary philosophers.

Edmund Husserl

Edmund Husserl, referenced as the founder of phenomenology, described phenomenology as a means of gaining deeper insights into accounts of phenomena (Berghofer, 2020; Patton, 2015). Husserl's phenomenology philosophy included the idea that lived experiences arose from conscious awareness and individuals give meaning to events through their senses. Out of these experiences and their interpretations, there is "essence or essences to shared [or similar] experiences" (Patton, 2015, p. 116). Patton (2015) and Nunea and Celis (2018) cited these experiences were reflective; therefore, attempting to explore experiences while they occurred, altered them. Husserl referred to this reflection as epoche', a primary focus of phenomenology. He believed individuals could not know things without reflecting on them and that researchers should be conscious of their judgments, biases, and prejudices but withhold them (Patton, 2015). Although Husserl provided a basic understanding of phenomenology, other philosophers expounded on or altered his works.

Martin Heidegger

Martin Heidegger, a protégé’ of Husserl, continued to refine the principles of phenomenology. Horrigan-Kelly et al. (2016) noted several facts about Heidegger’s philosophy. His concept of Dasein, “a being in the world” (Wheeler, 2018, Division 1, para. 4) made up lived experiences. Whereas Husserl saw individuals and their experiences as separate entities, Heidegger refused to acknowledge this separation between the being and their world. Heidegger believed in lived experiences and everyday ordinariness that made experiences authentic and genuine. His overall assumption was individuals understand life events through their interpretation of those events. Despite Husserl and Heidegger’s foundational differences of phenomenology, they continued to impact the discourse of this matter.

Since the intent and purpose of this study was to get to know and grasp the uniqueness of prenatal care experiences amongst emerging adults, Heidegger's approach was befitting. Phenomenology was a way to understand these lived experiences through in-depth interviews that gave mothers chances to tell their stories. A more detailed explanation of why his philosophical approach was chosen is included in Chapter 3.

Historical Overview

Prenatal care is better understood when its roots in midwifery are explored. Evidence of midwifery, women caring for other women throughout pregnancy and childbirth, had been practiced from the beginning of human history and before the institutionalization of medicine and doctors (Goode & Rothman, 2017). Women naturally understood pregnancy and the birthing process or learned from more experienced women who provided this skilled labor and knowledge within their communities (Díaz & Gonzales, 2016; Thomas, 2009). Female midwives played central roles in pregnancy care, treatment, and births in English and American societies (Kaplan, 2017; Shields et al., 2017; Thomas, 2009). Midwifery was a profession where men were not allowed, avoided, or discouraged to partake; however, males believed that midwives were untrained and unskilled by medical standards (Kaplan, 2017; Thomas, 2009). Examining this historical view expanded understanding of prenatal care as it exists today.

13th Century

Although females comprised the occupation of midwives, significant shifts occurred in midwifery during the 13th century. Midwives continued to provide simple and natural pregnancy care and treatment with hopes of obtaining good outcomes for mothers and their children (Thompson & Burst, 2015; Varney, 2016). They aided women in getting pregnant, maintaining or terminating pregnancies, birthing, and avoiding pregnancies using natural processes and herbs (Kaplan, 2017; Thomas, 2009; Thompson & Burst, 2015; Varney, 2016). However, the growing knowledge and study of the female body by males influenced and changed the occupation of midwifery and its practices (Fee, 2003; Goode & Rothman, 2017; Thompson & Burst, 2015; Varney, 2016).

Simultaneously, male surgeons developed medical devices and surgical interventions such as forceps and birthing stools that caused midwifery to include more invasive methods when natural procedures failed during the pregnancy process (Campbell, 2018; Fee et al., 2003; Kaplan, 2017). These novel ideas of medicine redefined pregnancy and childbirth not as a normal process, as midwives did, but as an illness and pathology that unskilled women were no longer equipped to handle despite many centuries of caring for pregnant women (Goode & Rothman, 2017; Shields et al., 2017; Thomas, 2009; Varney, 2016). Additionally, this new perspective of pregnancy shifted the midwifery paradigm from females to male midwives or doctors. In turn, they redefined “pregnancy, contraception, fertility, and abortion” processes (Goode & Rothman, 2017, p. 66). Consequently, pregnancy care and treatment would never be the same.

15th to 19th Centuries

Even in biblical times, where the roles between genders were distinct, female midwifery was central to everyday life. One verse stated, “And the king of Egypt spake to the Hebrew midwives, of which the name of the one was Shiphrah, and the name of the other Puah” (Exodus 1:15, The Kings James Version). Genesis 35:17 stated, “And it came to pass, when she was in hard labour, that the midwife said unto her, Fear not; thou shalt have this son also” (The Kings James Version). Religious scholars translated this account of the Old Testament around 1604 – 1611 (Gebarowski-Shafer, 2016). This passage suggested similar experiences with midwifery that women faced no matter the period and showed the importance of female roles in pregnancy care and the birthing process (Dencker et al., 2019; Kachingwe et al., 2019; Stoll et al., 2016).

From the 15th to the 19th centuries, males maintained and sustained their dominance in medical fields, including midwifery. As their knowledge and expertise of the human body progressed so did their patriarchal influence (Thomas, 2009; Thompson & Burst, 2015). From the 1600s to the 1700s, men in the field of midwifery referred to themselves as man-midwives who proclaimed better services to pregnant women than female midwives because of their training and tools used in pregnancy care and births (Campbell, 2018; Shields et al., 2017). During the 1800s, male doctors understood pregnancy development, procedures, and conditions from experimentations and operations on the enslaved female (Goode & Rothman, 2017). These tests provided useful medical information that aided in successful pregnancies and births for white females (Goode & Rothman, 2017). CRT presupposed that this type of discrimination and violation of the rights of African American expectant mothers was a way of life. These mothers were powerless to change their conditions when considered as property. Despite medical advances gained through their lived experiences of pregnancy and prenatal care, they faced care disparities without corresponding social and economic gains.

Still, male doctors and surgeons continued refining processes that assisted women during and after their pregnancies (Campbell, 2018; Kaplan, 2017). Their goals were to assert themselves in the care and treatment of women and gain control over the women who were attending to expectant mothers (Fee et al., 2003). Even with a more significant presence and medical knowledge over female midwives, health conditions and experiences for mothers and infants did not prove to be better than care from female midwives (Vedam et al., 2018). Nevertheless, males proceeded to reshape and redefine the pregnancy experience.

During the late 18th to the early 19th centuries, the positivist philosophical worldview influenced all areas of study including medicine (Frère, 2019; Hasan, 2016; Heilbron, 2017). Herein, male doctors sought to know, observe, and understand the world of pregnancy care, treatment, and birth (Brown, 2018; Martucci, 2017). They applied scientific methods to explain, develop standards, and create interventions and inventions to assist in the process (Campbell, 2018; Shields et al., 2017; Williams, 2019). The medical profession evidenced this education as male midwives and newly established doctors were encouraged to view as many births as possible to study and learn what happened in the process. Through these observations, male doctors were able to gain the knowledge required to change the pregnancy experience forever for women (Grife, 2002; Kaplan, 2017). Resultingly, they gained control and power over pregnancy care, treatment, and birth from female midwives.

According to Kaplan (2017), to further develop their stronghold in midwifery, males campaigned to expose the weaknesses of this once female-dominated trade. Before the 18th century, communities lacked an understanding of the importance of safe and clean environments and their impact on people (Institute of Medicine, 1988). In the mid to late1800s, public health officials called for more favorable conditions for treating pregnant women in cleaner and safer environments to prevent the spread of germs and diseases (Kaplan, 2017). Ideas and activities to control the spread of diseases and germs began manifesting in the 19th century, a period known as The Great Sanitary Awakening with scientific advancements that sought to prevent such hazards (IOM, 1988). However, during the 20th century, the understanding of individuals maintaining proper hygiene and cleanliness became the focal point to improving the spread of disease and illness (Diaz & Gonzalez, 2016; IOM, 1988; McLellan et al., 2019). Additionally, prenatal screenings for harmful elements in environments were established (Grindler et al., 2018).

Consequently, doctors believed and promoted midwives as being incapable of offering pregnancy care, treatment, and deliveries within germ-free and sanitary contexts that caused suspicion and fear in a field women and mothers relied upon and trusted (Morrison & Fee, 2010; Thomas, 2009; Varney, 2016; Weisband et al., 2018). Thus, in continued efforts to strengthen their positions, male doctors organized themselves and established the American Medical Association (AMA) in 1847 (Williams, 2019). This order solidified qualifications, training, and educational requirements for doctors that further negatively impacted and exposed shortcomings of the work of midwives. As a result, the ideas and processes of prenatal care continued to change.

Still, more advances came in the 19th century to establish different prenatal care standards as doctors managed more pregnancies and childbirths, although midwives remained responsible for most births (Goode & Rothman, 2017). Also, during the early 1900s, the medical profession changed the title of care to pregnant women from midwifery to obstetrics and accoucheur, according to Shields et al. (2017). In the mid-1920s, doctors established the American Board of Obstetrics and Gynecology to set themselves apart as the premier profession to care for, treat, and oversee pregnancies, treatment, and childbirth (Grife 2002; The Editors of Encyclopedia Britannica, 2018). This organization continued to develop more specialized training, education, and qualifications and, in turn, redefined and reshaped the idea of pregnancy and childbirth as it is known today (Shields et al., 2017). The profession stood more as overseers of the pregnancy process than second-hand observers; they were now in charge of it and would dictate all policies and procedures as experts and authorities of pregnancy care and childbirth (Grife, 2002; Shields et al., 2017). These specialists deemed pregnancy a condition that required management due to its risks that continued to be out of the scope of untrained female midwives (Shields et al., 2017). Consequently, as obstetrical care increased, the demands for community-based female midwifery diminished (Goode & Rothman, 2017). Even amidst these advances, doctors remained unrelenting in their efforts to overshadow the roles of female midwifery in pregnancy care and treatment.

In this metamorphosis of pregnancy care, other measures influenced the shift away from midwives and their care of pregnant women. The medical professions called for increased sanitary conditions, improved medicines, and better techniques to alleviate pain and decrease infant and maternal mortality (Kaplan, 2017; Martucci, 2018). These issues were caused more by methods and lack of knowledge about pregnancy and the birthing processes of male doctors versus midwives (Kaplan, 2017). However, during the 1890s to the 1900s, American doctors began to accept the ideas of Louis Pasteur's germ theory, handwashing, and the spread of disease and its connection to pregnancy care, treatment, and birth (Nakayama, 2018; Tomes, 1997). The theory was one idea put into practice that revolutionized the care of mothers and their infants. Therefore, the fear of the spread of diseases that doctors claimed midwives could not contain caused a further shift from the use of midwifery and its unique approach to pregnancy care and treatment.

Notwithstanding the many hardships female midwifery faced during the 1900s, their care for expectant mothers continued to fare on par with their experienced and qualified counterparts (Brown, 2018; Hutton et al., 2016; Kozhimannil et al., 2015). Goode & Rothman (2017) reported six white women and 11 black women died for every 1,000 live births in states where public officials kept statistics, primarily attributed to male interventions (Brown, 2018). The female presence in the profession remained crucial for offering prenatal care and experiences where mothers and infants were important and significant (Weisband et al., 2018). Female midwives brought a connection in their relationships with mothers, a general understanding of the female body, processes of caring for the body, and bringing forth infants in childbirth. Feminist theory would suggest that female midwives who could identify with pregnancy experiences offered insights and enhanced the prenatal care experience.

Within the context of midwifery care, expectant mothers could converse with their midwives and express their concerns, fears, delights, and wishes throughout their pregnancy experiences (Kaplan, 2017; Kozhimannil et al., 2015; Thompson & Burst, 2015; Varney, 2016). This relationship was primarily due to their familiarity with midwives who lived in their communities which made communication more probable (Ashforth & Kitson-Reynolds, 2019; Martucci, 2018; Varney, 2016; Weisband et al., 2018). In contrast, male doctors’ approaches limited contact with expectant mothers or failed to listen to their worries or troubles. Doctors considered themselves experts who gave instructions and directions with little input from the mothers (Campbell, 2018; Goode & Rothman, 2017; Grife, 2002; Roman et al., 2017; Torres, 2016). Communication theory explains how this lack of two-way communication between parties can negatively influence experiences.

During the 1970s, increased use of midwifery as a method of prenatal care proved safe with natural interventions; it produced better birth outcomes at lower costs than doctors (Lucas & Wright, 2018; Roberts, 2019; Vedam et al., 2018; Weisband et al., 2018). From a feminist point of view, this type of midwifery brought more empathy, sensitivity, and sympathy with natural interventions versus their male counterparts who demonstrated a detachment from the experience they could not fully understand or comprehend (Ashforth & Kitson-Reynolds, 2019; Guerra-Reyes & Hamilton, 2017; Lucas & Wright, 2019). Nevertheless, the medical profession's continued presence in prenatal care remained influential.

In the mid to late 1900s, two primary legislations impacted midwifery labors, the care of pregnant women and their infants, and helped further institutionalize medical care and treatment. The Sheppard-Towner Maternity and Infancy Protection Act of 1921 helped establish and implement medical education systems and the care of expectant mothers and infants that included midwives (Madgett, 2017). Then the Hill-Burton Act of 1946, which ushered in the funding and building of hospitals, forced the care of pregnant women from their homes in their communities to newly found medical structures (The Hospital Survey and Construction Act, 1946).

Within this environment, medical personnel dictated pregnancy care, treatment, and birth because of insurances, safety issues, therapeutic interventions, and provider choices that, subsequently, created fewer demands for inexperienced midwives (Dunham, 2016; Kozhimannil et al., 2015; Vedam et al., 2018). Additionally, structured medical settings offered women safer births, minimal pain, and better health outcomes (Kaplan, 2017). Today, prenatal care is known for its medical and technological interventions and pain-relieving sources that created viable avenues of care for pregnancy care, treatment, and childbirth.

20th Century

Advancing from midwifery to obstetrics until the 1900s, 20th-century doctors continued to organize and implement changes in prenatal care for expectant mothers. There were variations in pregnancy care and treatment (Piper, 2016). However, during the 20th century, prenatal care became more structured which caused women to share similar levels of care and experiences (Narain & Kean, 2015). The medical profession established prenatal care guidelines, developed scientific methods to monitor fetuses, learned to repair ruptures and tears during childbirth, and implemented assessments to identify needs and complications before, during, and after pregnancies (Narain & Kean, 2015; Piper, 2016). Standards of care also involved educating pregnant women and redefining pregnancy as a normal process of life that did not, in every circumstance, require advanced medical intervention (Narain & Kean, 2015). Consequently, the benefits of prenatal care increased for expectant mothers.

With the advancements of science and the medicalization of prenatal care, methods used in centuries past were updated, outlawed, or remade to create safer and better prenatal care experiences for mothers (Iltis, 2016; Martucci, 2017). During the 20th century, prenatal care models included several elements (Gennaro & Melnyk, 2016; Mazzoni & Carter, 2017; Narain & Kean, 2015). The medical profession set guidelines to determine when pregnancies occurred, dividing this period into trimesters. This process included assessing expectant mothers for physical, emotional, social, and financial needs while examining the level of care, the setting of care, their adherence to medical treatment and advice, and the quality of care (Carter et al., 2016; Gennaro & Melnyk, 2016; Iltis, 2016; Piper, 2016). Prenatal care became the model of care for expectant mothers.

Resultingly, the lived experiences of prenatal care for women evolved. Earlier experiences of prenatal care involved immense feelings of the fear of death, pain, and vaginal and abdominal disfigurement that prevented future births or made them more difficult. Women described their experiences with dread, apprehension, and the expectancy of harm and loss. Personal testimonies of experiences of pregnancy and childbirth between the years of 1750 to 1950 reflected lamentations of these experiences (Leavitt, 1986). One 18th century mother claimed she prepared for her death and the death of her infant or some form of incapacity as she came near her delivery (Leavitt, 1986). Another mother reported horrendous pain and suffering and the dread of dying (Leavitt, 1986). Regardless, doctors continued to learn from these pregnancy experiences and attempted to develop less traumatic ones.

Accounts of prenatal care during the 20th century reflected quite different scenarios. The institution of medicine pushed for more precision in pregnancy care, treatment, and births (Piper, 2016). Technological innovations and increases in positive maternal and infant birth outcomes shifted the medical professions’ focus to care of the fetus, particularly with the use of ultrasounds (Piper, 2016). This shift in focus gave fetuses the right to care and protection (Piper, 2016). Other indications of this period were increased cesarean sections, the use of anesthesia, and the desire of expectant mothers to deliver in hospital settings (Martucci, 2017). However, amidst the push for hospital-based care, there was a renewed interest in midwifery. A 20th-century mother claimed, “birth is a natural process that should not be interfered with unless medically necessary” (Martucci, 2018, para 5). Simultaneously, feminists advocated for respectful and considerate experiences of expectant mothers as active participants during their treatment and care (Martucci, 2018).

Prenatal care even took on new dimensions in communications. Medical environments still existed where standard ways of exchanging medical information occurred even without medical personnel or provided without one exchange from patients (Rueben, 2016). However, Rueben found health communication changed from providers distributing one-directional information to transactions that considered patients’ cultural, physical, mental, emotional, and linguistic faculties. In current health care environments, patients and patient advocates are demanding more participation or two-way dialog in the communication process to understand medical situations fully. Arguably, Rueben’s study showed that providers are no longer sole sources of health care messaging. The internet, TV, books, libraries, pharmacies, and advertisements contributed to medical information, which has advantages and disadvantages for users of medical systems. This climate of open and accessible communication empowered women and gave them a voice as active participants in their prenatal and health care unlike their predecessors from the 13th to 19th centuries. Communication theory has contributed to health care providers’ and researcher’ consideration of how appropriate messaging can be helpful in any setting (Rueben, 2016; Shannon, 1948; Shannon & Weaver, 1963). These changes are present in prenatal care settings that reshaped expectant mothers’ lived experiences.

Models of Prenatal Care

In response to creating better prenatal care experiences, health care providers implemented non-traditional models for pregnancy care, treatment, and births. Sharon Schindler Rising, a trained nurse-midwife, developed a centering pregnancy model (Rising, 1998). The concept of centering pregnancy or group prenatal care provided prenatal care within group settings where nurses, social workers, nutritionists, and doctors followed cohorts throughout their pregnancies (Buzi et al., 2015; Kania-Richmond et al., 2017; Magriples et al., 2015; Mazzoni & Carter, 2017; Nasso et al., 2018; Schellinger et al., 2017; Smith et al., 2016; Trotman et al., 2015; Vekved et al., 2017). The authors noted these prenatal care settings provided supportive and empowering environments where expectant mothers gained knowledge about their pregnancies, became advocates for their health care, and increased their awareness of barriers that impeded successful pregnancy care and treatment. Another focus of these models was identifying risk factors that impacted expectant mothers' pregnancy care and treatment. Considering health care disparities and inequalities within traditional prenatal care settings dominated by white providers, this model yielded successful health care outcomes with pregnant women of color.

Gillberg and Jones (2019) discussed three models of health care in which two of them addressed the core values of feminist theory. Health care settings that are paternalistic maintained an atmosphere of power and authority of providers which ignored, disregarded, and silenced the information and knowledge patients brought to the medical encounter. The authors argued this approach was not conducive to promoting gender or power equality between patients and health care providers. Conversely, patient-centered models of health care are the proper steps toward shared acknowledgment of patients' experiences, perceptions, and input into service delivery. A feminist pragmatic model is a more well-rounded approach to bringing equality between providers and users of health care systems. In the feminist pragmatic model, Gillberg and Jones noted that just knowing its concepts is not adequate to bring about changes and that gender equality and equity only occurred within systemic changes. The nature of the feminist pragmatic model enhanced lived experiences by everyone participating in establishing genuine engagement that is less biased, racist, and discriminatory. Using any of these models can help understand different encounters expectant mothers experienced in their prenatal care.

In an ethnographic study, Wright et al. (2018) wanted to see how the interactions of midwives with prenatal mothers fostered negative or positive “women-centered” (p. 163) practices in hospital settings. The researchers conducted interviews and observations of 16 midwives caring for 88 women with first-time or multiple pregnancies within six clinics in South Australia. They concluded that midwives developed various approaches in providing environments where mothers felt they had adequate time to talk, share, and receive relevant medical information. In this context, mothers had a sense of continuity of care (woman-centered) despite hospital and standard pregnancy protocols that influenced these interactions. These elements empowered mothers during and after their journey as expectant mothers. Therefore, opportunities to engage, ask questions, provide input, and encourage two-way dialogue can be rewarding for women and expectant mothers during their prenatal care experiences.

Wernham et al. (2016) noted across the world, medical-led prenatal and birth care dominated the scene. In Wernham et al.'s (2016) study of 244,047 females with single deliveries, the mothers who experienced care with midwife models of care versus medical models of care experienced increased adverse birth outcomes. There were more favorable outcomes with medically led models. However, midwife-led supervision remained a viable option of care. A corresponding study by Eri et al. (2020) cited similar reasons for using midwifery as a model of care. However, Sandall et al. (2016) noted mothers who received prenatal and birth care under midwives experienced fewer interventions and expressed greater satisfaction with their care. Wernham et al. (2016) and Wiegerinck et al. (2015) suggested using both models collaboratively to provide experiences for mothers that were safe and satisfying. Thus, within this context of accessing compassionate and culturally sensitive care, treatment with midwives alongside structured care with higher safety standards, and medical interventions in medical models of care, expectant mother' chances of optimal prenatal care experiences increased. Even biases, discrimination, and prejudices in such a collaborative environment would diminish.

Barriers to Prenatal Care

Even through the evolution of midwifery, technological advances in medicine, and standardized treatment in prenatal care, racial barriers and disparities to quality care remained. Ayers et al. (2018) found mothers of color who interacted with prenatal care providers who failed to consider cultural differences in prenatal care practices, perceptions of discrimination, difficulties getting to visits, and financial concerns negatively impacted their prenatal care experiences. Dahlem et al. (2015) noted that the quality of communication between prenatal care providers and expectant mothers of color shaped their prenatal care experiences. The authors surmised that when mutual and respectable communication is prevalent and prejudice and biases are not dominant, mothers perceive their prenatal care experiences as more satisfying and positive. Correspondingly, Till et al. (2015) found finding creative ways to get mothers to prenatal care visits helped eliminate barriers to care. Their study showed how providing money, supplies, or resource incentives to pregnant women of color proved useful in getting mothers to care and positively impacted prenatal compliance. Efforts to lessen the impact of barriers in providing quality care remain a challenge.

Besides institutional racism and discrimination, other factors became barriers that intruded on and affected prenatal care experiences. Physicians structured prenatal care in controlled ways that determined levels and quality of care for expectant mothers and, consequently, expected compliance. However, research has shown that adhering to this structured approach had challenges that resulted in inadequate or no prenatal care for expectant mothers (Ayers et al., 2018; Martin et al., 2018, Scarlett & Young, 2016). In some instances, individuals failed to acquire an understanding of their medical status and treatment, had faulty perceptions about their health conditions, embraced diverse health beliefs, and were ignorant or ill-informed about medical and medication routines (Jones et al., 2014). At other times, individuals feared adverse outcomes of treatment and medications, had perceptions of biases, discrimination, and disrespect, and complained of cultural insensitivity. Further issues included mistrust of medical professionals, lack of access to care and transportation, time issues, lack of support, pressing concerns to meet daily needs, stressors of everyday life, or negative encounters, communication, and feedback from providers (Ayers et al., 2018; Farmer et al., 2016; Gibson et al., 2013; Heaman et al., 2015; Levi et al., 2017; Torres, 2016; van Mierlo et al., 2015).

Still, other barriers existed. Financial concerns and quality of care are primary barriers to prenatal care (Coley et al., 2017; Heaman et al., 2015). Heaman et al. highlighted barriers for inner-city women were more likely to include childcare support, addictive behaviors, time spent waiting for care, and shorter times spent with providers. Torres (2016) added with Hispanic expectant mothers, accessing care, language differences, and cultural considerations were challenges to their prenatal care experiences. Whittle et al. (2016) suggested that medical and office visit noncompliance was due to characteristics of patients and that measures should be taken to anticipate, assess for, and identify these characteristics during initial medical care that predicted possibilities of noncompliance.

Rathbone et al. (2016) found that compliance issues were not unique to any population but spanned across age, race, gender, location, types of medical treatment, or medical conditions. One solution to this matter was that providers made efforts to better explain and communicate medical treatments and regimens, practice sensitivity to their patients, and encourage medical compliance. Despite the many types of barriers to medical and prenatal care, Roozbeh et al. (2016) summed up these challenges into general categories of individual, financial, organizational, social, and cultural barriers that shaped and influenced the lived experiences of expectant mothers during prenatal care.

Notably, payment concerns are significant barriers to prenatal care for expectant mothers (Coley et al., 2017; Heaman et al., 2015). One of the most significant efforts in eliminating financial barriers to accessing prenatal care was the establishment of

Medicaid, a social insurance program (Fee, 2015). It has been the largest payor source in medical environments that made medical insurance coverage available to low-income mothers (Fee, 2015). Wherry (2018) found that mothers enrolled in Medicaid were more likely to engage in prenatal care and subsequent medical care for themselves and their infants. A primary goal of Medicaid was to eliminate barriers to health care for low-income and disadvantaged populations that would improve health and pregnancy outcomes (Kim et al., 2018; Wherry, 2018). Medicaid has made health care providers more willing to provide care to disadvantaged people and, yet, indirectly communicated messages that racial and gender equality in health care settings is valuable. In the end, removing financial barriers for expectant mothers to access prenatal care was a smart move in the evolution of the practice.

Expectant mothers experience one or more impediments that shape the meaning and value of their prenatal care experiences. Out of this deeper understanding, the prenatal care establishment can offer behavioral, cultural, biological, financial, medical, linguistic, and sociocultural support. These elements are needed to provide all expectant mothers with productive and qualitative prenatal care experiences. Racial disparities and discrimination can be addressed and lessened within this holistic and supportive environment. Additionally, opportunities can be created for women to take control of their prenatal care experiences to help systemically eradicate barriers to quality care.

No matter the barriers, women desire improved quality of care. Their 13th to 19th-century counterparts encountered prenatal care experiences that became the foundation for changes as we knew them in the 20th century. The call to action by critical race, feminists, and communication theorists for quality within human interactions transcends even the intersectionality of race, gender, communication, disability, ethnicity, religion, or other human characteristics. Prenatal experiences today, in some ways, may mirror historical experiences; however, researchers and medical institutions have made great strides to create and sustain better care.

Obtaining quality of care is no longer elusive to pregnant women during prenatal care. Their voices and experiences of the past and present shaped their future prenatal care. Mothers are calling for and experiencing improved patient-provider relationships and communication (Baird & Mitchell, 2014; Dahlem et al., 2017; Coley et al., 2018; Mitra et al., 2017; Roman et al., 2017; Torres, 2016), cultural competency and sensitivity (Ayers et al., 2018; Goode & Rothman, 2017; Coley et al., 2018; Torres, 2016), competent and continuity of care (Coley et al., 2016), patient-centered approaches (Liu et al., 2017; Roman et al., 2017; Till et al., 2015; Wright et al., 2018), and models of prenatal care designed to alleviate barriers to quality care.

Coley et al., (2018), reported in their study, the desires of prenatal care mothers. One mother explained how she preferred coordinated prenatal care for herself and her infant. In contrast, an African American mother rallied for providers who understood her special pregnancy needs and having sickle cell anemia. Equally notable, a mother stated quality of care meant having accessibility, adequate finances, and mutually respectable time considerations in her prenatal care (Coley et al., 2018). Even though their experiences differed, the notion of quality of care for all expectant mothers in the 20th century is more of a reality.

Emerging Young Adult Mothers

Prenatal care can be daunting and challenging for experienced and mature mothers but more so for younger first-time mothers because of distinct life issues and circumstances. Erik Erickson’s eight stages of psychosocial development highlighted characteristics of this young adult group (Cherry, 2019; Greene, 2017; Syed & McLean, 2018). In his identity versus role confusion, stage 5, individuals between the ages of 12 – 18 are developing a sense of who they are. They are just beginning to discover life, trying new things, and wondering how they fit into their world. Simultaneously, engaging in risky behaviors is a hallmark of this phase (Harrison, 2017; Sawyer et al., 2018). Navigating this stage of life can be confusing and chaotic; without proper resources, care, encouragement, and guidance, some young adults may be unsuccessful in emerging with healthy selves. This emotional uneasiness and instability in pregnancy and prenatal care impacts their experiences.

Correspondingly, Erickson’s stage 6 of intimacy versus isolation also highlighted the following explanations of the nature of emerging young adults (Cherry, 2019; Greene, 2017; Syed & McLean, 2018). From 20 – 40 years of age, these individuals are searching for healthy and intimate relationships in their lives. Here, individuals can work through complicated interactions with others and form lifetime habits and strategies in relationships. According to Erickson, any violations in navigating this stage can lead this group to feelings of loneliness, isolation, and compromised relationships. However, a successful passage can lead to desired healthy relationships this group seeks. For this study, adding pregnancies, new experiences of motherhood, and interfacing with unfamiliar medical systems can manifest concerns at this time of life. Therefore, social workers and health care providers should attempt to understand the unique makeup of this group to offer sensitive and appropriate prenatal care.

The distinction of clearly defining young adults is vague. Researchers tend to group this population with adolescents and adults (Burton, 2016; Sawyer et al., 2018; Torres, 2016). Consequently, medical systems and researchers neglect to realize young adults' unique qualities, characteristics, and life circumstances (The Society, 2017). In his seminal works, Arnett (2000) was the first to identify the concept of the emerging adult as individuals 18 to 25 years of age and the period of life between adolescence and adulthood. Arnett (2000) and Stanley (2016) highlighted emerging adults’ unique mental, emotional, and developmental attributes that set them apart from their younger and older counterparts. Similarly, The Society for Adolescent Health and Medicine (2017) defined young adults as ages 18 to 25. However, the Center for Disease Control and Prevention (2017) grouped young adults with adolescents that included ages 15 to 24 (CDC, 2017) while the World Health Organization (2014) reported the age range to be 10 to 24 and up to 30 years of age (WHO, 2014). White and Cooley (2018) noted youth and young adults to be aged 12 to 26. With such defining variations, the focus of this study was 18 to 22-year-olds, the early transition period from adolescence to adulthood.

The Society (2017) reported women 18 to 25-years old experienced higher rates of unplanned pregnancies, accessed health care at lower rates than their adolescent and adult counterparts, and experienced immature physical, mental, and biological development. Because of these unique characteristics, The Society noted this phase of life represented a “vulnerable developmental period in need of specific focus and attention” (p. 758). This group is coming out of adolescence where they were under the care, guidance, and responsibility of others to become responsible for their own social, emotional, medical, financial, and sexual selves.

White and Cooley (2018) reported that young adults represented a population emerging into adult independence and self-reliance. Risky behaviors are evident within this group; however, they do not use health care responsibly to manage their health. White and Cooley noted this group has distinctive needs; therefore, engaging and communicating with them should be just as discriminating. Since young adults are transitioning from parental-lead health care to independent care, social workers and health care providers should make accommodations to assist them in entering and accessing the adult world of health. When race, ethnicity, and other social factors come into play, White and Cooley noted health disparities for this group increased exponentially. White and Cooley added that communicating with this population required attention to their new and independent roles in their health care. Communication with them should reflect this sensitivity, their lack of familiarity with adult-based health care that requires planning, coordination, and confidence, and skills still developing in this population. Consequently, one can surmise, for expectant mothers who fall within this category, risks are higher and care can become more complicated.

Understanding gender inequality in health settings for adolescents and young women is also part of the female experience in prenatal care. From a feminist perspective, Goldberg et al. (2009), Sawyer et al. (2018), and Slater et al. (2001) found it essential to consider the physical, emotional, mental, and psychosocial development of expectant mothers when providing health services. These authors agreed the experiences of adolescents and young females are distinctly varied from expectant adult mothers. They found experienced mothers presented with more maturity and knowledge about the prenatal care experience while younger mothers did not. They also noted that this developmental period for younger mothers marked identity confusion, gender role confusion, feelings of not being heard, uncertain and unstable relationships, physical body changes, and new emotions. These mental and physical instabilities lead to negative self-esteem, depression, violence, premature sexual encounters, and substance use (Sawyer et al., 2018; Slater et al., 2001). Although their male counterparts experienced similar notions, the females' gender exacerbates negative perceptions in how health care providers viewed and related to them. Mixing this chaotic state within unfamiliar health care settings where females encounter discrimination face predisposed notions about who they are and what they do, leads to being ignored and left as disengaged participants in their health care.

Specifically, examining the lived experiences of prenatal care for females coming out of adolescence to adulthood applied to this study, a group Torres (2016) referred to as emerging adults. Torres noted emerging adults, generally between the ages of 18 to 22, presented with similar characteristics as their adolescent peers, however, with higher states of mental and emotional instabilities as they learn to navigate and cope with life on their own. He stated this group is at higher risk of problems during and after their pregnancies that health care providers should consider. Advanced knowledge of this group's unique needs, perspectives, and developmental issues create opportunities to provide services that would more efficiently identify potential risk factors and offer practical ways to interact with them in meaningful ways (Torres, 2016). However, without a feminist framework to highlight the attributes of this group, the lack of understanding could further negatively influence their lived experiences within health care systems and prenatal care.

There is more than adequate research showing the use of prenatal care amongst multi-parous and teen mothers but the literature significantly decreased when evidencing the uniqueness of prenatal care experiences for emerging young adults who are first-time mothers (Ayers et al., 2108; CDC, 2017; D' Angela et al., 2016; Dahlem et al., 2015; Illinois Department, 2018; Liu et al., 2017; Roman et al., 2017; Till et al., 2015; Torres, 2016). Consequently, my study filled this gap by adding to the body of literature and data for emerging adults who are first-time expectant mothers.

Summary

Chapter 2 highlighted a review of the scholarly literature on expectant mothers and their lived experiences with their prenatal care. The conceptual framework included critical race, feminism, intersectionality, and communication theories. Interspersed throughout Chapter 2 were specific testimonies of expectant mothers' real prenatal care experiences that shed light on their historical and current views. The chapter also provided a historical accounting of its evolution from midwifery to the sophisticated and disciplined system of care today. Once a female-dominated informal method of caring for and treating pregnant women, including cultural taboos hindering male involvement, ended up being male-dominated with tools, inventions, and interventions unavailable or withheld from female practitioners throughout the centuries. Nonetheless, the female contribution to the concept of prenatal care remains.

The literature revealed an intentional focus on research conducted with adult and expectant adolescent mothers. However, there is a gap in addressing prenatal care concerns and the needs of emerging adults 18 to 22. Often grouped with adult or adolescent mothers during care, the literature showed that this group has distinctive developmental, mental, emotional, and social challenges. Providers and social workers rarely address these areas of concern dismissed or ignored in prenatal care systems. Also mentioned in Chapter 2 were personal, social, and structural barriers to adequate prenatal care.

Consequently, understanding the uniqueness of emerging adult expectant mothers requires thought into how to capture their experiences. In this qualitative study, interpretive phenomenology is an appropriate methodology to gain insights into expectant mothers’ shared experiences through in-depth interviews. Chapter 3 provided a more detailed evaluation of this phenomenological method used to explore emerging adults between 18 and 22 years of age lived prenatal care experiences as first-time expectant mothers.

Chapter 3: Research Method

Introduction

Chapter 3 continues the exploration of emerging adults' lived prenatal care experiences as first-time expectant mothers. This section details the choice of applying Heidegger's interpretive phenomenology as a suitable qualitative research method that allowed opportunities to obtain richer and deeper insights into these individuals' prenatal care experiences. It also highlights two types of nonprobability sampling techniques: purposive and snowballing, where culturally sensitive and respectful recruitment strategies were applied.

The chapter covers a review of interviewing as a data collection tool incorporating IPA as a data analysis method. Sensitive matters such as confidentiality are mentioned as well as data collection, retrieval, storage, and eventual disposal. Correspondingly, the conceptual framework consists of elements from critical race, feminist, intersectionality, and communication theories as a lens into data collection and analysis. The chapter concludes with a discussion of activities that addresses credibility, transferability, dependability, confirmability, and ethical issues.

Research Design and Rationale

This study focused on answering the following research question: What are emerging adult's lived prenatal care experiences as first-time mothers? In answering this question, interpretive phenomenology was used as a foundation to explore these experiences and the meanings that expectant mothers assign to them. This methodological approach revealed similar patterns of this phenomenon within this group of 18 and 22-year-olds. It influenced sampling, recruitment, data collection, and data analysis strategies that are described later in this chapter.

Understanding the concept of a phenomenon (Creswell & Creswell, 2018; Patton, 2015; Rubin & Rubin, 2016) gives clarity and direction in this study. A *phenomenon* is a human sensory experience of life's events and circumstances that is open to observation, description, and explanation (Merriam-Webster, n.d.), a central element in qualitative phenomenology. In phenomenological research, lived experiences are actual events, circumstances, or phenomena that individuals encountered that have meaning for them (Creswell & Creswell, 2018).

Philosophers of phenomenology added more to defining lived experiences. Edmund Husserl, known as the father of phenomenology, believed that these encounters are daily world experiences of phenomena that individuals process through their consciousness (Berghofer, 2019; Christensen et al., 2017; Nunea & Celis, 2018; Patton, 2015; Rodriquez & Smith, 2018). In contrast, Martin Heidegger, former protégé' of Husserl, understood lived experiences to be culminations of human interactions in the world that cannot exist from past experiences, histories, or backgrounds that are part of their "being" (Rodriquez & Smith, 2018). Lastly, Alfred Schutz, a significant contributor to the philosophical understandings of phenomenology, theorized that as people experience the world, they see the world in ways that make sense to them. Consequently, individuals create and give meaning to those lived experiences (Babbie, 2017; Barber, n.d.; Hammersley, 2019; Strabheim, 2016; Yudin, 2016). The phenomenon under study in this research project was the prenatal care experiences of emerging adults as first-time expectant mothers.

Qualitative Research

A qualitative approach is appropriate to capture individuals’ lived experiences of phenomena and had advantages for this study. Applying this approach provided opportunities for direct contact with participants via audio-recorded in-depth interviews, a qualitative strategy (Babbie, 2017; Creswell, 2009; Creswell & Creswell, 2018) used to obtain stories and narratives of the mothers’ prenatal care life experiences. Correspondingly, during data analysis, shared patterns and themes emerged from collected data and resulted in insights into the meaning of the lived experiences. This process included being attentive to the influence of my presence, thought processes, background, and past experiences (Creswell & Creswell, 2018; Patton, 2015). Qualitative research was a practical option for this study to access firsthand accounts of emerging adults’ prenatal care life events.

Qualitative research provided chances to explore and examine events in detail that quantitative research lacks. Ravitch and Carl (2016) stated that individuals have ways of seeing and experiencing their world in a context; in sharing these experiences, researchers can better understand human conditions. Babbie (2017) found that qualitative approaches revealed more profound meaning and insights from observations and interpretations of events and experiences. Similarly, Aspers and Corte (2019) noted that common elements in qualitative research are observing, interpreting, and understanding phenomena. In light of these authors’ support, qualitative research was suitable to gain more knowledge and insights into the prenatal care experiences of emerging adults as first-time mothers.

Phenomenology

Whereas qualitative research is a general method of studying prenatal care lived experiences amongst emerging adults as first-time mothers, phenomenology offered a closer examination into these experiences. Phenomenology is a hallmark approach to qualitative research that focuses on exploring human experiences (Aspers & Corte, 2019; Babbie, 2017; Creswell & Creswell, 2018; Neubauer et al., 2019; Patton, 2015; Ravitch & Carl, 2016; van Manen, 2016; van Wijngaarden et al., 2017). Researchers design phenomenological studies to gain firsthand descriptions of experiences without attempting to explain individuals’ perceptions of those experiences or causation (Babbie, 2017; Barber, 2018; Hammersley, 2019; Strabheim, 2016). Patton (2015) concurred and added that phenomenology captures lived experiences in their purest forms that, generally, exclude theoretical or conceptual frameworks. However, in this study, I applied a conceptual framework as introduced in Chapter 2. This method revealed external factors, such as the intersection of race, gender, and communication, that shaped and affected prenatal care experiences and their meaning.

Patton (2015) also found that phenomenological studies entail understanding what people experience and how they come to experience and create meaning around those events. Finlay (2014) wrote that phenomenology focuses on obtaining firsthand accounts of experiences as individuals report those experiences. Adams and van Manen (2017) saw phenomenology as addressing lived experiences and how researchers articulate those experiences void of their own biases and preconceptions. Phenomenology, then, becomes a perspective that researchers apply in their research to examine and report lived experiences. Nevertheless, researchers must contend with and select the variation of phenomenology that best suits their study.

Phenomenology Variations

In Chapter 2, a conceptual framework that included critical race, feminist, intersectionality, and communication theories, along with phenomenology, created the lens for this study. These elements were the foundation to explore the impact and power imbalances of race, discrimination, prejudices, health communication, and gender differences, as well as how they intersected and shaped the lived experiences of emerging adult expectant mothers. However, to decide which variation of phenomenology was right for this study, an examination of significant viewpoints was necessary.

The philosophy of phenomenology became well-known in 1807 via Hegel's writings, *Phenomenology of Spirit*, long before its rise to philosophical popularity in the 20th century (Spiegelberg, 1975; Spiegelberg & Biemel, 2017). Although Husserl is known for developing phenomenology as a philosophical approach, forerunners of phenomenology such as Johann Heinrich Lambert, Immanuel Kant, and Johann Gottlieb Fichte were also part of its roots (Spiegelberg, 1975; Spiegelberg & Biemel, 2017). Following phenomenology's rise to fame through Husserl, other variations of phenomenology have existed, including realistic, transcendental, existential, naturalistic, genetic, interpretive, constitutive, generative, and dialectic (Harris, 2016; Smith, 2018; Suarez, 2017). These varieties of approaches expanded researchers' choices in capturing lived experiences from different perspectives and added to the presence and relevancy of phenomenology in scientific communities.

Another well-known phenomenologist, Clark Moustakas, considered himself a Husserlian but incorporated the thoughts of other phenomenologists in his works. Moustakas embraced a methodological versus a philosophical understanding of phenomenology that his predecessors influenced (Moustakas, 1994). His belief in "wholeness of experience and a search for essences of experiences" (Simon & Goes, 2011, p. 1) was essential to the relationship between a "phenomenon and the person experiencing the phenomenon" (Simon & Goes, 2011, p. 1). In efforts to clarify his thoughts, he developed heuristic inquiry that involved six phases: initial engagement, immersion, incubation, illumination, explication, and creative synthesis which collectively aided researchers in understanding lived experiences (Moustakas, 1994). From there, he developed one of the most prolific processes for researchers wishing to conduct valid phenomenological studies.

Even though well-known names have contributed to developing aspects of phenomenology, there is one distinct name, Alfred Schutz (Yudin, 2016). He contended that individuals' construct realities based on how they see and experience their worlds (social construct) rather than express their experiences objectively from the way that the world really is (Yudin, 2016). Schutz continued to refine his understandings of phenomenology and authored his most celebrated work, "*The Phenomenology of the Social World,*" in 1932 (Barber, 2018). Despite philosophical differences, Husserl considered him "an earnest and profound phenomenologist" (Barber, 2018).

However, two primary schools of phenomenology are most recognized and influential. Edward Husserl's descriptive (transcendental) phenomenology is a qualitative philosophical approach that involves studying events and phenomena as individuals see them in their consciousness and is descriptive (Albertazzi, 2018; Drummond & Hoffe, 2019; Farber, 1943; Jennings, 1992; Neubauer et al., 2019; Qutoshi, 2018; Rodriquez & Smith, 2018). His descriptive or transcendental phenomenology focused on obtaining firsthand accounts of phenomena or experiences void of researchers' preconceptions and biases to gain significant insights. Husserl took an epistemological approach that explained how individuals obtained knowledge that helped distinguish between beliefs and opinions (Berghofer, 2019; Neubauer et al., 2019; Sundler et al., 2019; van Manen, 2016; van Wijngaarden et al., (2017).

Husserl, as a mathematician, believed in subjectively studying human experiences and everyday shared experiences, rather than focusing only on the physical world and studying numbers (Smith, 2018). He contended that people's experiences come out of their consciousness and become their realities. To gain the essence of authentic experiences, Husserl spoke of *epoche'*, *reduction*, or *bracketing*, terms that admonished researchers to exempt and separate themselves from previous thoughts, beliefs, knowledge, and perceptions about a phenomenon to see it clearly and obtain the true meaning of that phenomenon (Moustakas, 1994; Nunea & Celis, 2018; Patton, 2015).

Patton (2016) outlined additional elements of Husserl's descriptive phenomenology that included researcher's intense involvement, describing lived experiences from neutral positions devoid of previous knowledge or thoughts, known as *intuiting.* In *analyzing,* researchers take collected data, review and code the data, then look for patterns and themes that are revealed, supported by phrases and statements. *Describing* involves researchers putting structure to the data in ways that show the experiences and the meanings that people assign to those experiences out of their consciousness. On a final note, Patton (2015) included Husserl's idea of *reflection*, which presupposes that lived experiences become part of peoples' consciousness and that people can only tell about experiences as they look back on them. However, during and after Husserl's lifetime, other scholars revised or added to his work in phenomenology.

Conversely, Martin Heidegger, a notable student of Husserl, altered Husserl's view of phenomenology and developed interpretive (hermeneutics) phenomenology. This aspect of phenomenology follows the same course of observing everyday lived experiences but involves look for reasons that individuals see experiences as they do (Patton, 2015; Zahavi, 2018). Philosophers and researchers have found Heidegger's interpretive phenomenology challenging to understand; however, they have noted that the concept of *being* in human experiences, in contexts, gave meaning to lived experiences that individuals shared with others (Guerrero-Castañeda et al., 2019; Horrigan-Kelly et al., 2016; Neubauer et al., 2019; Rodriquez & Smith, 2018; Zahavi, 2018).

Heidegger's ontological perspective sought to discover "What is Being?" (Rodriguez & Smith, 2018, p. 96). His theoretical opinions were counter to the epistemology of knowing and obtaining knowledge that was the basis of Husserl's philosophy and embraced the "science of being" (Rodriguez & Smith, 2018, p. 96). Heidegger understood the impossibility of individuals separating their experiences from the world they live in, their lifeworld, and that all experiences take place in context (Patton, 2015; Rodriguez & Smith, 2018). He posited that individuals' and researchers' experience phenomena that have connections to their culture, world, circumstances, and history. In turn, these influences are inseparable, practical, and meaningful (Nunez &

Celis, 2017; Wheeler, 2018). Consequently, within these contexts, researchers find the deep and rich meaning they look for in phenomena.

Heidegger's interpretive phenomenology incorporated hermeneutics, the philosophy of interpreting, to expand beyond observations of experiences into understanding phenomena through thoughtful interpretations and detailed descriptions (Horrigan-Kelly et al., 2016). Heidegger strengthen this level of interpretation using the hermeneutic circle (Patton, 2015; Rodriguez & Smith, 2018). This concept occurs as researchers continuously revisit data as a whole and its parts to interpret the meaning of texts. When researchers interject their unique lifeworld experiences, they reveal the essence of someone else's experiences beyond what was said or omitted. As this analysis happens, researchers shed light on and discover new knowledge in shared experiences. It was a step further in understanding lived experiences that enhanced his predecessor, Husserl's, work. With the phenomenological deviations from Husserl, Heidegger managed to provide alternate ways of understanding the same everyday shared experiences of individuals through exploration and interpretation of the meaning of those experiences from different perspectives.

In applying an interpretive hermeneutical viewpoint to emerging adults' lived experiences of prenatal care as first-time mothers, experiences and choices they made during their prenatal care were shaped in the intersectionality of a world of racial, gender, and economic inequalities, power imbalances in the health care system, and socioeconomic differences. Although expectant mothers shared experiences of prenatal care, how they gave meaning to those experiences related to how they saw themselves in the world which encompassed their being, histories, culture, and past experiences. There were shared similarities and differences. Researchers applying interpretive hermeneutics try to provide interpretations of shared lived experiences through reflexivity. Patton (2015) asserted that researchers and individuals must engage in reflection to gain deeper insights into a phenomenon. Researchers play direct roles in interpreting the experiences of the subjects they study.

Phenomenology Applied

Research has shown that applying phenomenology or versions of this type of inquiry was beneficial when exploring experiences of expectant mothers. For one, Ayers et al. (2018) used phenomenology as a methodology in their study to explore barriers to prenatal care amongst Pacific Islanders via in-depth interviews. Their research concluded that insurance, transportation, and language issues were predominant obstacles to these mothers receiving adequate prenatal care. Aparicio et al. (2019) conducted a phenomenological study of 18 foster care youth ages 19 to 22 (group considered emerging adults). Their findings showed that members of this group experienced inadequate pre/post support during their pregnancies. Because of a lack of support and supportive services, they encountered pregnancies at 2 to 3 times the rate of their non-fostercare peers. Additionally, their pregnancy experiences were emotionally painful but renewing, and they learned the power and strength of their bodies.

Badakhsh et al. (2020) used hermeneutic phenomenology. The team interviewed 20 expectant mothers, who had single and multiple pregnancies, to explore their experiences during their high-risk pregnancies. The authors found that these mothers expressed fears about their care during and after their pregnancies, birth outcomes, and future pregnancies. Lastly, Dahlberg and Berg (2019), in interviews with 10 expectant mothers, explored their lived experiences with health care during and after their pregnancies. The mothers reported that being able to discuss their concerns, risks, and responsibilities with their health care providers was significant. Similarly, the mothers expressed their needs to have attentive and engaging health care providers while being actively involved in their own care. Amid such variations in the application of phenomenology, lived experiences are still a central focus. Therefore, an interpretive (hermeneutic) phenomenological approach was suitable for exploring the emerging adults' lived prenatal care experiences as first-time mothers.

Role of the Researcher

My role as a researcher is new; I admit to the lack of skills research requires; however, I took the following steps to increase my competencies and skills during this study. Having a dissertation committee with experienced individuals who were experts in research protocol, subject matter, methodology, and document review, provided the guidance and oversight I needed. Their feedback ensured the alignment of the study's components from the justification of studying the phenomenon, choosing the research tradition, to data collection and analysis. Additionally, presenting the findings and interpretations was the final part of the alignment.

Due to the COVID-19 pandemic, my intended role as an observer changed. Face-to-face interviews became unsafe, so I became an active listener, using audio recordings, phone calls, and reading the transcripts. Researchers use their senses and skills to make immediate adjustments to interview questions and processes, chances quantitative researchers lack (Creswell & Creswell, 2018; Patton, 2015; Rubin & Rubin, 2016).

No matter what role I played in conducting this research, my personal biases were present. I addressed my personal biases by acknowledging them in my reflections, discussions with my chair, and developing strategies to minimize them as I proceeded in the research.

Because of my past prenatal care experiences, I acknowledged my biases of over-identification with expectant mothers, mainly African American mothers. I grew up as a middle-class, educated, African American female born to under-educated parents who were laborers. Living in and next to mixed-income communities, single, adolescent, and young adult females who were pregnant was not an anomaly. They were neighbors, relatives, and close personal friends who experienced first-time pregnancies. Their reports of their prenatal care experiences were frightening and full of uncertainties and false expectations. Today, as a highly educated African American female and mother, I still identify with these populations. However, I managed my biases through (a) continued awareness, (b) journaling and discussing my thoughts and feelings, and (c) speaking to and relating to the mothers as fellow human beings who deserved respect and dignity. Finally, I remained sensitive to mothers' different experiences during prenatal care, and I also stayed open to hearing the unique experiences of emerging adults as first-time mothers.

In addition to revealing my biases, a discussion of my philosophical worldviews was necessary. I acknowledged I hold a constructivist worldview with beginnings in the philosophical teachings of Immanuel Kants (Burkholder & Burbanks, 2016; Jankowiak, n.d.). Researchers of this worldview believed individuals give and construct the meaning of events as they encounter their world. They interpret the importance of these experiences in the context of history, culture, and interactions with others. Therefore, shared experiences can occur.

Within this constructivist perspective, ontologically, individuals expressed truths subjectively; truth can be as varied as individuals (Burkholder & Burbank, 2016; Creswell & Creswell, 2018). Epistemologically, individuals constructed and gave meaning to their experiences through interactions with others (Burbank & Holder, 2016; Creswell & Creswell, 2018). Applying qualitative, interpretive, or hermeneutic methods was consistent with this worldview, as Burbank and Holder (2016) and Creswell and Creswell (2018) noted. It also provided a foundation for outlining the research process that helped explore the meaning expectant mothers gave to their prenatal care experiences. Strategies to avoid super-imposing my worldview onto the participants included journaling and recording different worldviews if they arose. I acted as an active listener, engaged in peer discussions about conflicting viewpoints, and respected individuals' different worldviews when talking to the mothers.

Reflexivity

Because qualitative research is subjective, it allows the characteristics of researchers to influence their works. Researchers present with their unique histories, culture, biases, social status, prejudices, identities, and experiences that become interwoven into their research (Creswell & Creswell, 2018; Patton, 2015; Ravitch & Carl, 2016), issues researchers should not deny. For example, being an African American female, social worker, and mother, I identify and sympathize with expectant mothers, mothers of color, and interactions they encountered during prenatal care experiences. This self-awareness and over-identification could skew reports and interpretations of participants' unique experiences. However, reflexivity is a strategy researchers use by writing down or talking through thoughts of biases and prejudices; allowing other researchers to review their processes, interpretations, collection methods, and yet remain aware and conscious of these influences (Ravith & Carl, 2016; Patton, 2015). Aspects of researchers never go away but managing their impact is possible during research.

It was necessary to reveal earlier works with pregnant mothers of all ages who experienced prenatal care. I worked for a social service organization on the west side of Chicago, Illinois, as director of programs. I provided administrative oversight to the social work staff in the home visiting programs for mothers, infants, and expectant mothers. There were times I worked directly with the families conducting intakes, home visits, care coordination, education, training, and referrals. During those times, I met pregnant women of all ages. I listened to varied stories about their prenatal care experiences, many of them disturbing which heightened my interest in studying more about prenatal care experiences. However, recruiting for samples in the larger area of the Austin community decreased the likelihood that mothers I knew would be included in the study.

Methodology

Participant Selection Logic

Participants were current or past pregnant women between the ages of 18 and 22. They were recruited from the Austin community, located on the westside of Chicago, Illinois (Chicago Health Atlas, 2018; Eltagouri, 2017; Greater Austin, n.d.). Galewood, The Island, North, and South Austin are four neighborhoods that make up the Austin community which covered zip codes 60624, 60644, 60639, 60707, and 60651. Austin's population as of 2017 was 98,000 with a racial mix of 81% African Americans, 13% Hispanic, 5% Whites, and 1% Others. The median income was $36,000 with 47% males and 53% females (Chicago Atlas, 2018; Community Data, 2019). The community is well-known for high rates of violence, teen pregnancies, infant and maternal mortality, crime, gang involvement, juvenile justice involvement, underemployment, and unemployment (Chicago Atlas, 2018; Community Data, 2019; Eltagouri, 2017).

Sampling Strategy

Non-probability sampling, most often used in qualitative studies, was the strategy in this study. It is a technique not based on theories, numbers, or lists but focused on the accessibility of individuals and used when small samples are necessary (Babbie 2017; Patton, 2015). Purposive sampling, a type of non-probability sampling, aims to recruit participants based on specific characteristics that fit the purpose of studies based on researchers' judgment (Babbie 2017; Patton, 2015). Additionally, purposive sampling is a proper method to single out individuals who have experienced or been a part of a phenomenon (Babbie, 2017). Current or past first-time expectant mothers were the sampling units in this study.

Phenomenological researchers using purposive sampling must consider sample sizes. Moser and Korstjens (2018) stated the researchers' interest should be to target individuals who want to talk about and share their knowledge of a phenomenon. From these participants, researchers can reach others who have the same shared experiences and gain deeper insights into others. The number of participants researchers need for this sampling type in phenomenology ranged from three to 52 (Guetterman, 2015; Hagaman & Wutich, 2017; Vasileiou et al., 2018). However, phenomenological studies have lower numbers to obtain in-depth knowledge of experiences (Patton, 2015). There were 10 to 13 participants targeted for interviews in this study. I continued to add extra participants until saturation was met which is evidence of no new findings while collecting data, according to Creswell & Creswell (2018). Saturation points in qualitative phenomenology varies (Creswell & Creswell, 2018; Guetterman, 2015; Moser & Korstjens, 2018).

Snowball sampling was another non-probability technique that relied on participants to access individuals who have experienced the same phenomenon (Patton, 2015). A review of the selection criteria was conducted with participants at the end of each interview and they were asked to share the study's information with mothers they knew. From those referrals, appropriate candidates were chosen using the same inclusion criteria. A reminder question in the closing section of the interview guide (Appendix) was inserted as a reminder to ask the mothers for referrals.

Inclusion and Exclusion Criteria

Mothers for the study met the following inclusion criteria:

- biological females,
- between the ages of 18 to 22,
- delivered within six months of the study or,
- currently in their third trimester of pregnancy at the time of the study,
- first-time live pregnancy,
- English speaking,
- resided in the designated zip code areas, and

- willing to talk about their prenatal care experiences.

Exclusion criteria included mothers

- younger than 18 and older than 22 years of age,
- who gave birth more than six months of the study,
- who lived outside of the designated zip code areas,
- who had not reached their third trimester of pregnancy,
- who were non-English speaking, and
- mothers who had more than one child.

Recruitment Strategy

The initial task for recruiting involved developing messages. English messaging was simple, brief, large print, colorful, 4th-grade literacy levels, culturally sensitive, and consistent across mediums (Awasthi et al., 2017; Hogan et al., 2018; McCrorie et al., 2016; Weaver et al., 2018). All messages included

- the researcher's name,
- email address,
- phone number,
- university affiliation,
- title of the study,
- incentives,
- location(s),
- a brief narrative,
- interviews as means to obtain information, and

- criteria for participation.

Additionally, the messages included notification of a onetime $20 incentive for individuals who were selected and completed their interviews.

Message Distribution

With Institutional Review Board approval and sites secured, messages were distributed on flyers, via emails, and throughout and around the designated neighborhoods in park districts, laundry mats, corner stores, libraries, high schools, beauty shops, and barbershops with site approval. Individuals or locations that refused to accept the flyers or hear about the study were not coerced in any way. Although I worked on the west side in the Austin community, as a director, in a social service agency that served expectant mothers, I had no unique connections to the population that interfered with fair and equitable recruitment efforts or consent (HIPAA Journal, 2018).

Interested Individuals

When interested individuals responded to recruitment efforts via face-to-face encounters, emails, or phone calls, they were screened and selected using the inclusion criteria to determine fit. Upon selection, individuals provided their verbal or written consent to participate in the study and were referred to as “participants.” Protocols to obtain informed consent, using Walden University’s Consent Form, in-person or electronically were followed. Participants reviewed, signed, and returned the consent forms electronically, postal mail, face-to-face, or had the materials picked up at mutually agreed upon and secured drop-off locations such as a library or police station.

Participants were notified they could terminate participation at any time and freely express any discomforts that arose without retaliation. Written or electronic documentation of all responses participants submitted were maintained. Consent documents with any participants' identifying information were de-identified and secured in a locked file cabinet in a locked room. Individuals who did not meet inclusion criteria or were unable to participate were thanked for their interest. They were asked to share the study's information (flyer) with mothers they knew and have individuals contact me via phone, email, or email face-to-face.

Instrumentation

Interviewing is a data collection method used in qualitative phenomenological studies where researchers are the tool for collecting the data (Babbie, 2017; Creswell & Creswell; Ravitch & Carl, 2016). There was only one researcher who conducted the interviews. For validity measures, handheld digital recorders with built-in microphones to audio record the interviews and a similar recording device for backup were used. The interviews were face-to-face, in-depth semi-structured interviews (DeJonckheere & Vaughn, 2019) with open-ended questions consistent with qualitative phenomenological research. However, phone interviews or video conferences via Zoom, Skype, or Free Conferences were alternate methods as social and environmental conditions called for changes in the data collection approach. Interviewing was a suitable instrument to explore this phenomenon based on the research question, "What are the lived experiences of prenatal care as first-time mothers?". This method allowed the participants to freely share firsthand details and nuances of their experiences.

Each session was an hour-long with 45 minutes of interviewing, a 10-minute introduction section, and a five-minute closeout section. Interviews took place at community libraries, mutually agreed upon sites, or via videoconferencing. Interview guides as a tool to structure the interview process, common in qualitative studies, were used (Creswell & Creswell, 2018). They were used as guides rather than an imposed rigid approach in the interview process. The interview guides helped address all elements of the interviews, provided space for notes, aided in keeping place and focus, and ensured consistent questioning of participants. Even with interview guides, participants were allowed to share freely.

The interview guides had three sections. A ten-minute introduction section to get acquainted with the participants and to review elements on the consent documents. I explained the purpose, voluntary nature, and duration of the interview, addressed confidentiality, debriefing, participant referrals, data sharing, data collection, recording, transcription, analysis, and reporting. Participants were notified of receiving a one-time $20 stipend upon completion of their interviews. At the end of this section, I answered participants’ questions and thanked them for their participation.

The middle section was 45-minutes in length and had five primary interview questions listed separately with space for observations and notations. The items were designed to target the participants' experiences and encourage them to talk about their experiences, consistent with qualitative interviewing (Patton, 2015). Additionally, the interview questions were compatible with phenomenological traditions that emphasized researchers obtaining detailed descriptions of the essence of individuals’ experiences (Patton, 2015; Nunea and Celis, 2018). Probing questions were asked to explore responses more in-depth when appropriate. This structuring of the interview questions yielded sufficient data to understand what prenatal care experiences were like for emerging adults as first-time mothers.

In the 5-minute closeout section, expressions of appreciation to the participants were made. Additionally, final questions were asked for clarity, data sharing information was reviewed, participants were reminded to make referrals, and participants' final responses and thoughts were collected. Participants who required debriefing to express and address their concerns, ideas, or expressions needed for closure were included. Additionally, permission was obtained to call participants later for issues of clarity. To ensure greater integrity in this study, weekly discussions with another designated doctoral candidate regarding the research project, alignment, the interview process, data collection and analysis, as Ravitch and Carl (2016) suggested. Additionally, throughout the research process, I consulted with my Chair to ensure my approaches to this study were not in conflict with Walden University's IRB protocols, as needed.

Interview Protocol

Individually, participants were consulted to schedule interview times, locations, and preferred format in person or via email. Reminder emails and phone calls were made to participants a day before the interviews. I will keep a calendar of the scheduled interviews for tracking purposes, revising interview appointments, or future references during the study.

Site Selections

Libraries were the places of choice for this study as they are well-known and secure sites in communities. However, participants were able to choose interviews in other mutually agreeable locations. All sites were secured for participants' privacy, designated enclosed rooms that were pre-selected and secured before the interviews.

Permission was granted to place do not disturb signs on the rooms. On the day of the interviews, the participants were greeted and ushered to the interview rooms. However, because of the restrictions of the current pandemic, the interviews were also conducted via phone or video conferencing. These options were present in the Informed Consent form.

Data Organization

All the audio recordings and written notes from the interviews were collected for data organization. The audio-taped records were sent to a reputable transcription company and the data was transcribed verbatim, in English, with all silences, breaks, and noises for immersion into the data. The transcripts were read and reviewed with the audio recordings simultaneously as soon as the transcriptions were received. This method was used to ensure congruency, consistency, and accuracy between the two sources. Notes were made wherever there were discrepancies. Creswell and Creswell (2018) and Saldana (2016) encouraged researchers to organize data as it evolved to minimize dealing with massive quantities of information. Participants were contacted within a week of their interviews to resolve any discrepancies, if necessary. All the data were labeled by the interview date, interviewer's name, numerical identifiers of participants, and recording (interviews, notes, memos, audio, transcription).

All interview notes, memos, journals contained corresponding labels to the conversations. For example, a filing for an interview will be 04092020.McClerklin.PART#1.Audio recording, 04092020.McClerklin.PART#1.Transcription, while its corresponding notes are 04092020.McClerklin.PART#1.InterviewNotes. For this study, the names of participants were not relevant and will not be used in or on interview recordings, transcriptions, data reporting, analysis, or distribution. However, their names were cross-referenced in

separate files for future references when further contact with them as necessary.

Data Storage and Disposal

All the data from the interviews, transcriptions, notes, and audio recordings are stored in a locked cabinet in a locked room and will remain there for five years at my current home address. On the outside of the filing cabinet drawer, labels are visible with the study's date until its fifth anniversary. Directions are secured, with my family, to send all files to a disposal company for shredding, maintain receipts as proof of disposal of all interviews, audio recordings, transcriptions, and notes in the event of my incapacitation or death. The instructions are placed outside the file cabinet where the data is stored.

Coding

After the second review of each interview, I completed first-level in vivo coding of participants' statements and responses. In vivo coding helps researchers remain faithful to participants' voices and keeps a connection to the data by using exact words or phrases from participants (Saldana, 2016). Also, in this process, I used the conceptual framework to help further extract and analyze the impact of race, gender, communication, and intersectionality in the prenatal lived experiences amongst the participants. I used NVivo software for data organization and management to make data collection and analysis less burdensome. I had no prior experience with qualitative coding software completed tutoring and training before data collection began. Saldana (2016) suggested that "first-time or small-scale studies, code on hard-copy printouts first, not via a computer monitor" (p. 29). However, for more tech-savvy researchers, software and computer programs would be more feasible, less time-consuming, analyze the data in ways humans could not, and minimize learning curves (Saldana, 2016).

After first-level coding, I continued to second-level grouping or categorizing of the in vivo codes of the participants' statements and responses. After this step, I began looking for patterns, similarities, differences, and relationships across the datasets that helped answer this study's research question. From these categories, I searched through the data for themes that emerged (Saldana, 2016). I developed definitions for all codes, how and when to use them via a codebook, and provided verbatim words and quotes from the text to support the codes. I understood this process was cyclical, iterative, and reflective and noted changes during the data collection, analysis, and reporting phases.

Data Analysis

I used IPA and Heidegger's hermeneutic circle in the data analysis process. According to Smith and Osborn (2015), assumptions of IPA acknowledged that individuals experience life and attach meaning to those experiences. These experiences are unique to individuals but others can share the same experiences. Experiences are significant to individuals; they occur in context, and individuals have their unique interpretations of their lived experiences. In understanding insights into these experiences, researchers must understand the participants' perspectives (Smith & Osborn, 2015). Researchers move back and forth within the data to discover and reveal the deeper meaning of the participants' lived experiences which involves Heidegger's concept of the hermeneutic circle.

I brought my "being" into data analysis, which indicates the application of the hermeneutic circle. It required continual reading and rereading of excerpts from the interview transcripts, reviewing the audio recordings, and reflecting on my interpretations to see beyond what participants said. This process helped me explore the stories of the participants' lived experiences (Harris, 2017; Patton, 2015) and challenge, confirm, or negate the impact of the conceptual framework assumptions, experiences, and biases that underlie this study. I immersed myself in the data for greater understanding, clarity, and interpretation of the data. Consequently, I uncovered deeper meanings during the hermeneutic circle process.

As added measures in the data analysis, I listened to all the recorded interviews while reading the transcriptions to ensure accuracy and made notes where there were discrepancies. I notified participants when I needed clarity of words, phrases, concepts, or engaged them to clear up discrepancies in data interpretations. I made notes on the transcripts or interview guides where data was confirmed, expanded, or revised, in whole or in part. All subsequent contacts with the participants were audio-recorded and treated as part of the data analysis process. I labeled and documented the second recordings as outlined in the data organization section of this chapter. Also, I consulted with a peer who was knowledgeable about qualitative research processes. I provided copies of the transcripts to my peer for reading, discussion, coding, and theme comparisons. Discussions included discrepancies with the coding and themes until consensus was reached.

Issues of Trustworthiness

Credibility

Credibility measures in qualitative studies ensure that researchers account for accuracies in all phases of their research (Babbie, 2017; Creswell & Creswell, 2018;

McDonald et al., 2019; Ravith & Carl, 2016). I took measures to ensure the alignment of my research question, literature review, research methodology, sampling, data collection, analysis, and interpretation through guidance and direction from my dissertation committee. When needed, I contacted participants via phone, video conferencing, or face-to-face for opportunities to share issues about the transcripts, clear up questions, or misunderstandings, in the interpretation of the data. I adjusted any differences of opinions or clarity from participants in the analysis. I had an ongoing consulting relationship with my dissertation committee to discuss the research process.

Most importantly, I made notes of my biases based on over-identifying with African American pregnant women and their prenatal care experiences through ongoing journaling of my observations, feelings, and conflicts during the research process. I maintained all records, data collected, recordings, transcripts, notes, and journals as an audit trail to my research findings. Lastly, I made sure to choose participants who met all inclusion criteria and had a firsthand account of prenatal care experiences through purposive and snowball sampling.

Transferability

Transferability in qualitative research refers to the likelihood the information researchers obtain can be referenced to other groups, contexts, or settings (Ravitch & Carl, 2016). Small sample sizes used in qualitative research make generalizability unlikely (McDonald et al., 2019); however, researchers can present their findings in ways that readers can connect to other settings (Creswell & Creswell, 2018; Ravitch & Carl, 2016). To address transferability, I used detailed face-to-face interviewing along with observations to provide in-depth data. I was attentive and made notes regarding contextual nuances such as voice tones, gestures, silences, expressions of feelings, locations, and movements to get more detailed and thick descriptions from the mothers' narratives. Additionally, I discussed the final sample size and any variations during the data collection and data analysis phases of this research.

Dependability

Ravitch and Carl (2016) discussed dependability as an added element to increase the rigor of research projects. Dependability considers the data collected from participants and its alignment to the research findings and interpretations. In this study, expectant mothers told stories of their prenatal care experiences that were documented, recorded, and transcribed. The data coded from these narratives became the foundation for the study's results, findings, and interpretations. Oversight from my dissertation committee ensured alignment in all phases of my research beginning with the literature review, research design, data collection, sampling strategies, to data analysis.

Confirmability

Including confirmability along with credibility, dependability, and transferability creates well-built qualitative studies (Korstjens & Moser, 2017). Researchers bring issues of bias and understand the impact of their historical, cultural, professional, and social factors that can influence data collection, analysis, and reporting. So, what they observe and write requires insights from other researchers or participants. Therefore, I had another Ph.D. researcher review all transcripts and data analysis to get feedback on codes, themes, narratives, and analysis. I maintained a journal throughout the research process as a method to track significant milestones such as IRB approvals, number of codes in the first-round coding, number of categories, emerging themes, and unexpected findings.

Lastly, I resolved discrepancies by reviewing notes, transcripts, calling, or video conferencing participants to confirm their experiences or comments as needed.

Ethical Procedures

I submitted a first-level plan to address ethical violations to Walden’s IRB for approval (#11-06-20-0668169). I followed IRB protocols and used the feedback to improve my practices before and during the study. Even though ethical issues can occur at any time during research, having strong personal, professional, moral, and ethical beliefs are the foundation for proper investigations (Campbell & Morris, 2017; Ferdowsian et al., 2020; Nellhaus & Davis, 2019; Seiler, 2018; U. S. Department of Health & Human Services, 2020a). I understood and embraced the philosophy that all persons should be treated with respect, dignity, and integrity and have the right to make autonomous decisions, when appropriate, without fears of retaliation or retribution. These values are consistent with the National Association of Social Workers (2017) professional code of conduct. Singularly, these personal and professional values were not enough; therefore, complying with Walden’s IRB protocols and having committee oversight added more rigor to minimize ethical concerns in this study.

I was aware of the social and environmental stressors families faced in communities like Austin on the west side of Chicago. With guidance from my dissertation chair, reporting was accurate without data manipulation to my advantage or the disadvantage of the participants and their communities. All participants were treated with respect and dignity during

- recruiting by applying culturally respectful messages that were free from bias, racism, and prejudices,

- interviewing by incorporating their voices, showing respect of culture, personal space, time, and resources,
- data collecting by capturing accurate information,
- data analysis by maintaining their voices and true meaning through the interpretation process,
- confidentiality of the participants in the collection, reporting, and distribution of their data, and
- journaling and consulting with my peers and my dissertation chair helped me monitor my bias of over-identifying with African American mothers who face discrimination and prejudices in every facet of their lives.

Any personal information obtained in this study was not sold or used for any economic gain.

Participants' data collected throughout the study, in future publications, or reporting will remain confidential. Additionally, their identities will remain confidential using numbers and letters to represent their names. I provided information in the Informed Consent form for participants to access a copy of the final study once it was approved via Walden University. I debriefed with a peer to discuss potential themes and biases. I was prompt in contacting and responding to participants to show respect for their time. When scheduling interviews, I considered participants' time and refusals to respond to questions were accepted without mistreatment or abuse.

I explained to the participants the cards were only incentives and a token of appreciation for their time and not for any payment toward participation. Consequently, this amount was reasonable and demonstrated appreciation toward the participants but did not interfere with the integrity of their involvement. I provided verbal notice that participants had the right to accept or deny such incentives; however, their choice did not affect their chances to participate. Overall, I practiced complete transparency with participants, peers, and my dissertation committee throughout the study. I consulted with my dissertation chair weekly and received guidance to produce a qualitative project.

Summary

In this chapter, I outlined the application and alignment of qualitative interpretive phenomenology and IPA as methods to investigate, explore, and analyze the emerging adults' lived prenatal care experiences as first-time mothers. These approaches influenced participant selection strategies that included purposive and snowball sampling and data collection techniques such as audio-recorded in-depth interviewing with interview guides that added order, uniformity, and accountability in the data collection process. I also discussed the need for culturally relevant messaging during recruiting and included steps to ensure respect and dignity to all participants. Plans to secure, disclose, store, and dispose of data were integral to maintaining the mothers' data confidentiality. Chapter 4 includes data collection and analysis, addresses deviations from what I proposed in Chapter 3, includes a final sample size, and overall study results.

Chapter 4: Results

Introduction

The purpose of this interpretive phenomenological study was to explore emerging adults' lived prenatal care experiences as first-time mothers. This approach provided meaningful, detailed, and insightful data from participants' semi structured interviews with open-ended questions. Using IPA and Heidegger's philosophical concepts, a rich and robust data analysis was possible to answer the research question below.

RQ: What are emerging adults' lived prenatal care experiences as first-time mothers?

This chapter includes the data collection and analysis process and a presentation of the research findings relative to interpretive phenomenology and the trustworthiness of those findings.

Setting

The nine participants lived in the greater Chicago, Illinois area. Eight interviews were conducted via audio-recorded telephone calls. A Zoom videoconference, audio-recorded only, was completed for one interview, a viable option according to Archibald et al. (2019) and Irani (2019). All interviews were completed from the privacy of the participants' homes and took place between December 2019 and April 2021. The setting was altered from what was proposed in Chapter 3 due to the coronavirus 19 (COVID-19) pandemic. Governments imposed safety restrictions during the pandemic as early as December 2019 (Bilal et al., 2020), and nationwide community lockdowns were implemented from March 2020 until July 2021 (CDC, 2020a; Joy et al., 2020; Morlock et al., 2021; Webb et al., 2021). This unforeseen situation interrupted face-to-face contacts as well as physical movement and activities, and it restricted or altered individuals' access to services and resources across communities (CDC, 2020b; Masjoudi et al., 2020; Singu et al., 2020; Zhao et al., 2020). Details of the COVID-19 pandemic's impact on this study are outlined in the Data Variation section.

Demographics

Nine individuals were included in the study. There were seven African American participants, one Hispanic/Latina participant, and one White participant. Two participants had infants 1-month-old, one participant was in her third trimester of pregnancy, and one participant had a 2-month-old infant. Two participants had 4-month-old infants; one participant had a 6-month-old; and one participant had a 5-month-old. These mothers received prenatal care and delivered during the COVID-19 pandemic. Contrastingly, one participant had an older 16-month-old child but received prenatal care and delivered pre-COVID. Participants' ages ranged from 18 to 21 with a mean age of 20. Of the nine participants, two were 18, two were 19, one was 20, and four were 21 years of age.

All the participants identified as female and single. Three of the nine participants were unemployed, while the remaining six were employed either full or part time. Every participant lived 200% or more below2020 federal poverty levels for families of two as noted by the U.S. Department of Health & Human Services (2020b). Two had less than a high school diploma, four were high school graduates, and three had completed 1-3 years of college. In terms of sexual orientation, eight participants identified as heterosexual and one identified as a lesbian. Table 1 provides a snapshot of each participant.

Table 1

Demographic Profile of Participants

Participant's age	Child's age	Race/ ethnicity	Education status	Employment status	Sexual orientation
18	1 month	AA	hs senior	unemployed	heterosexual
18	3rd trim	AA	hs graduate	part time	heterosexual
19	2 months	AA	hs graduate	part time	heterosexual
21	4 months	AA	1 year of college	part time	heterosexual
21	6 months	White	3 years of college	unemployed	lesbian
21	5 months	AA	hs graduate	part time	heterosexual
19	4 months	AA	hs graduate	full time	heterosexual
21	16 months	Hispanic	1 year of college	part time	heterosexual
20	1 month	AA	11th grade	unemployed	heterosexual

Note: All participants were single (demographic not included in table). Income levels used were based on a family of two according to the 2020 federal poverty guidelines (U. S. Department of Health and Human Services, 2020).

Data Collection

Data collection began after approval from Walden University's Institutional Review Board (IRB) on November 6, 2020 (approval #11-06-20-0668169). Of the 23 individuals who responded to recruitment efforts, nine individuals met inclusion criteria and participated in the study. Six of the 23 individuals did not meet inclusion criteria because they had previous pregnancies that were identified during the screening process. To note, one of these participants who did not meet inclusion criteria progressed past the screening process and was interviewed. However, it was revealed during the interview that she had a previous pregnancy. Data collected from this individual’s interview were not used in the study. Another two participants did not meet inclusion criteria because one was in her second trimester of pregnancy and one was less than 18 years of age. Additionally, three other participants declined to participate once they learned more about the study, and three more did not respond to callbacks.

Consent forms and flyers were sent via email with messages instructing participants to review the documents and respond “I consent” in the body of their return emails. Once the consent email was received, participants chose a time and method for interviewing. A semi structured interview guide was used to provide consistency of questioning across interviews, which included my handwritten reflective notes related to personal biases, thoughts, and feelings invoked during the discussions. The guide contained five open-ended questions or statements and probing questions related to answering the research question.

Data were collected from audio-recorded telephone and video conference interviews between December 2020 and April 2021 from the privacy of the participants’ homes. There were gaps of time between interviews due to recruiting problems caused by the COVID pandemic. One videoconference interview, via the Zoom platform, took place in December 2020; two telephone interviews took place in January 2021; three telephone interviews took place in February 2021; one telephone interview took in March 2021; and the final two telephone interviews took place in April 2021. Data were collected until saturation occurred.

Interviews were facilitated and recorded from the privacy of my home office using a password-protected cell phone linked to a password-protected Google account. Participants were notified before recordings started. One participant consented to a videoconference via Zoom from her home; it was securely audio recorded over the platform. The remaining eight participants chose interviews conducted over their phone from the privacy of their homes. The average recorded interview time was 30 minutes. However, demographic information obtained from the introduction (research briefing, demographic questions, etc.) and closing sections (summary, debriefing, thank you) of the interview was not digitally recorded or transcribed, due to cost constraints, but written in designated sections on the interview guides. Responses to the interview questions were transcribed verbatim via Rev.com, a professional transcription company.

Data Variations

Several discrepancies occurred in the methodology from what was initially proposed in Chapter 3 due to safety restrictions implemented by governments and communities nationwide because of the COVID-19 pandemic. Resultingly, responses to recruitment efforts were low. Therefore, with approval from Walden University's IRB, recruitment target areas were expanded from the Austin communities to Cook and Suburban Cook Counties on January 15, 2021 to the United States on March 16, 2021. Despite efforts toward a national search, interested individuals and subsequent participants came from the greater Chicago Cook County area, which included the Austin community on the west side of Chicago, a previous targeted area presented in Chapter 3. Additionally, this last change on March 16, 2021 extended recruitment to individuals with children up to 2 years of age instead of 6 months of age. The rationale was that women wait at least 2 years between pregnancies (Ahrens & Hutcheon, 2018).

Another change that took place involved recruitment activities. Initially, I planned on recruiting through face-to-face encounters with individuals or placing flyers inside public places. From December 2019 to February 2020, flyers were posted on poles, trees, gates, or areas visible to people walking, in cars, or riding buses. The same approach occurred near or outside essential businesses such as street corner stores, bus stops, grocery stores, gas stations, hospitals, clinics, and so on. However, when community lockdowns occurred in March 2020, recruitment activities changed to sending emails, text messages, and making phone calls to social service agencies, faith-based agencies, colleagues, family, and friends who had access to the targeted population.

Last, the use of a handheld recording device became obsolete because face-to-face encounters were not feasible. Therefore, participants chose to be interviewed from the privacy of their homes over Zoom or via phone calls. I conducted the interviews from a private home office. The interviews were recorded using a password-protected cell phone linked to a password-protected Google account. All other data collection processes proposed in Chapter 3 remained the same.

One participant only had time to interview on the spot; however, the interview guide was not accessible to me so there were slight deviations in the interview questions. Although her responses included data similar to what other participants talked about, they focused on the pregnancy and not the prenatal care experiences. Resultingly, no data from this interview were used but the participant agreed to a second interview, with data from the second interview included in data collection and analysis.

Data Analysis

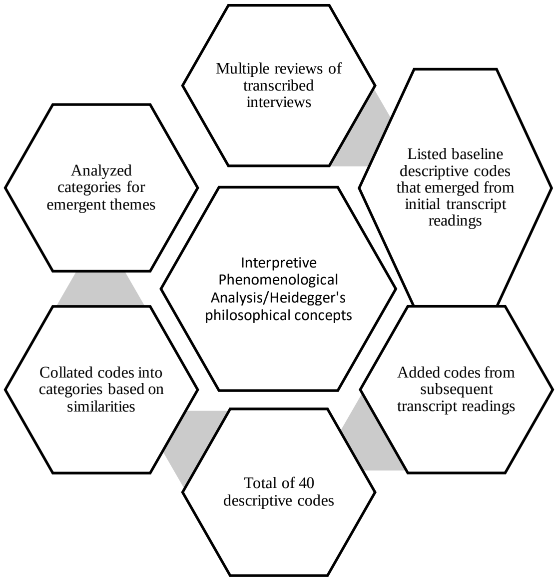
Using IPA served two purposes in data analysis. First, it allowed for a more in-depth look into the emerging adults' lived prenatal care experiences through constant reading and rereading the transcripts. Additionally, this type of analysis encouraged me to constantly reflect on the participants' experiences, moving more profoundly into what was not said and allowing the essence of the experience to emerge.

Coding Process

After each interview, audio recordings were sent to a professional data transcribing company. Once the transcriptions were received, they were compared to the corresponding audio recordings to ensure accuracy, clarity, and immersion into the participants' narratives. Handwritten notes were made of missing or unclear data on the transcripts. Then, I reread the transcripts noting keywords and phrases and hand coding using interpretive and contextual clues that established a set of baseline descriptive codes. After manually hand coding printed versions of each transcription, I uploaded their electronic files into Dedoose, qualitative software used to help organize and analyze data. Once uploaded, each transcription was reviewed, keywords and phrases were highlighted, and then codes assigned were manually transferred and set up in Dedoose. The program organized a list of all codes that made categorizing and referencing keywords and phrases in the transcripts easier. The coding process included a review of handwritten notes on the typed transcripts and the interview guides to help add meaning to codes assigned to texts and passages. Figure 3 shows the relationship and interconnectedness of this inductive process that informed coding to emergent themes.

Figure 2

Inductive Process From Coding to Emergent Themes



Note. Heidegger's philosophical concept of the hermeneutic circle included.

After initial readings of all nine transcripts, 36 codes emerged; the second readings yielded two more; two more codes were added after the third. After this process, 40 descriptive codes emerged and were collated into nine categories based on similarities. From the categories, two themes and one subtheme were prevalent, as shown in Table 2.

Table 2

Categories to Emergent Themes

Categories	Themes
Lacked knowledge of prenatal care Unplanned/unexpected pregnancy Scared/nervous/fearful/stressful/emotional about the unknown	Prenatal care/pregnancy knowledge
Relationship with providers Treatment of participants by providers	Provider/participant interactions
Talking and discussing matters with providers Being educated, informed, listened to	Effective communication

Note: Themes are accompanied by definitions used in this study. Two major themes are prenatal care/pregnancy knowledge and provider/participant interactions. Subtheme is effective communication.

Results

Discrepant Cases

Variations in the data that emerged throughout the participants' transcripts and the coding process were incorporated into the data analysis and considered equally valid experiences that could occur in larger populations. For example, while discussing prenatal care concerns with one of her midwives, a participant reported negative racial comments that affected her prenatal care experiences. Other examples of discrepant cases included a participant who talked about having support from her family and the child's father and a few participants who noted the negative impact of the COVID-19 pandemic on their prenatal care experiences. Although these responses were not part of the essence of prenatal care experiences, they did add to an expanded analysis of the potential variations of the themes that explain the essence of prenatal care experiences. A more detailed analysis of these variations and their impact on the essence of prenatal care experiences is discussed in the next section.

Emergent Themes

This section contains an analysis of the two themes and subtheme, with supporting quotes, that helped characterize the essence of prenatal care experiences for participants in this study. The themes are prenatal care/pregnancy knowledge and provider/patient interactions with effective communication as a subtheme. The analysis helped answer the research question: What are emerging adults' lived prenatal care experiences as first-time mothers?

Theme 1: Prenatal Care/Pregnancy Knowledge

All the participants entered their prenatal care as first-time mothers lacking knowledge about their care and of pregnancy. The knowledge that they brought influenced and shaped their experiences in both positive and negative ways. Some participants reported fear, stress, uncertainty, nervousness, and apprehension navigating through their prenatal care experiences. In contrast, every participant talked about the anticipation of responsibilities for their babies' new lives. One variation to this experience was notable. When a participant talked about having the support of family members, she reported that it increased her knowledge and understanding about her prenatal care experiences. She stated, "talking with my mom, godmother, and grandmother helped me understand about being a first-time mom." Support from partners and family members also influenced prenatal care experiences; however, support was limited by COVID restrictions during prenatal care where no additional individuals could attend prenatal care visits or testing.

Prenatal care/pregnancy knowledge emerged as participants described their thought about prenatal care. Participants had ideas that prenatal care was “care of a mother who is expecting a child and making sure they are well physically and emotionally” or “it is just at the beginning of my pregnancy.” Other accounts were “ensuring you are getting the proper vitamins and sources of energy that you need to keep yourself healthy and help your baby to grow” and “how the mother takes care of herself while she is pregnant.” Still, other participants noted prenatal care was “the medicine I was taking,” “care during pregnancy, post-pregnancy, and postpartum like the last six to eight weeks making sure that your nutrition is all together.” Others believed prenatal care was “when you go get checked up on from the doctor.” Overall, they demonstrated partial knowledge of prenatal care and pregnancy, however, their descriptions lacked a holistic understanding of the prenatal care cycle and the pregnancy process. They were unaware that prenatal care started from conception up to the birth of a baby, their roles in prenatal care, what happens during pregnancy, and the process related to prenatal care or testing.

In review of the demographic makeup of the participants, there were no characteristics (participants’ ages, education, race, baby’s age) that contributed to the participants’ levels of understanding of prenatal care. For example, an 18-year-old African American high school graduate in her third trimester of pregnancy, noted her prenatal care as “the medical advice, attention, and help me and the baby get along the way. She added, “especially me not really knowing and going into the whole experience and knowing nothing about having a child.”

A 21-year-old White participant with college experience and a six-month-old infant noted:

> I think prenatal care is basically ensuring that you are getting the proper vitamins and sources of energy that you need to keep yourself healthy and help your baby grow. Being a first-time mom, you don't really know what you are supposed to expect.

A participant who was 20 years old, African American, currently in the 11th grade with a 1-month-old infant explained her understanding of prenatal care as "when you go get checked up on from the doctor. I had fears what I thought it was going to be."

Theme 2: Provider/Participant Interactions

This theme emerged as participants described encounters with their providers. Most participants reported mutually respectful interactions with their providers, whether traditional doctors or midwives. They reported that their providers' behaviors were helpful, caring, and supportive. One participant noted:

> I had the same doctor. It was a good experience because she told me things I was unsure of. That made me feel comfortable because I did not have to keep explaining everything. I felt like we built a bond.

Another participant shared the following about her doctors:

> They were very patient with me. Some things they said I did not like but you know they were concerned for me and the baby. She would call me a day before my appointments. Sometimes if my regular doctor couldn't get to me it would be a different doctor. My doctor would ask me all the time am I okay, drinking enough water, taking my pills, etc.

Still, another participant stated, “I had a better connection with my midwife. They were more attentive. They showed they cared a little more.”

Even with a partial knowledge of prenatal care and pregnancy, participants expected interactions with their providers to be caring and nurturing. A participant noted, “I honestly didn’t know what I was supposed to expect but I felt like they [doctors] cared and they took their time to understand my circumstances and listen.” Another participant reported, “I expected nothing but the best when it came down to my prenatal care. They [doctors] went beyond my expectations. They talked to me and made sure the baby was okay and told me things I never knew.”

In contrast, a few participants had different encounters that impaired interactions with their providers and made their prenatal care experiences and expectations challenging and unfulfilling. Interruptions in interactions with their providers adversely impacted the relationships. One participant noted:

> My expectations are that I am fully informed. My first prenatal doctor was the best that I could have chosen or had. If I could have had her my entire pregnancy, I probably would have. But the second one I would not recommend.

Another participant expected her providers to “provide more help and guidance and understanding about prenatal care which I didn’t get.” Subsequently, she felt her expectations were unfulfilled.

Amid COVID restrictions, challenges occurred in provider and patient interactions. A participant reported:

> I only got to half of my prenatal care visits because of COVID “because my doctor wasn’t’ really there. It was like they did not care. They tell me they were

> going to call me back. They never called me back but my doctor would tell me that he didn’t even know that I was trying to get a hold of him. He’ll check me, and then say okay you can leave now. It was like my doctors did not care.

Another participant expressed, “I had a few problems with my doctor. She made me feel like my pregnancy was unimportant. I felt unwelcomed when I went to the doctor's office.” However, when participants faced challenging encounters with providers, some made their disapprovals and concerns known to their providers to improve the situation. For example, a few participants expressed discontent with their providers and requested different ones or midwives. One participant talked about a negative racial interaction with a provider during her prenatal care experience. The participant noted that "the other one was more judgy", a reaction she perceived as racially motivated and, subsequently, terminated interactions with the provider. While this was the participant's experience, in this situation, racial encounters are not present in all encounters between providers and pregnant women.

Two, a more unusual condition like the COIVD-19 pandemic drew extra attention for the participants during prenatal care. Although uncommon, its presence altered prenatal care experiences and made navigating the prenatal care system more challenging. For example, it caused frustrations and delays in scheduling prenatal care visits, missed appointments, engaging multiple providers and facilities, and exposure to COVID dangers. Dealing with numerous doctors and facilities made interactions for participants short-lived, inconsistent, and caused discontinuity in their care and provider and patient relationships.

Subtheme: Effective Communication

The theme of effective communication emerged as an essential part of the participants' interactions with their providers. Most participants reported shared experiences of meaningful two-way dialog that was respectful and informative. Their interest focused on being educated about prenatal care processes and pregnancy. More importantly, talking about their concerns and asking questions were necessary for their prenatal care experiences, creating positive interactions with providers. A participant stated, "She was giving me information about things I needed to learn about. I think they felt like, because of my age, I was doing a good job projecting my voice and asking questions."

One participant thought her doctors would just tell her what to do and not consider her input but realized her expectations of communicating with her providers was unfounded.

> I thought it was going to be do this, that, and this. But it was not like that. I thought it was only going to be checkups and they were going to keep various stuff from me. They were going to try and discourage me and tell me what to do. I really enjoyed it to the point where I want to go back to the same midwives.

Another participant noted, "I'm not a person who likes to express myself. She [doctor] made it easier" while another participant added, "communication between us was good. Conversations were kind of difficult at first, but as we kept going on they started getting easier and easier. We had a better understanding of each other." Lastly, a participant shared, "she made sure that I was comfortable with talking to her about everything that was going on. When she felt like I didn't want to say anything, she'll ask or something."

These examples highlighted mutually respectful dialog that had a positive impact on the participants' prenatal care experiences.

In contrast, a few participants expressed different views that reflected barriers participants experienced in the communication process with their providers. The lack of or interruption in communication between participants and providers negatively impacted the prenatal care experience. A participant shared:

> So my prenatal care experience was okay and sometimes it wasn't. I thought I would be able to get to my appointments and they [doctors] would answer their phones. But I don't think I will go to the same hospital if I have another baby because it was not how it was supposed to be. Having multiple doctors during the COVID-19 pandemic impacted a participant in another way.
>
> It was hard because I had more than one doctor. One doctor would tell me one thing, then you would have another doctor who would tell you another thing. It was different stuff that they were telling me that I should do.

Still, another participant explained:

> It was annoying trying to retell my entire experience every time I saw a new doctor or talk about my symptoms and my options and stuff every single time I saw a different doctor. But communication could have been better at times.

In some instances, communication was unreliable or inconsistent and negatively affected the provider and participant interactions. As one participant described her challenges in communicating with her provider, she reported, "like they would tell me they would call back. They never called me back. Then they said they tried to call but I never had a phone call."

Essence of Prenatal Care Experience

Emerging adults' lived prenatal care experiences as first-time mothers are influenced by their foreknowledge of prenatal care and pregnancy. Initially, this bit of knowledge frames and informs their experiences and expectations. However, when this information is insufficient, they rely on providers or support networks, when available, to provide further understanding. They seek to be educated and informed as they navigate the prenatal care process and increase their knowledge and understanding that shapes their experiences. Additionally, they enter into prenatal care with expectations about their care, treatment, and interactions with providers. Once engaged in prenatal care systems, interactions with providers are crucial and affect their experiences. Positive interactions with providers are characterized by mutual respect, caring, and support, as well as respectful communication, where both parties are open to receiving and giving feedback.

Conversely, factors that negatively influence their experiences are probable. Adverse interactions occur when providers are perceived as inattentive, insensitive, or uncaring, compromising the relationship with emerging adult mothers. In response, these mothers either seek different providers to make their experiences meaningful and fulfilling or remain with providers but voice their concerns. In cases such as COVID, unusual or uncontrollable events or circumstances can alter the routine of prenatal care, interrupting communication with providers and requiring adjustments from both providers and mothers. Subsequently, the essence of the emerging adults' lived prenatal care experiences as first-time mothers are shaped by many factors that make the experience positive, fulfilling, or lacking. Nevertheless, every encounter the mothers navigate during prenatal care, shape and give meaning to their experience.

Evidence of Trustworthiness

Credibility

I used four methods to establish credibility: First, I immersed myself in the data which involved hours and days of reading and re-reading the nine transcripts while engaging in reflections, hand-coding, and writing. This process provided a deeper understanding of and familiarity with each participant's narrative that helped minimize my personal biases. Second, data saturation occurred by the ninth interview as no new data emerged after the sixth one. However, I included three additional interviews to ensure saturation. Third, a peer familiar with qualitative methods, reviewed the data collection and analysis process and provided critique, clarification, and feedback. Last, participants were selected using purposive sampling for best selection based on established criteria in the research.

Transferability

The sample of this study primarily represented single, low-income, African American emerging adults as first-time mothers who lived in the greater Chicago area. As previously mentioned in this paper, researchers have defined emerging adults from 18 to 30 years of age. Therefore, findings may be insightful to understanding aspects of the general population of emerging adults as first-time mothers but specifically, insights into the types of experiences emerging adults as first-time mothers 18 to 22 years of age might experience in prenatal care settings.

However, there are limits to transferability. Due to the small sample size, generalizations to other groups or settings are not possible. Areas where the participants lived were not reflective of diverse communities where emerging adults as first-time mothers live and seek prenatal care. The COVID-19 pandemic was unexpected and an unusual factor in prenatal care environments. Consequently, the influence of the pandemic was specific to the prenatal care experiences of participants in this study which is not readily applicable to non-pandemic experiences. Finally, the targeted population for this study was a subgroup of pregnant women, limiting the conclusions and findings to younger or older groups of pregnant women. I provided a detailed description of the entire research process to give future researchers enough data to review and decide if the conclusions and findings would apply to their studies.

Dependability

For dependability, reading and re-reading the data took hours and days to become familiar with and gain a deeper understanding of the participants' lived experiences. Efforts were made to ensure consistent alignment throughout the study with a qualitative approach between the conceptual framework, research design, and research question development to data collection, analysis, and reporting. Research protocols were written in the research design section approved via IRB and followed as described.

Confirmability

I applied another qualitative researcher's review of transcripts, coding, and data analysis to ensure confirmability. After reading the transcripts, I held discussions with the peer reviewer about notes taken from the interviews (on interview guides) and notes related to personal biases and perceptions. Other measures included a research log of significant milestones as an audit trail; and reviewing and maintaining all interviews, interview guides, and audio recordings that validated the narratives and documented completion of the participants’ interviews.

Summary

This chapter included findings and results from data collected and analyzed in the interviews. The results presented characterized the participants’ lived prenatal care experiences as first-time mothers in two themes: prenatal care/pregnancy knowledge and provider/participant interactions and one subtheme: effective communication. Also included were discussions of trustworthiness relative to these results and findings. A broader discussion and interpretation of these themes and the limitations and implications of the findings are forthcoming in Chapter 5. Additionally, recommendations for future research and social change efforts will be explored.

Chapter 5: Interpretations, Limitations, Recommendations, and Implications

Introduction

This interpretive phenomenological study explored emerging adults' lived prenatal care experiences as first-time mothers. The nature of this study was interpretive phenomenology to gain greater details and more profound meaning from individual and collective prenatal care experiences. Findings were consistent with the literature review described in Chapter 2. Two major themes emerged concerning the essence of these experiences: prenatal care and pregnancy knowledge and provider-participant interactions with a corresponding subtheme of effective communication. Findings revealed the essence of the lived prenatal care experiences and that emerging adults as first-time mothers prefer to interact with respectful, supportive, and caring providers in settings void of discriminatory behaviors. A mutually respectful exchange of information is essential for effective communication for this group. When these conditions are absent, emerging adults rely on their self-knowledge and support networks to understand pregnancy and the prenatal care process even under unusual circumstances.

Interpretation of the Findings

Findings from this interpretive phenomenological study confirmed that members of this population present to prenatal care systems with unique needs, challenges, and concerns that affect their prenatal care experiences differently than their adult and adolescent peers. This comparison is a subject for future research. The themes from the findings set the context for understanding and discussing these experiences and how they relate to previous literature.

Prenatal Care/Pregnancy Knowledge

Emerging adults between 18 and 22 years of age may enter prenatal care settings with minimal knowledge of prenatal care and pregnancy. They look to expand that knowledge based on information that they currently have and through interactions and communications with their providers and support networks as they navigate their prenatal care (Ayyala et al., 2020). These findings support the importance of continued health literacy and education in prenatal care systems for these mothers. Ingram et al. (2020) found that African American mothers aged 18 to 21 possessed less knowledge of prenatal care information than their White and Hispanic counterparts and called for further education. These results align with the sample size of this study. The research also found that expectant mothers engage in their healthcare with relatively low or mixed health literacy levels and rely on their providers to fill in the gaps (Nawabi et al., 2021; Solhi et al., 2019; Taheri et al., 2020; Yee et al., 2021; Zibellini et al., 2021). Guler et al. (2021) discovered that two thirds of the participants in their study had low health literacy levels, which coincided with low prenatal care knowledge. Hence, prenatal care knowledge may be limited among emerging adults as first-time mothers.

Provider/Participant Interactions and Subtheme: Communication

Consistent with current literature, emerging adults seek mutually respectful, attentive, and caring interactions with providers. These interactions are predicated on a couple of factors. It is necessary for providers to accept and acknowledge emerging adults as active participants and partners in the prenatal care experience. Jensen et al. (2018) found that in this population’s search for independence, control, and autonomy, members decide what their interactions will look like and what information they will share. During patient/provider interactions, effective communication should be unambiguous and nonjudgmental, and mothers should be treated as active decision makers to enhance prenatal care experiences (Decker et al., 2021). African Americans as a marginalized group, may find that their concerns and input are minimized and most often face structural racism, according to Bishop-Royse et al. (2021). However**,** Van Liew et al. (2018) found that the quality of relationships and communication about health should be based on the patient's characteristics to contribute to positive health outcomes and patient satisfaction. Nevertheless, emerging adults contribute to provider/patient interactions and communication failures or successes (Pusch et al. 2019).

Cheng et al. (2020) concluded that to provide services to expectant mothers, providers need to create environments where emerging adults can ask questions, express concerns, contribute to decision making, take active roles, and not be viewed as problematic. Historically, precedence for prenatal care and interactions was directed toward providers, according to Howard (2020). However, contemporary directives align with providers and patients partnering in prenatal care, as they both bring their expertise to the relationship and create environments for active participation (Howard, 2020). For example, the CDC (2021) has designed the HEAR Her Campaign which encourages mothers to take more active roles in pregnancy. The campaign aims to encourage and empower women and their support networks to dialogue with providers during their care.

Despite their levels of prenatal care and pregnancy knowledge and communication efforts, emerging adults foster expectations for their care that evolve as they move through the system. They expect quality care for themselves and their unborn children that leads to positive birth outcomes. However, these mothers can bring unrealistic expectations to the prenatal care experience that must be discussed and resolved in their encounters with providers. For example, if a mother requests care from a single doctor, it may be possible in one situation. However, it could be a false expectation in the presence of extenuating medical, social, or environmental issues such as the COVID-19 pandemic, which caused unanticipated changes (CDC, 2020b; Jakab et al., 2020) in prenatal care systems. When mothers' expectations are not realized, the quality of their prenatal care experiences can be disappointing or dissatisfying. Still, these disappointing moments become opportunities to further clarify concerns as well as educate and inform first-time mothers about the prenatal care process or pregnancy.

Conceptual Framework

Critical Race Theory

In further discussions of these interactions, other factors are considered. Racial issues are part of societies that require addressing when necessary. CRT is a reminder that racism is deeply entrenched in systems (Crenshaw, 2017), where even prenatal care systems are not excluded. In contrast, Hicken et al. (2018) noted that perceived racial encounters are not always indictive of systems but can be reflections of individuals with prejudices and biases within the system. As mentioned in the literature review, emerging adults' prenatal care experiences included facing racial encounters with providers who demonstrated insensitive practices and behaviors, particularly for women of color (Ayers et al., 2018). Ingram et al. (2020) found that 18 to 21-year-old African American mothers are more likely to be less educated and face structural racism and inequalities than their White and Hispanic peers. When pressure, discrimination, and bias present in providers' behaviors in prenatal care settings, they are more likely experienced by women of color and result in negative prenatal care experiences (Dillion et al., 2020). Dillon et al (2020) reported that discrimination against African American and Hispanic mothers between 14 and 21 years of age existed within prenatal systems. They subsequently reported negative experiences if they perceived any forms of discrimination based on age, race, or their physical characteristics.

As Daumeyer et al. (2019) noted in their study, implicit and explicit biases may occur. They found that the explicit biases of people of authority such as doctors and policemen were addressed more than their implicit biases. In this study, comments made by a provider were viewed by a participant as racist, negatively impacting her prenatal care experience. In contrast, most participants in this study who raised concerns about their pregnancies were met with skepticism and doubt from their providers. Either way, emerging adults as first-time mothers may experience racism, prejudice, and discrimination in various ways during prenatal care.

Feminist Theory

Being active participants and exercising agency in their lived prenatal care experiences can be complicated for emerging adults as first-time mothers. Their lack of experience and knowledge calls into question their abilities to interact and participate in decision-making in an institution that prides itself on its knowledge, expertise, and professionalism. A propensity to engage in high-risk behaviors, particularly with marginalized groups (Sandoval et al., 2021), further alienates the validity of decision making. Their rights are compromised in cases where conflict exists between them and providers, which jeopardizes their autonomy, freedom of choice, and agency (Jenkinson et al., 2017, Mick, 2019). However, safety and medical necessity should take precedence.

Although current trends reflect that 59% of obstetricians are women, in contrast to 7% in the 1970s, along with 82% female enrollment in residency programs and declining numbers of males entering and maintaining positions in the obstetrical field (Kaiser Health News, 2018; Karlamangla, 2018), men still hold major positions of power in obstetric organizations (Kaiser Health News, 2018). These positions of power have greater influence on the prenatal care industry than the doctors who work in it. Even with women taking the lead in obstetrical care, these trends may not make up for racial, gender, and ethnic inequalities and disparities that emerging adults as first-time mothers face in prenatal care systems.

Added to this situation, emerging adults as first-time mothers may face pregnancy and prenatal care experiences with little to no support from family, partners, or fathers. In this study, only one participant expressed gratitude for the help that she received from other women in her family. However, it is not uncommon for fathers or partners to be involved in pregnancies and prenatal care experiences. Information sharing and involvement of fathers and social networks for pregnant mothers, particularly those who are urban and have low socioeconomic status, are essential (Yogman et al., 2018).

Deibel et al. (2019) found that fathers wanted to be involved in prenatal care and found the experience rewarding. However, they suggested that more research is needed to discover how fathers’ involvement take place. In their study, Hawkins et al. (2021) realized that family support and involvement in prenatal care increased African American mothers’ mental and emotional health and became a protective factor during their experiences. Ayyala et al. (2020) and Wessberg et al. (2017) found comparable results supporting family and social support during prenatal care. When this support is absent or lacking, group prenatal care models help supplement social supports for expectant mothers (Chae et al., 2017; Mazzoni & Carter, 2017). Mazul et al. (2017) suggested that African American mothers underutilize prenatal care services more than White mothers. However, finding appropriate models of care, advocating for positive patient-provider relationships, and encouraging social support during prenatal care will address the underuse of services. Without family, partners, and social support networks, these experiences can be exacerbated. Consequently, added support for emerging adults as first-time mothers is helpful and necessary, representing an area for future research.

Communication Theory

In this study, the way that emerging adults as first-time mothers desired to communicate with their providers was consistent with Shannon and Weaver's communication model as it depicted the process toward meaningful dialogue as noted in the literature review in Chapter 2 (Shannon & Weaver, 1963). The model suggested that communication is a two-way process in which individuals bring their whole selves when talking, listening, and responding to each other, a combination for effective communication. In an unfamiliar prenatal care system, first-time mothers benefit from effective messaging and communication that build bonds and connections in their prenatal care experiences. Providers taking time to explain, educate, inform, and listen to emerging adult mothers translates into showing care and support. Correspondingly, emerging adults' as first-time mothers have to become an active part of the communication process by listening and being willing to ask questions, overcome inabilities to express themselves, and receive feedback in constructive ways. The process is not one-way. Chang et al. (2018) realized that more studies are needed to determine modes of effective communication in maternity care. Atkinson and McNamara (2017) found that communication was compromised when providers and patients had poor communication skills and avoided talking to one another. Similarly, how providers communicate determines levels of participation from expectant mothers (Varga et al., 2021). Therefore, emerging adults as first-time mothers and their providers must share in the responsibility to ensure that effective communication occurs during prenatal care experiences.

Intersectionality Theory

Emerging adults as first-time mothers who are still formulating their developmental, cultural, social, educational, and career identities, along with relationships and their places in the world interface with prenatal care system with the hope of fair treatment (Cherry, 2019; Greene, 2017, Syed & McLean, 2018). When confronted with encounters that they perceive to be oppressive, discriminatory, or prejudiced, they, at minimum, push to be heard, recognized, and have their issues considered. However, at the intersection of their age, race, gender, socioeconomic and educational status and other social health determinants, the impact on their prenatal care experiences is further compounded.

In prenatal care systems where an imbalance of power dominates, these mothers are at a disadvantage. They meet providers who are slow to acknowledge their roles in their prenatal care. Profiles exist that determine providers' mistreatment of disadvantaged expectant women because of their lower education and socioeconomic status and race (Vedam et al., 2019). Mistreatment can included verbal insults, dismissive behaviors, and in extreme cases threats (Vedam et al., 2019). Contrastingly, the profile of expectant mothers who are less likely to receive these forms of discriminatory mistreatment includes Caucasians, multiparous mothers, and mothers over the age of 30 (Vedam et al., 2019).

Profiles even exist about expectant mothers who enter prenatal care which includes mothers having less than a high school education, single, and young. Blakeney et al., 2019). Combs et al. (2018) found that 18- to 22-year-old pregnant mothers were at risk for early pregnancies, had more challenges, and were more likely to be unemployed with low education which was similar to the demographic profile of participants in this study. This mindset is notable for providers who engage this population. First-time expectant mothers are not aware of these profiles and bring different expectations to their prenatal care experiences. However, what happens during their prenatal care and what they expect are often different, particularly for mothers of color (McLeish et al., 2020; McLeish et al., 2021). Consequently, profiling and false expectations further shape their prenatal care experiences.

On a positive note, McLeish et al. (2021) noted that first-time pregnancies were challenging no matter the differences in socio-demographic backgrounds. However, the researchers noted that when providers interacted with mothers attentively, caring, emotionally supportive, and with self-confidence, the mothers’ coping skills increased. In this context, the mothers learned new health behaviors and gained opportunities to reframe their prenatal care experiences. Even with the challenges in prenatal care settings, first-time mothers may thrive in supportive environments that help create meaningfully lived prenatal care experiences.

At the intersection of age, race, gender, class, sexual orientation, and socio-economic and educational status, dynamics change and tensions occur in prenatal care experiences. Both providers and emerging adults as first-time mothers bring stereotypical, biased, and preconceived ideas that become problematic in their encounters. No person escapes their biases and prejudices. Providers who make little to no eye contact, rushes through appointments, disengage in discussions, are unreceptive, gives medical instructions and recommendations without input, neglect to listen or explain, and makes assumptions based on stereotypes and misunderstandings are part of the prenatal care system (Ayers et al., 2018; Coley et al., 2018; Jinga et al., 2019; Van Liew et al., 2018; Wright et al., 2018). These factors can determine the quality of the interactions and communication between providers and emerging adults.

Conversely, emerging adults as first-time mothers add to this tension. They bring an awareness of historical medical trauma, real or imagined, that informs their interactions in medical settings. Conflict continues as they attempt to interject being experts of their bodies while providers defend their positions as medical experts. This tension may arise when mothers ask questions, provide input, or question their providers' behaviors or information. In this study, an example of this type of tension occurred when participants voiced health and pregnancy concerns to their providers but felt their issues were ignored or minimalized. Such interactions may become offensive to the medical experts who provide prenatal care services.

Barton et al. (2018) noted that having a voice in any setting is significant, particularly for African Americans. However, to minimize these tensions, Figueroa et al. (2021) found that digital health implemented during the COVID 19 pandemic, such as telemedicine, access to portals, and medical apps, aided in patient-provider interactions and communication. Similarly, Ayyala et al. (2020) noted a positive impact of technology when used during prenatal care. These tools lowered perceived negative observations in face-to-face encounters and were successful for females engaging in health care systems. While these tensions may continue, the essence of the emerging adults' prenatal care experiences, as shown in this study, reflected their desires to affect positive encounters while navigating the prenatal care system.

While socioeconomic status and poverty play significant roles in aggravating tensions between providers and their patients, it is the providers' responsibility to promote these positive interactions regardless of any biases, prejudices, or racial interests they may possess (Manchikanti et al., 2017). The Affordable Care Act of 2010, or Obamacare, federal legislation that offered health insurance coverage for qualified prenatal care to women who would otherwise be unable to afford care, initiated accountability measures for providers (Adams et al., 2019; Manchikanti et al., 2017). Thus, providers are incentivized or de-incentivize to maintain high prenatal care standards and outcomes. Providers have a great deal at stake to ensure prenatal care interactions lead to quality care.

In contrast, there are no standard restrictions placed on expectant mothers to ensure they participate in alleviating tensions in their interactions with providers. Although they, too, bring biases to the encounters. In this study, when participants talked positively or negatively about their interactions with providers, they focused on the providers' behaviors. They reported their most significant responsibility was to show up for the prenatal visits and follow providers' instructions. Penalties for their non-compliant behaviors are non-existent since expectant mothers cannot be denied care (Valji et al., 2018). However, providers must maintain standards of care even though they cannot control women's health behaviors who seek prenatal care (Washio et al., 2021). This discrepancy may account for providers refusing to relinquish or share medical control with patients, a stance that crosses socioeconomic lines.

Limitations of the Study

This study documented the experiences of emerging adults who took part in prenatal care. It excluded emerging adults who did not engage in prenatal care and providers from the narrative. Second, the sample size was small and limited to the greater Chicago area and not a representative sample of emerging adults in the larger Cook and Suburban Cook counties of Illinois or across the country as intended. The sample size was biased toward single African American mothers with low incomes. Additionally, the study was conducted during the COVID 19 pandemic, a phenomenon uncommon to prenatal care experiences. Therefore, the findings may have been different in a pre-COVID prenatal care environment. This information is valuable in understanding the experiences of similar populations who experience intersectional marginalization. Nonetheless, caution is necessary in transferring these results to the broader population of emerging adult prenatal care experiences. Future research should explore how class, relationship status, and geographical location influence these experiences.

Recommendations

Due to the makeup of the sample and its size, there are various recommendations for future research. These findings contributed to further understanding emerging adults' lived prenatal care experiences. Further research is needed to gain a fuller understanding of these experiences. Considering providers were not involved in this study, their absence creates an opportunity for future researchers to include provider perspectives on the emerging adults' prenatal care and pregnancy knowledge and how providers interact and communicate with the emerging adults. Unless providers are involved, the study's conclusions are biased toward emerging adults.

Another recommendation is to compare first-time mothers aged 18 to 22 to older emerging adults, 23 to 30 years of age, with different socio-demographic profiles. This comparison will offer a broader understanding of their prenatal care experiences. Additionally, researchers can investigate the experiences of mothers who were excluded from the study, such as first-time mothers who did not use prenatal care or those who experienced a loss during the prenatal care experience. This future examination can broaden and deepen insights into the phenomenon. A comparison of emerging adults across geographically diverse areas is research worthy of determining if and how location affects the essence of their lived experiences. Finally, continued research is crucial to ensure prenatal care systems can create environments where mothers are treated fairly, justly, and equally regardless of race, gender, ethnicity, culture, age, education, or marital status.

Implications

Practice Implications

This research is influential to the field of social work in numerous ways. It adds to the body of rigorous research efforts conducted by social workers that increases credibility in the profession. Specifically, the study offers insights into the prenatal care experiences of emerging adults as a unique subpopulation of first-time expectant mothers.

Additionally, it provides social workers with an understanding of factors that influence and shape the emerging adults' prenatal care experiences and how those experiences might appear. Hence, social workers who are more knowledgeable about this phenomenon can be more effective advocates as they assist emerging adults through their prenatal care experiences as first-time mothers.

Policy Implications

To address practices and behaviors that might appear biased, prejudiced, or discriminatory, administrators and leaders in prenatal care systems can refine and implement policies that offer alternative models of prenatal care that meet the needs of women who engage these services. Currently, providers follow standards and guidelines when delivering prenatal care as outlined by the ACOG (n.d.). However, comparable universal standards that ensure prenatal care environments address the unique needs, attributes, and culture of pregnant women across the spectrum of prenatal care or for emerging adults as first-time mothers, are challenging to find. Therefore, policies are needed that ensure these alternatives are available, viable, and accessible to provide mothers with choices that best fit their needs rather than limit them to traditional practices in prenatal care.

As mentioned in the literature review, there are existing models of prenatal care that consider individual needs in a more holistic context. These models have been proven effective for disadvantaged mothers and women of color. Models of care can incorporate an educational component that informs and increases expectant mothers' knowledge about their pregnancy and prenatal care. Another factor to consider is the development of socio-emotional skills that empower and encourage mothers to interact with providers and staff in respectful and meaningful ways. Learning to communicate and express their needs and concerns to providers is vital while navigating the prenatal care system. Relevant screenings and assessments that reveal risks and problems unique to these mothers, otherwise unnoticed and lost in larger prenatal care systems, can help. Last, prenatal care systems can continue implementing components that address social factors that become barriers to accessing and maintaining proper prenatal care while offering support and resources to fill the gaps.

Suggested models of care include supportive prenatal care programs, centering pregnancy model (Rising, 1998), feminist pragmatic model (Gillberg & Jones 2018, 2019), and midwives' model of prenatal care (Eric et al., 2020; Sandall et al., 2016; Wernham et al., 2016; Wright et al., 2018). Even as these models exist, no current policies enforce these options in the traditional prenatal care system. This gap in knowledge can be a topic for future research. No one model of prenatal care fits everyone.

Social Change Implications

Findings from this study can help raise the awareness of prenatal care providers about the unique needs and characteristics of emerging adults as first-time mothers. This awareness may better equip providers to build supportive and nurturing environments and recognize this population's strengths and challenges during the prenatal care experience. These findings can inspire continued conversations to ensure these women are informed, understand their pregnancy and the prenatal care process, and empower these mothers to engage in meaningful dialogue and discussions as active participants in their care. Most importantly, the results of this research provide social workers with knowledge and understanding to advocate for emerging adults as first-time mothers. As a social change agent, I aim to communicate my research findings to prenatal care providers, leaders of maternal health organizations, and other stakeholders through various methods.

Conclusion

This interpretive phenomenological study explored the lived prenatal care experiences of emerging adults as first-time mothers. Based on the findings, two major themes and one subtheme set the context for describing this phenomenon, leading to a core description of the experience. The results were consistent with a review of the literature and the conceptual framework presented in Chapter 2. In addition, I included a discussion of the study's limitations, recommendations for future research, and suggested practice and policy implications.

The institution of prenatal care has been around since the 1900s. It has made astounding advancements since it evolved from the art of midwifery. Nonetheless, it is not a perfect system and will require more effort to help it remain a premier standard of care. Hence the need for researchers to continue scrutinizing prenatal care processes and systems. This study has added to this examination with a small group to understand better how the prenatal care institution can continue to evolve in serving the needs of emerging adults as first-time mothers and women seeking prenatal care support. The prenatal care system can benefit by responding to the diversity and the diverse needs of mothers in their care. No one prenatal care idea fits all.

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Appendix: Interview Guide

Date:
Time:
Participant ID Code:
Location of Interview/Setting:

Parts of the Interview	**Interview Questions**
Introduction (10)	Introduce myself Ask participant how they are and what race/ethnicity they identify with. How did you hear about this study? **Research Question:** What are emerging adults' lived prenatal care experiences as first-time expectant mothers? • Purpose of this research • Participation is voluntary; terminate at will • Use interviews to collect information about your prenatal care experiences • Duration of the interview • Let me know if you feel uncomfortable • Information is confidential • Share information with my dissertation chair and one peer • One-time $20 gift card as a token of thanks after the interview is completed

	• Interview will be audio recorded and will be transcribed to help me remember and capture all you say, correctly • Analysis and reporting of the information as a part of my dissertation • Request permission to conduct any follow-up contacts for clarification of data or member checking • Request copies or how to access results of the study • Need for debriefing • Do you have questions? • Do I have your permission to start? **Demographic Information:** • What is your age? • What race/ethnicity do you identify with? • What gender do you identify with? • What is your marital status? • What is your highest educational level? • What is your current income level? • What is your current employment status? • What is your sexual orientation?

Parts of the Interview	**Interview Questions**
Question #1	**Primary question(s):** What do you think prenatal care is? Once answered in their own words, define prenatal care for all participants as the period of medical care from pregnancy confirmation until the birth of babies.

Parts of the Interview	Interview Questions
Question #2	Tell me about your prenatal care experiences. **Follow up question(s)**: • Tell me about the place where you received care. • Did you attend all scheduled visits? • If you missed, why? • Did you follow your doctor(s) advice? If no, why? If yes, why?

Parts of the Interview	Interview Questions
Question #3	**Primary Question(s):** What were your prenatal care visits like? **Follow up question(s):** • Describe a typical prenatal care visit. • Describe your most positive prenatal care visit experience. • Describe your most negative prenatal care visit experience.

Parts of the Interview	Interview Questions
Question #4	**Primary question(s):** What was it like talking about or discussing concerns with your primary medical provider? **Follow up question(s):** • How did they respond? **Primary question(s):** What was it like talking about or discussing concerns with the medical staff? **Follow up question(s):** • How did the medical staff respond?

Parts of the Interview	Interview Question
Question #5	**Primary question(s):** • How did your prenatal care fulfill your expectations for seeking care? I want to make sure that I understand your prenatal care experiences. Is there anything else I should know to understand your experiences? Are there any other questions that I should be asking all participants to understand their prenatal care experiences?

Parts of the Interview	Interview Questions
Closing (5)	I appreciate the time you have taken to complete this interview. I will summarize the interview. • Additional questions for me • Additional information to share • Information is confidential • Share information with my dissertation chair and one peer • Interview audio recorded and will be transcribed to help me remember and capture all you say, correctly • All data will be destroyed • Analysis and reporting of the information as a part of my dissertation • Need for debriefing • Review the kind of people I need for this study. Do you know of anyone who would fit these criteria? • I may need to contact you for additional information or clear up things on the transcript. Is it okay to contact you by phone, email, or video conference? (Get details) I thank you again and here is your $20 gift card. For participants not able to meet in-

	person, they will be notified their gift cards will be mailed via postal services.