HEALTH AND WELLNESS OF THE POSTPARTUM WOMAN BASED ON CULTURAL AND PERSONAL PERCEPTIONS OF MEDIATED REPRESENTATIONS OF PREGNANCY

by

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A DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Communication and Information Sciences in the Graduate School of The University of Alabama

TUSCALOOSA, ALABAMA

2014
ABSTRACT

More than 80 percent of women in the United States will become pregnant and give birth
to one or more children and many will experience pregnancy complications that can inhibit
postpartum success. Research suggests that proper maternal care should be given prior to, during
and after pregnancy. In order to assist in the reduction of maternal risks, identify problem areas
in the health and wellness of postpartum women and train healthcare professionals to provide
proper assistance and postpartum advice, there must first be an understanding of the needs of a
postpartum woman. And, in order to effectively provide care for these postpartum women,
knowledge must be gained regarding expectations of the postpartum period.

A large problem with postpartum health and wellness lies in the educational focus during
pregnancy. Because the media has been suggested to play a substantial role in the development
of individual and cultural perceptions and expectations, this study examined health beliefs and
expectations as they are fostered through mediated representations of pregnancy and the
postpartum period. By assessing the opinions and expectations of 343 postpartum women, this
study details ways in which the media, and other factors, influence the health and wellness of
postpartum women. Significant findings from this study suggest that personal health beliefs (p =
.000), body image (p = .028), mediated representations of pregnancy (p = .039) and pregnancy
related education (p = .002) are related to the health and wellness of postpartum women.

This study suggests that being knowledgeable of the realities of the postpartum period
can positively impact the success of the postpartum period; thus, confirming the necessity of not
only postpartum education, but also improvement in postpartum care. A better understanding of
the false expectations influencing success in the postpartum period will allow the opportunity to
provide better postpartum care as women prepare for the realities of the postpartum period and
the transition to motherhood. Better care will provide a greater chance of increasing the health
and wellness of postpartum women as they prepare for positive behavior changes necessary to
achieve success in the postpartum period.
DEDICATION

This dissertation is dedicated to my husband, Erik, who encourages me to be the best version of myself; and to my sweet baby girl, Eleanor, who ALWAYS keeps me moving!
LIST OF ABBREVIATIONS AND SYMBOLS

α  Cronbach’s index of internal consistency
β  Standardized coefficient: assessment of independent variable on dependent variable
F  Fisher’s F ratio: A ratio of two variances
M  Arithmetic mean
N  Sample size
SD  Standard deviation
r  Pearson product-moment correlation
R2  Coefficient of determination
p  Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value
t  Computed value of t test
<  Less than
>  Greater than
=  Equal to
%  Percent
ACKNOWLEDGEMENTS

First and foremost I would like to thank the Lord for blessing me with the opportunity to attend graduate school and even write this dissertation. He has truly worked out the details for me every step of the way.

I would like to thank my husband, Erik, for encouraging me and being my biggest cheerleader as I have decided to go back to school – twice – since being married. I could not have done this without you and I appreciate all of the late night coffee runs more than you will ever know.

To my parents, Rick and Susie Rush, who have always supported, sacrificed, and loved me unconditionally. I could not have done this without all of your help and prayers. I read a quote recently that said, “Your children will become who you are, so be who you want them to be.” That perfectly sums you up! You have encouraged all of us to chase after our goals, to make education a priority and to finish what we start. I have been able to use every one of those lessons throughout this program. To my brothers and sisters (Sarah, Richard, Stephen, Rebekah and Seth), thank you for not only your encouragement, but also the time that you have given to help me in so many ways while I worked through this program. Having a baby just before my second year created a huge need for babysitters, as well as comic relief, and you guys came to the rescue.
I truly couldn’t have completed this dissertation, yet alone the doctoral program, if it weren’t for a few key individuals. First, I must acknowledge Dr. Kim Bissell, my dissertation chair, advisor, and friend. I could not have done this without her help. Dr. Bissell, your attention to detail, encouragement and professional guidance have enabled me to have success. I have been so fortunate to have been able to work with and learn from you. Secondly, I would like to thank Ms. Diane Shaddix. Diane, you have made possible all of the steps associated with this program. You have given me great advice, encouragement and made sure that I don’t miss any deadlines or forms in order to achieve this goal. I appreciate your kindness more than you will ever know. I would also like to thank Dr. Phelps for not only encouraging me to enroll in this graduate program, but for giving me the opportunity to teach courses in the APR department and gain invaluable experience in the classroom. It was this experience that prepared me for the job market and the next step in my professional career.

I would also like to thank my committee, Dr. Billings, Dr. Gower, Dr. Wright and Dr. Leeper. It has been such a pleasure and honor to work with each of you in my journey through this graduate program. Thank you Dr. Billings for helping me with my first publication! Thank you Dr. Gower for your support (and letters of recommendation) from undergrad through the Ph.D. program. Thank you Dr. Wright for your professional advice and encouragement – it has been a blessing to work with you both professionally and academically. And, thank you Dr. Leeper for agreeing to take on this dissertation when you already have so many on your plate! Your knowledge of this topic (and professional references) has been instrumental in my being able to bring everything together.

Thank you to my sweet baby, Eleanor. You don’t even know it yet, but you have been to classes, meetings and countless hours of writing sessions. And, you have pushed me to be better
all along the way – I love spending my time with you and can honestly say that you make getting this degree so much sweeter!

And, lastly to Mom: if I could share this degree with anyone, it would be you. You are not only the best teacher; you are also the best encourager. Giving up your mornings to take care of our girl has allowed me the freedom to work, meet, clean, grocery shop, regain my composure, collect my thoughts and find some sanity. I truly could not have done this without you!

So excited to be here!
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CHAPTER ONE

INTRODUCTION

More than 80 percent of women in the United States will become pregnant and give birth to one or more children (CDC, 2010) and from that 80 percent that give birth, at least 31 percent of these women are reported to experience pregnancy complications, ranging from depression to the need for a cesarean delivery (CDC, 2006). The CDC (2010) also estimates that roughly 1 in 10 women are depressed during pregnancy or within the first year after delivery. Because depression is only one of the illnesses that can inhibit a postpartum woman’s ability to perform daily activities, bond with her infant, and relate to her family, research suggests that proper maternal care should be given prior to, during and after pregnancy (Northrup, 2010). However, in order for medical staff and caregivers to provide proper assistance and postpartum advice, they must first have an understanding of the needs of a postpartum woman (Logsdon, Wisner, & Pinto-Foltz, 2006).

Research regarding postpartum health and wellness will not only assist in the reduction of maternal risks, but also provide researchers and educators the potential to identify problems areas in the health and wellness of postpartum women. Current research regarding maternal health and wellness includes work in the separate areas of body image (Jordan, Capdevila, & Johnson, 2005; Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009; Downs, DiNallo, & Kirner, 2008; Loth, Bauer, Wall, Berge, & Neumark-Sztainer, 2011), media (Gow, Lydecker, Lamanna, & Mazzeo, 2012; Dworkin, & Wachs, 2004; Breese, 2010), health beliefs (CDC, 2010; Healthy People, 2020; Hoffnung, 1989; Northrup, 2010), mental health (Logsdon, Wisner,
& Pinto-Foltz, 2006; Downs, DiNallo, & Kirner, 2008; Misri, 2006; Vinamaki et al., 1997; Vennemann et al., 2009), socioeconomic status (Goyal, Gay, & Lee, 2010; Sword & Watt, 2005) and educational interventions (Fineberg, 2013). While there is a vast amount of research available regarding pregnancy, there is very limited U.S. based pregnancy and postpartum research stemming from the discipline of communication. In fact, the field of communications does not present any current literature from a health perspective that encompasses a myriad of postnatal factors; nor does it offer research examining the relationship between mass media portrayals and personal and cultural pregnancy-related perceptions and expectations. It is important that knowledge be gained in the U.S. regarding pregnancy expectations and perceptions in order for researchers to better understand the needs of postpartum women in support of their health and wellness.

With regard to perceptions of reality, research related to the spiral of silence theory suggests that there are dominant perceptions of reality or assessments of an individual’s social environment that may not be accurate with reality due to a fear of unconformity with the majority opinion (Scheufele, 2007). As individuals perceive specifics of their social reality, they are less likely to speak out against accepted norms and the opinion of the perceived majority becomes accepted as reality (Noelle-Neumann, 1993); therefore, looking at perceptions of reality for postpartum women, and addressing these knowledge gaps, will also report opportunities for curriculum development as women learn to differentiate the perceived (and expected) from the realistic, in preparation for the postpartum period.

“Quality care and education during pregnancy, can prevent an untold number of costly problems” (Northrup, 2010, p.446).
A large problem with postpartum health and wellness lies in the educational focus during pregnancy. Many midwives find that they encounter great opposition when discussing postpartum expectations during pregnancy because expectant mothers are generally concerned about the birth; yet, postpartum women have previously reported feeling under-educated and under-prepared for post-birth experiences (Green, Coupland, & Kitzinger, 1990). Whether related to the expectations surrounding the healing process, weight gain and management, breastfeeding or understanding of a new familial role, proper education could help them prepare for their needs and experiences during the postpartum period. The lack of postpartum educational information coupled with the possibility of extreme situations as related to new physical, mental and emotional experiences of postpartum women, creates a great need for more postpartum knowledge and strong support systems (Robertson, Grace, Wallington, & Stewart, 2004; Feldman et al., 2009).

Because the media has been suggested to play a substantial role in the cultivation of individual and cultural perceptions and expectations (Gerbner, Gross, Morgan, & Signorielli, 1986; Segrin, & Nabi, 2002; Morgan, & Shanahan, 2010), the goal of this study was to examine pregnancy and postpartum health beliefs and expectations as constructed through mediated representations of pregnancy. By assessing the opinions of postpartum women regarding pregnancy-related perceptions and expectations – as influenced by meditated examples of pregnancy – this research sought to suggest ways in which media influences the health and wellness of pregnant and postpartum women. As a new, and necessary, contribution to the literature, postpartum women (0-15 months after giving birth) will have the opportunity to detail their perceptions regarding mediated representations of pregnancy and to explain what affects
these “pregnancy ideals” had on their personal pregnancy expectations and on the expectations they feel from others regarding their pregnancy.

This research contributes to knowledge in the field through its extensive nature, element of mediated influence and qualitative component. An appraisal of pregnancy-related perceptions (both personal and cultural) as influenced by mass media messages allowed this research to reveal the influence of outside factors on postpartum success. A better understanding of the postpartum woman’s needs and expectations beginning after the delivery of her baby allowed this research to recommend educational opportunities for maternal care and the health and wellness of postpartum women. Providing researchers and educators with needs specific to health and wellness in the postpartum period will assist this research in defining best practices for success in the postpartum period (ie: motivating change in health and wellness behaviors) as women move from the perceived to the realistic.

Most mothers report a desire to be the best they can be for their new baby; however, there are external factors that stand in the way of positive changes in health behaviors (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009; Goyal, Gay, & Lee, 2010). Confirmed by the research in this study, these external factors include (but are not limited to) new stressors related to birthing and caring for an infant, lack of personal time, lack of motivation or familial encouragement, knowledge of best practices and available finances. With these factors in mind, this research suggests relationships among the role of health beliefs, personal and cultural perceptions of pregnancy and the postpartum period, as well as mass media’s influence on pregnancy and the postpartum period. A review of the above listed factors with the addition of a qualitative component (covered in one research study) will expose further catalysts for change in the health and wellness decision making of postpartum women.
The following literature review traces a trajectory through the areas of: defining health and wellness, belief and culture, culture in America, cultural expectations for health in America, maternal health in America, female, mental and emotional health, body image, media’s role in body image, pregnancy and expectations, predictors of postpartum wellness and self-perception, education and wellness interventions. The presentations of current literature as well as the results of this study are reviewed through the theoretical framework of the health belief model and social comparison theory. These theories are used to suggest media effects on current perceptions of pregnancy and the postpartum period and to recommend the impact that health behavior intervention opportunities can have for postpartum women.

When operationalizing theoretical constructs and definitions, health researchers, educators and professionals should “develop an understanding of an individual or group’s characteristics (ethnicity, socioeconomic status, gender, age, geographical location) and then refine those constructs into variables” (Resnicow, Braithwaite, Dilorio, & Glanz, p. 485, 2002). In order to have an effect on, or change, behavior, the promotion designer must understand the culture and social environment of the population. Being aware of the problems, resources and opinions of the population will allow the educators, researchers and professionals a greater chance of accomplishing goals and increasing behavior change. Thus, for the purposes of this research, the definitions of postpartum and health and wellness are as follows:

- Postpartum – referring to a woman who has just given birth, immediately after the birth through 15 months.

- Health and wellness – referring to the complete physical, mental and emotional health
CHAPTER TWO

REVIEW OF LITERATURE

Beginning with an overarching concept of health and wellness and tracing the trajectory specific to pregnancy-related research; chapter two will present a review of literature in the following areas: Defining health and wellness, belief and culture, culture in America, cultural expectations for health in America, maternal health in America, female mental and emotional health, body image, media and body image, pregnancy and body image, predictors of postpartum wellness and self-perception (self-esteem, nutrition, exercise, SES, internet usage) and educational wellness interventions.

Defining health and wellness

Research shows that there is not one definition of health or wellness in the United States because health and wellness are found to be fluid, affected by cultural and personal factors. However, in 1948, the World Health Organization (WHO) declared that health was the, “state of complete mental, physical and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1948). The definition, as according to the WHO has not been amended since its adoption in 1948 and is used as a seminal point of reference for most all health and wellness definitions.

Since that time, other organizations, as well as individuals, have described health and wellness in different ways. Carter and Wilson (1982) define health as a condition resulting from an interaction between heredity environment and lifestyle. Hales (1994) suggested that health is
the process of discovering, using, and protecting the resources within our bodies, minds, spirits, families, communities, and environment. More recently, Zautra, Hall and Murray (2010) defined health as “Resilience”, suggesting that by age 65 most Americans will hold significant risk for illness; however, those who live to see 65 are expected to live another 20 years.

The term wellness has also been defined in different ways and applied to different applications of individual necessity. While there are different views on what wellness means or includes, the National Wellness Institute, founded in 1977, suggests through general industry agreement that wellness is “positive, affirming and is a conscious, self-directed multidimensional, holistic and evolving lifestyle process of achieving full potential with regards to mental, spiritual and environmental well-being” (Hettler, n.d.). Therefore, operationalizing wellness as “an active process through which people become aware of, and make choices toward, a more successful existence” (Hettler, n.d.). An additional definition of wellness given by wellness educator Joanne Cannon suggests that wellness and physical prowess is the ability to meet the demands of the day and have enough extra for one emergency (Northrup, 2010).

Bringing together the definitions of national health and wellness, there are a few measuring agencies that help to define health goals, benchmark current health positions and measure future health aims. The Department of Health and Human Service's Healthy People (2020) functions as a key research and information foundation for healthcare professionals and educators in the field of health and wellness. Serving as a comprehensive set of national health objectives developed with the goal of measuring the nation’s progress related to health and health-related behaviors, Healthy People provides a format for not only preventing disease and illness, but also promoting health and a more positive quality of life for all members of society. This collection of research and data provides a national framework for reaching underserved
populations and at-risk populations with significant threats to health (U.S. Department of Health and Human Services, 2012). Healthy People focuses on prevention and improvement of health behaviors and quality of life issues by providing measureable goals.

In 2013, Healthy People (2020) reported that health has different dimensions and determinants, both of which will affect an individual’s health status. Healthy People (2020) suggests that all determining factors of health fall within the following five dimensions: physical, mental, emotional, social and spiritual, and are related to four primary determinants of health status: education, income, race/ethnicity and location. Therefore, it is important for researchers, educators and health care providers to understand the cultural and personal factors (and beliefs) that influence a population or individual’s complete health status. Further knowledge in the area of postpartum health and wellness is imperative for influencing beliefs and inspiring change in health and wellness – specifically with regard to the postpartum woman.

Belief and culture

Belief formation is based in psychology and is said to be a psychological state where individuals learn of a proposition and hold it to be true. Sagie and Elizur (1996) suggest that beliefs represent an individual’s perceptions of reality. Belief, characterized as a propositional attitude, is a mental frame of mind where an individual has an attitude or opinion about a proposition that they believe to be true. Beliefs are traditionally defined as relationships or propositions that individuals hold to be true (Fishbein, 1965); however, these beliefs or propositions have to be accepted by the individual in order to be considered true. Just as an individual can accept a proposition but not believe it to be true, they can also believe a proposition without applying it to lifestyle or habit.
Research has shown that an individual’s beliefs are formed and most strongly determined by those around them in the formative – early – years (O'Neill & Gopnik, 1991). Although cultural values have been suggested as the major player in cultural research, beliefs have been suggested to be more useful in explaining cultural differences with regard to individual behaviors (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Thus, health educators agree that programs and interventions will be more effective when they are appropriate in plan and design with regard to the beliefs of the populations they serve (Champion & Skinner, 2008).

While there does not seem to be one single definition of culture that is universally accepted by social scientists, there is general agreement that culture is learned, shared, and transmitted from one generation to the next. “Culture can be seen in a group’s values, norms, practices, systems of meaning, ways of life, and other social regularities” (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003, p.133). In 1980, Triandis, Lambert, and Berry suggested that elements such as individualism, collectivism, spirituality, familial roles, communication, and beliefs about personal control may help define culture for a given group of people. Some of these elements are further explained below through Hofstede’s dimensions of national culture. Health educators can use these elements along with Healthy People’s (2020) five dimensions of health (physical, mental, emotional, social and spiritual) and four main affecting factors (education, income, race/ethnicity and location) to understand cultural needs and issues as they design health promotional materials.

Literature has long suggested that health researchers and educators should anticipate factors related to acceptance and adoption of health programs and messages (Pasick, D’Onofrio and Otero-Sabogal, 1996). As previously discussed, beliefs have been suggested as a useful tool for explaining cultural differences with regard to individual behaviors. Therefore, it makes sense
that health programs and messages will be more successful when developed with an appropriate understanding of the cultural and personal factors and beliefs that influence a population or individual’s complete health status.

Based on the previously discussed literature, the first two research questions were posed to assist researchers and educators in determining the effects of cultural and personal health beliefs on the health and wellness of postpartum women:

RQ 1: To what extent do cultural health beliefs influence the health and wellness of postpartum women?

RQ 2: To what extent do personal health beliefs influence the health and wellness of postpartum women?

Culture has been suggested as a “given” element throughout the course of an individual’s development because one cannot alter their ethnicity, race or family history, and they must make a conscious and calculated decision to change their country or religion (Becker & Murphy, 2009). Because cultural beliefs and perceptions are said to be embedded within each individual, understanding that the formation of beliefs and perceptions of pregnant and postpartum women in America requires a deeper look into the formation of cultural dimensions and the established values influencing American thought.

Culture in America

In the 1980’s Hofstede discovered five dimensions of national culture that are not only fundamental to the individual culture, but that can also be seen to illustrate different values in different national cultures (Hofstede, 2009). These dimensions can be used to illustrate values which are deeply rooted in individual societies, as well as suggest consequences for individual behavior in a cultural, work-related or personal setting. Hofstede’s five cultural dimensions are:
power distance, uncertainty avoidance, masculinity vs. femininity, individualism vs. collectivism, and long vs. short term orientation. All dimensions are measured on a scale of 100 points.

Power distance is measured in values of low and high, as related to individual cultures. In cultures with low power distance, individuals are expected to feel that power is distributed equally, and are also likely to accept that power is possibly distributed to individuals that are less powerful (Hofstede, 2001). However, the opposite of this low power is a high power distance culture. Individuals in high power distance cultures are likely to expect and recognize that inequality exists.

Uncertainty Avoidance is a measure of a culture’s lack of tolerance for uncertainty. In order to rid anxiety, these cultures will work to minimize doubt with rules and policies (Hofstede, 2009). Individuals living in cultures with a high degree of uncertainty avoidance are likely to feel uncomfortable in uncertain situations. However, individuals living in cultures with a low degree of uncertainty avoidance are much more tolerant of change, and are found to be comfortable in uncertain environments.

Masculinity vs. femininity details a culture’s emphasis on masculine or feminine characteristics. Masculine characteristics are defined as: competitiveness, assertiveness, materialism, ambition and power. Feminine cultures place more value on relationships, quality of life, as well as personal and humanistic goals such as a friendly working climate and cooperation (Hofstede, 2001). These characteristics are used to explain how individuals could be motivated in cultures to obtain societal objectives.

Individualism vs. collectivism helps to suggest the level of connectedness of a culture. In individualistic cultures individuals are found to portray themselves as individuals, be more
concerned with personal achievement, try to accomplish individual goals and meet individual needs (Hofstede, 2001). Individuals in this culture are suggested to show little concern for the common good of the culture. In collectivistic cultures, individuals, or members of society, seem to place greater emphasis on the welfare of the group or culture as a whole whereas individualistic ideals such as individual wants and needs are disregarded for the common good.

Long vs. short term orientation was added after the original four dimensions. Long term orientation is the acceptance of understanding results and the length of time it takes to achieve a goal. Short term orientation refers to the length of time that it takes to reach a goal, but recognizes that the results are set and can be reached within a specific time frame (Hofstede, 2009).

When comparing the culture of the United States to that of other cultures, Hofstead found that, as a society, Americans culturally rated very high (91) in Individualism. As described above, this value of Individualism details the level of independence a society has, and how much they actually depend upon other members of that society. In Individualist societies, individuals are said to care for only themselves and their immediate family. A score of 91/100 on this dimension suggests that Americans are highly individualistic and are internally unconnected. A score high in individualism also suggests that the expectation of society is one that supports individual responsibility for self.

Masculinity ranked just below Individualism in the United States with a score of 62/100. This score is considered high and suggests that the United States has a “masculine” society. Americans are motivated by success, competition and achievement. A low score on the Masculinity dimension suggests a feminine society where the dominant cultural values are relationships and quality of life. With a high score in Masculinity, it is evident that the
motivation of American society is based on wanting to be the best. Americans are seen as people that “live to work” as they are generally willing to work longer and harder than people in many societies in order to attain the status quo (Prescott, 2004).

Under the mid-point, and considered low scores, were the scores of Uncertainty Avoidance (46), Power Distance (40) and Long Term Orientation (29). Therefore, in addition to being an independent, masculine society, America shows cultural values of accepting uncertainty and having a willingness to try new things, while they demonstrate low opinions of power distance and small traces of long-term orientation. Hofstede’s research suggested that America is a short-term oriented culture preferring quick results.

These cultural rankings help researchers to understand what drives the general American population as well as provide insight into the response of the population when faced with a health intervention or petition for change. Because Americans are found to be competitive, ambitious, self-focused and immediate, they appear to be an appropriate culture on which to test maternal health interventions. The traits that make the American people competitive and ambitious will drive them to be the best that they can be on an individual basis. Even if these individuals do not act out of concern for the whole, they will reportedly act out of concern for self, and that is one of the best ways to encourage or promote postpartum health and wellness.

This study confirmed previous research suggesting that new mothers generally want to be the best that they can be for their baby and for themselves after giving birth, but they report a lack of post-partum education, significant barriers success or a lack of support to actually implement change (Dennis & Chung-Lee, 2006; Kanotra et al., 2007). Researchers and educators with an understanding of the cultural strength embedded in American society (postpartum women included) will recognize that although uncertainty avoidance is low, adoption of new
beliefs and ideas is a possibility. However, it is the implementation of those new beliefs that will actually create new perceptions and expectations, therefore evoking change in the life of a culture (Sniehotta, Scholz, Schwarzer, 2005; Northrup, 2010).

The United States has set predetermined health objectives and a system of checks and balances for health and wellness – the World Health Organization (WHO). With that predetermined system in place, cultural expectations for health in America are made known throughout each state and community. Known as health indicators, these health objectives encourage individuals to make positive changes in health behaviors, possibly altering past health beliefs, in order to initiate forward progress for health and wellness.

Cultural expectations for health in America

While Healthy People (2020) acknowledges that great strides have been made over the past decade with regard to health in the United States, there are still challenges that remain. As a nation, we have seen positive changes with regard to life expectancy at birth and rates of death from coronary heart disease and stroke. Through Healthy People 2020, the Department of Health and Human Services has taken their national goals for improving health in America and condensed them into what are known as Leading Health Indicators. These indicators are used to “assess the health of the Nation, facilitate collaboration across sectors, and motivate action at the national, State, and community levels to improve the health of the U.S. population” (Healthy People, 2020).

In order to better understand the encounters of different life stages, including the challenges of postnatal women, Healthy People (2020) takes a “life stages” approach to leading health indicators. By specifically examining health through the lens of different stages of life,
researchers have been able to suggest specific risk factors and elements of health throughout the life span of the United States population. “Health and disease result from the accumulation (over time) of the effects of risk factors and determinants. Intervening at specific points in the life course can help reduce risk factors and promote health” (Healthy People, 2020). Examining the life stages perspective allows researchers and educators to better understand one of the primary goals of Healthy People (2020) which is “to promote quality life, healthy development, and healthy behaviors across all life stages”. Additionally, selecting women as a specific target audience has been acknowledged by the World Heart Federation as a way to reach into the family unit and promote healthy transformations.

The World Heart Federation has selected mothers as their target for implementing positive health changes, not only because of their individual health risks as women, but also because of the influence that they have on the health choices of their children and family. The World Heart Federation describes women as the “gate keepers” to their family’s health (World Heart Federation, 2012). For this purpose, it is important to not only assist and equip women as they make healthy choices for themselves and their families, it is also imperative that researchers examine and understand the dichotomy between maternal health expectations and existent maternal health in American culture. A greater understanding of the gap between expectations and reality will help researchers as they propose plans for creating and implementing new health ideals and approaches.

Maternal health in America

As previously stated, Healthy People reports that more than 80 percent of women in the United States will become pregnant and give birth to one or more children (CDC, 2010). Out of
the 80 percent that give birth, at least 31 percent of these women are reported to experience pregnancy complications, ranging from depression to the need for a cesarean delivery (CDC, 2006). The CDC (2010) also estimates that roughly 1 in 10 women are depressed during pregnancy or within the first year after delivery. Because depression is only one of the illnesses that can inhibit a woman’s ability to perform daily activities, bond with her infant, and relate to her family, Healthy People suggests that maternal care should be given prior to, during and after pregnancy.

There are many adjustments and experiences associated with the postpartum period for which a woman should be prepared. Educating women on some of these adjustments will positively affect both the mother and child. For example, breastfeeding was reported as a major adjustment and challenge during the postpartum period. Both mother and baby receive great benefits, but it also creates a substantial postpartum stressor. Research has found that mothers (with and without gestational diabetes) who breastfeed greatly reduce their risk for high blood pressure and obesity (Vennemann et al., 2009) and a 20 year study conducted by Gunderson et al., (2009) found that mothers who breastfeed are less likely to get type-2 diabetes, breast cancer and ovarian cancer. The World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians all recommend that mothers breast-feed exclusively for six months (Northrup, 2010) but any postpartum woman will admit that this is no easy task when combined with the numerous other challenges she faces and the needs she must meet during this period of postpartum adjustment.

Pregnancy-related complications can also extend into the post-natal period; therefore, healthcare beginning preconception (before pregnancy) and continuing post-delivery or
interconception (between pregnancies), for those who will have more than one child, will provide researchers and educators the potential to identify risks and prevent future challenges regarding the health of maternal women. Healthy People (2020) suggests that pregnancy-related complications and risks for the mother and infant can be reduced by improving maternal access to quality care before, during and after pregnancy.

Healthy People (2020) recognizes that the well-being of mothers, along with infants and children, will determine the health of the next generation. What is possibly meant as a comical adage - “if mama ain’t happy, aint nobody happy”- describes potentially serious implications for a family unit if “mom” doesn’t care for her personal health and wellness. Much too frequently, culture believes in the “motherhood mystique,” which suggests that motherhood is easy, natural, and enjoyable (Hoffnung, 1989), and they additionally define a good woman as one who meets everyone’s needs but her own (Northrup, 2010). Differences in expectations and realities have long been a problem with pregnancy and the postpartum period as Nicholson (1990) reported, over 20 years ago, the assumption of society is that there is total fulfillment and happiness in becoming a mother. And, while many women currently report these exact same feelings, there is a level of expectation that is always different from what becomes a reality with motherhood (Beck, 2002a).

A detailed metasynthesis consisting of 18 qualitative studies (Beck, 2002a) examined the importance of maternal health as related to expectations and reality. Eight of the studies included in the research project focus on conflicting expectations and experiences of motherhood and suggest the relationship of these variables to postpartum depression. Although women report feeling disillusioned with new motherhood when they feel that they have failed to fulfill personal expectations (Buultjens & Liamputtong, 2007), they also were found to remain silent about
issues because they believe themselves to be the only ones experiencing a problem. Beck (2002a) found that for each woman, the struggles encountered were related to personal beliefs of motherhood.

Because the health and well-being of the mother has been shown to affect the unborn child (Franko & Walton, 1993), as well as the newborn infant (Miller & Tucker, 2011), it is important for researchers to determine the most appropriate way to promote maternal health and well-being by verifying the problem areas for postpartum women. A review of the literature regarding American culture and expectations of maternal health introduces the third research question. In order to further examine the expectations for postpartum women, this study sought to observe the effects of cultural expectations for the postpartum period:

RQ 3: How do postpartum women’s perceived cultural expectations of pregnancy relate to their own health and wellness?

A postpartum health initiative cannot be properly developed or evaluated without including a look into the importance of female mental and emotional health. In her 2010 book, Women’s Bodies, Women’s Wisdom, Dr. Christine Northrup discusses the evolution of female health with regard to female mental state and the importance of finding balance. Through this book she illustrates how bodily issues are affected by the mind, and how issues of the mind are affected by the body; therefore encouraging every woman to strive for a life that is balanced in the areas of mental, emotional, physical and nutritional care. Northrup (2010, p. 15) suggests that “the body and its state of health will be a reliable barometer, letting the individual know when their basic needs are being met”. As researchers and educators study women’s health, a working knowledge of postpartum needs, with regard to mental positioning, will not only allow for appropriate postpartum initiatives, but will also allow for greater success in postpartum health,
and allow for appropriate follow-up evaluations to determine implications of maternally focused health campaigns.

Female mental and emotional health

Schaef and Fassek (1988) suggested that there is an original sin of being feminine for which all females fall prey and feel compelled to apologize. They believe that women are taught from youth to apologize for their feminine nature. However, this feminine nature, displayed emotionally, physically and mentally, has brought about praise for women as they display strength and hold a matchless ability to effect change (Lewis & Butler, 1984). Thus, women should command respect for themselves and from themselves, not giving in to the belief that they have reason to apologize for an inherent nature. Early research by Berkman and Syme (1979) suggested that hope, self-esteem, and education are some of the most necessary elements needed to create healthy choices and lifestyles. Current research by Hill and Pargament (2008), agrees and supports findings that suggest a connection among an individual’s physical, emotional, spiritual and psychological components. Northrup (2010) also suggests that these components are intertwined in such a way that the psychological and emotional factors influence physical health; thus, reinforcing a greater knowledge of health beliefs with regard to the health and wellness of the postpartum woman.

Research suggests that many women go through major physical, emotional and psychological changes that are not understood in this culture (Northrup, 2010). Known as the fourth trimester, the first three months after a birth are seen as some of the most critical for the mother (and the infant). During this time the postpartum woman is not only inundated with hormones that make her more sensitive to the surrounding world, but she must also adjust to her
new familial role, responsibilities and the stresses that ensue. These changes and adjustments (some expected and some unexpected) bring challenges and exhaustion during the first three months postpartum.

It has been reported that nearly 80 percent of women experience the baby blues for up to two weeks after delivery (Misri, 2006) and many women suffer from postpartum depression (Gavin et al., 2005). Research suggests that postpartum depression is underdiagnosed (Hendrick, 2003), and if a woman has a history of depression, she is at a more significant risk for postpartum depression (Vinamaki et al., 1997; Beck, 2002b). Adding to or worsening postpartum feelings of depression or negativity is the possibility of having an unexpected labor process, cesarean delivery and breastfeeding complications (Howarth, Swain, & Treharne, 2010).

Because of the possibility of intense physical, mental and emotional positioning of postpartum women, there is a great need for education and support systems. Research suggests that “women do not have nearly the support that they need during the post-partum time” (Northrup, 2010, p.509). Previous qualitative research by Clark, Skouteris, Wertheim, Paxton and Milgrom (2009) discusses in-depth the gap in pre-natal education with regard to the postpartum period. They also report that postpartum women desire exposure to postpartum knowledge and information before giving birth. Whether related to the healing process, weight gain and management, breastfeeding or understanding of a new familial role, maternal care given prior to, during and after pregnancy will not only help to prepare women for the birth and labor experience (as is the main general practice of Western medicine today) but also help them prepare for their needs and experiences during the postpartum time.

With regard to maternal changes and postpartum management of healthy lifestyle choices, body dissatisfaction takes its place as an additional stressor and area of concern for
postpartum women. The additional element of weight gain and bodily change that results from pregnancy can affect self-esteem and body image satisfaction. As a doctor and a mother, Northrup quotes herself as wondering, “how was I supposed to enjoy a disappearing waist, puffy cheeks, and increased fat on my hips in a culture that worships quasi-anorexia” (Northrup, 2010, p.450). Research has suggested that there is great cultural expectation and pressure in Western society to be and remain slim (Muehlenkamp & Saris-Baglama, 2002; Jones, 2001), and this pressure has been found to influence pregnancy-related body image as well (Lederman, 1996). Body image satisfaction levels have been associated with self-esteem issues, depression, anxiety and unhealthy eating habits, all of which could negatively affect a postpartum woman (Green & Pritchard, 2003; Stice & Whitenton, 2002).

Body image

The National Organization on Women and Body Image suggests that there is extreme pressure on women to be thin. Women are weighed, measured and compared with the cultural ideal from birth (Webster & Tiggemann, 2003) and they are found to report a personal ideal weight that is usually 5-10 pounds less what they should really weigh (Northrup, 2010). According to the National Organization on Women and Body Image, American women get an average of forty negative messages a day about their bodies the overwhelming pressure of the thin ideal, which significantly affects life experiences and self-confidence (Northrup, 2010).

Body image is recognized as the internal feelings or perceptions of one’s outer appearance based on perceived body attractiveness and feelings regarding body shape and size (Thompson, Heinberg, Altabe, Tantleff-Dunn, 1999). Recent body image literature has focused on the narrower topic of body dissatisfaction with regard to weight. Perceptions of body image
are said to be recognized early in females, and girls often start dieting as young as 10 years old. Research suggests that females have been shown to carry this concern with weight and body shape throughout their life (Tiggemann, 2004; Patel, Lee, Wheatcroft, Barnes, & Stein, 2005).

Many women have come to believe that their bodies are objects by which culture evaluates them as an individual (Muehlenkamp & Saris-Baglama, 2002). Jones (2001), suggests that women, even from a very young age, are aware of the cultural expectations on their appearance and image, and they feel pressure by their peers to conform to those ideals. While the thin-ideal is almost an impossible goal for the average American woman, this cultural “standard” for body image influences the way that many women view themselves against society. If a woman wants to present herself in a way that would be pleasing to society, early work by Bordo (1993) suggested that her ideals should be strongly influenced by cultural and societal ideals concerning body image.

As previously discussed, research has shown that there is great pressure in Western society to be and remain slim (Muehlenkamp & Saris-Baglama, 2002; Jones, 2001), and this pressure has been determined to reach into pregnancy-related body image as well (Lederman, 1996). Dissatisfaction with body image has been associated with self-esteem issues, depression, anxiety and unhealthy eating habits, all of which could negatively affect a pregnant or postpartum woman (Green & Pritchard, 2003; Stice & Whitenton, 2002). It is understandable that pregnancy is a time of changing attitudes toward many things, including body image and healthy choices.

Current research acknowledges the many changes and experiences of the postpartum woman. Duncombe, Wertheim, Skouteris, Paxton and Kelly (2008) report finding pre-pregnancy orientation towards weight as a key influencer regarding postpartum attitudes towards weight,
diet and exercise. And, while women do report distress with body image, Lips (1985) found, through a longitudinal study, that physical stress might be of higher concern. Research on postpartum women suggests that body concerns may re-appear post-birth because postpartum women report a sense of having a new body after having a baby.

Body image concerns have been more recently reported as peripheral concern and not significantly distressing because of the demands of, and focus on, motherhood as well as the lack of time a new mother has to worry about her body image. Personal expectations and perceptions for health and wellness after having a baby have been linked to the issues and concerns in a new mother’s life. Previous research by Jordan, Capdevila, and Johnson (2005) suggested that while body image is one concern, there are other issues (ie: new stress, greater importance of children and family and lack of personal space) that cause body image to become of unpredictable importance for many new mothers. A new mother has many postpartum roles that contribute to modified concerns about her body. As previously stated, body image is reported to be of varying concern due to the other issues such as family and stress, coming to the foreground.

With dissimilar findings related to the postpartum experience, it is important for researchers and educators to understand pre and post-natal expectations and perceptions on a personal level in addition to the cultural expectations for this postpartum period. Current research suggests that postpartum expectations – on a personal and cultural level – are influenced by mediated representations of pregnancy (Gow, Lydecker, Lamanna, & Mazzeo, 2012). It is therefore important for postpartum researchers and educators to gain knowledge in the area of media effects as it specifically related to pregnancy and the postpartum period.

Current research in the area of media and body image demonstrates that women compare themselves with the unrealistically high standards presented in the media (Kim & Lennon, 2007;
Strahan et al., 2008). This shift in society towards the thin-figured woman, both in terms of personal and cultural expectations, has long been attributed to media and its shift to the thin-ideal (Anderson & DiDomenico, 1992). However, since 1996, there has been very little research, and almost nothing founded in empirical measures, regarding perceptions and expectations of pregnancy and the postpartum as it relates to mediated versions of pregnancy. Taking a closer look at how the media has potentially cultivated individual and societal perceptions and expectations in this area, and blending those discoveries with personal expectations of body image (before, during and after pregnancy) as related to the needs of postpartum women will allow researchers and educators to develop appropriate curriculum that will accurately educate, encourage and benefit women during pregnancy and the postpartum period. Additionally, knowledge in this area will help to ensure that postpartum women are more successfully able to manage this new role in their life and are equipped to adjust to and handle the changes that it brings.

Media’s role in body image, pregnancy and expectations

Early work by Andreoli (1990) suggested that due to better nutrition, females have more body fat in today’s culture than they did in the culture of their mothers or grandmothers, yet today’s cultural ideal - the average fashion model – weighs a significant percent less than the average American woman. Current research suggests that the mediated projections of these ideal norms encourage thinness as an important attribute in societal and cultural attractiveness (Bissell, 2010; Bissell & Hays, 2010). These “expectations” for societal norms are now the definition of attractive and are therefore suggested to affect the way in which women evaluate their bodies.
Magazines, advertisements, movies and television series are filled with images of ultra-thin models, and young, attractive women whose body weight is significantly below that of the average woman in real life (VanVonderen, 2011; O’Brien, 2012). Studies have shown a direct relationship between media exposure and body dissatisfaction, especially related to thinness-depicting and promoting related media (Tiggemann & Pickering, 1996; Harrison & Cantor, 1997; Tiggemann, & Slater, 2004; Levine, & Murnen, 2009). And, in a culture where being thin is deemed so important (Muehlenkamp & Saris-Baglama, 2002; Jones, 2001), being pregnant can present a challenge for women.

Adding to this cultural perception of thinness, throughout pregnancy and into the postpartum period, is the recent media attention given to postpartum images of celebrities and others as they advertise their quick “slim down” after giving birth. With the proliferation of mediated representations of celebrity slim-downs following pregnancy, it is understandable that women, especially pregnant and postpartum women, might experience lower self-perception because their own experience does not match what is portrayed by the media. Additionally, these mediated representations could potentially affect cultural perceptions, expectations or opinions of “normal” body size and image (Gow, Lydecker, Lamanna, & Mazzeo, 2012).

While the portrayals of body image and satisfaction among postpartum celebrities have been reported as high – with only 6.2 percent admitting body dissatisfaction – the contrast seems quite substantial when compared to the 40 percent of average American women who have previously reported body dissatisfaction (Walker, 1998). While this discrepancy is likely from lifestyle differences ranging from support staff to available time (Gow, Lydecker, Lamanna, & Mazzeo, 2012), mediated versions of acceptable pregnancy and postpartum issues help to create a skewed version of reality for the average American woman and the culture in which she lives.
Magazines and their online sites often cover celebrity pregnancies. These celebrities are used as models or examples for what to expect and how to navigate the period of pregnancy and the postpartum. Research (Gow, Lydecker, Lamanna, & Mazzeo, 2012, p. 174) has suggested that such magazines are “likely sending an implicit message about what the ideal pregnancy and postpartum woman looks like”. Results from a study of three popular magazines reported that even average weight gain, falling within normal medical limits (Rasmussen & Yaktine, 2009), was frequently portrayed in a negative or neutral manner (Gow, Lydecker, Lamanna, & Mazzeo, 2012). Thus, potentially causing confusion or creating unhealthy pressures for pregnancy expectations and perceptions in America.

Unfortunately, pregnancy-related magazines are not the only magazines to cover pregnancy, birthing and postpartum stories. Celebrity pregnancies are covered frequently by popular entertainment magazines (Husbands, 2008; Meyers, 2009; Gow, Lydecker, Lamanna, & Mazzeo, 2012); a magazine category with reported viewership of over 13 million each month (Gow, Lydecker, Lamanna, & Mazzeo, 2012). The fact that anyone, male or female of any age, can log on to an entertainment magazine website or pick up an entertainment magazine while waiting in line at the market and learn about someone’s pregnancy-related story, only further exaggerates the perceptions and expectations of pregnancy and the postpartum period. While research regarding mediated perceptions of pregnancy and postpartum is very limited, findings in this area suggest that “women undergoing pregnancy-related changes in their body might seek out information regarding pregnancy ideals to evaluate and process their own experiences” (Gow, Lydecker, Lamanna, & Mazzeo, 2012, p. 172).

Whether looking at a true pregnancy and postpartum related magazine such as *Fit Pregnancy* (Dworkin & Wachs, 2004) or browsing the pregnancy stories of an entertainment
magazine such as *People* (Breese, 2010; Gow, Lydecker, Lamanna, & Mazzeo, 2012), formative findings (Handfiled & Bell, 1996) report negative messages in the areas of weight gain, agony in childbirth, changes in relationships and negative career consequences. However, research has suggested that most of the negative information was included in “trend stories”, which are stories that have been defined by Faludi (1991) as stories that lack factual evidence and have a propensity to cite unidentified sources.

A review of the literature regarding maternal and emotional health and media’s role in body image, pregnancy and expectations, generate research questions four and five. In order to assist researchers and educators in the development of realistic and reliable pregnancy-related material that is designed to increase positive postpartum experiences, this study sought answers to the following questions:

RQ 4: What role does body image play in the health and wellness of postpartum women?

RQ 5: To what extent do mediated representations of pregnancy affect expectations for pregnancy?

In addition to mediated representations of pregnancy, other factors are relevant to postpartum wellness and self-perception and deserve discussion as to the role they play in perceptions and expectations of pregnancy. The following predictors of postpartum wellness and self-perception are presented below: self-esteem, nutrition, exercise, SES and internet usage.

Predictors of postpartum wellness and self-perception

Self-esteem

As previously stated, Duncombe, Wertheim, Skouteris, Paxton, & Kelly (2008) found that throughout pregnancy, women report body image results similar to pre-pregnancy
satisfaction or dissatisfaction. Although there is limited research within the field of communications that precisely details self-esteem in pregnancy, this specific finding leads researchers to suggest the need for medical monitoring for those women who report body image dissatisfaction and dietary restraint prior to pregnancy. Those who report dietary restraint prior to pregnancy and body image dissatisfaction could require additional monitoring as those attributes can extend into the pregnancy.

Self-esteem has long been defined as the “extent to which one prizes, values, approves or likes one’s self” (Blascovich & Tomaka, 1991), also being found to vary over an individual’s lifespan, based on social environment and changes in maturity (Robins & Trzesniewski, 2005), and is considered a critical component of mental health. Good self-esteem results in mental well-being, whereas low self-esteem has been associated with poor physical health and mood changes (Hassan, Joshi, Madhavan, & Amonkar, 2003). The changes in body shape and size that women undergo during pregnancy are thought to reduce self-esteem both physically and mentally (Poudegivne & O’Connor, 2006). Low self-esteem has been found as a stimulus for body fat accumulation during pregnancy as well as postpartum depression (Beck, 2002b). When combining pregnancy changes (including physical, hormonal and psychological) with pre-pregnancy perceptions, self-esteem and body image can cause drastic fluctuations (positive or negative) for the expecting mother (Godfrey, 2009). Because body image and self-esteem are very individualized processes, especially with regard to pregnancy, research in the area of female self-esteem highlight the importance of including all women in the discussion of pre and postnatal body image concerns.

While self-esteem has been found to affect mental wellbeing, physical health and mood for women (Hassan, Joshi, Madhavan, & Amonkar, 2003; Penedo & Dahn, 2005), research has
suggested that certain factors serve as mediators to self-esteem outcomes. These factors include (but are not limited to): nutritional habits, physical activity and sports participation. Fox (2000) suggested that the above listed factors (nutritional habits, physical activity and sports participation) have all been shown to improve self-esteem and mental health in non-pregnant women; therefore, exercise and nutrition, when examined with regard to pregnancy, could be used to promote positive changes during and after pregnancy for postpartum health and wellness.

Exercise and Nutrition

Exercise and nutrition have become progressive topics of research study because exposure to sports has been found as a negative correlate to body dissatisfaction with sports exposure and participation affecting a female’s attitude about her body (Smolak, Murnedm & Ruble, 2000). A meta-analysis done by Hausenblas and Fallon (2006) found that exercise was associated with a positive body image and that body image was positively correlated with exercise. Hausenblas and Fallon (2006) also found that exercisers participating in an exercise intervention program reported higher levels of body image satisfaction at the conclusion of the program than did the non-exercising control group, therefore suggesting that exercise could be used to improve an individual’s body image.

Physical exercise and regular movement of some kind is fundamental to a healthy lifestyle and therefore the USDA food pyramid includes it as an important part of a healthy lifestyle (Northrup, 2010). Exercise has been shown to affect individual health in ways such as reduction or prevention of cardiovascular disease, type II diabetes (McDonald et al., 2006) and obesity (Cortright et al., 2006). Additionally, exercise has been used in the management of stress
and depression (Galper et al., 2006) as well as promotion of self-esteem and body image (Suris & Parera, 2005).

With an understanding of the general health benefits, many women choose to continue or adapt new exercise routines into their daily regime when they become pregnant or after delivery (Da Costa et al., 2003). Many women report being afraid of weight gain during pregnancy (Fairburn and Welch, 1990) and although research suggests that women adapt to the rapid body changes of pregnancy, individual feelings of concern or ease with body image tend to follow the individual through the pregnancy experience and into the postpartum (Duncombe, Wertheim, Skouteris, Paxton, & Kelly, 2008). Evidence of physical activity increase has been associated with a decrease in symptoms of anxiety and depression, and an increase of general well-being in women (Warburton, Nicol, & Bredin, 2006); therefore, it is important to look at ways in which the expectant mother could establish healthy patterns of health and wellness for herself and her unborn child.

Research suggests that regular participation in exercise activities is associated with a positive mental and physical state during pregnancy and the postpartum period (Goodwin, Astbury & McMeeken, 2000). Additional studies have suggested that women who continue to participate in healthy exercise habits through pregnancy and the postpartum period have higher levels of psychological well-being and show reduced levels of anxiety and insomnia (Goodwin, Astbury, & McMeeken, 2000; Poudieguine & O’Connor, 2006).

With regard to a moderately physical lifestyle versus a more sedentary lifestyle, Northrup (2010) reports finding health benefits in each of the following areas: lower cancer rates and better immune system function, decreased risk of breast cancer, longer life expectancy, significant reduction in heart attack and stroke risk as well as beneficial blood vessel function,
less depression and anxiety, better mental efficiency and speed, more relaxation, assertiveness and enthusiasm, a better attitude about body image, better self-acceptance and higher self-esteem. Additionally, Northrup (2010) reports that pregnant women who exercise moderately have decreased constipation, hemorrhoids, varicose vein complications and morning sickness.

Because there is substantial evidence that exercise positively influences a women’s physical health during pregnancy and postpartum (Da Costa, Rippen, Dritsa, Ring, 2003; Haskell et al., 2007), healthy pregnant and postpartum women are encouraged to meet exercise guidelines of 30-min daily moderate-intensity exercise to reduce their risk of complications like gestational diabetes, preeclampsia and postpartum weight retention (Chasan-Taber, Schmidt, Pekow, et al., 2007; Downs, DiNallo, & Kirner, 2008).

While exercise has been suggested as positive influencer during pregnancy and the postpartum period (Devine, Bove, & Olson, 2000; Symons Downs, & Hausenblas, 2004); many nutritionists live by the saying – you can’t outwork a bad diet. Therefore, understanding the importance of nutrition during and after pregnancy is vital to the health and wellness of the postpartum woman. Maintaining a healthy immune system and eating habits have been shown to influence maternal and fetal nutrition, which in turn affects the future of both mother and baby (Shapira, 2008). Proper nutritional habits and vitamin intake have been shown to affect energy, blood levels (anemia) and the lactation process (Anderson, 2001).

Research shows that dietary changes, while important, are not always used in a beneficial manner (Szwajcer, Hiddink, Koelen, & Van Woerkum, 2007). Weight is a concern for many women during and after pregnancy (Rooney, & Schaubberger, 2002), and many women perceive dietary change to mean food restriction in order to produce slimming effects. However, some women use pregnancy as a time to increase caloric intake well beyond the necessary allotment
and create for themselves unnecessary and, possibly unhealthy, weight gain. Society has been said to accept a woman eating additional quantities of food as long as she is “eating for two” (Anderson, 2001).

Studies have shown that desired body image influences eating habits and choices regarding healthy eating or eating restraint (Cooley and Toray, 2001; Stice, 2002). As previously discussed, societal norms regarding the thin ideal are prevalent and are promoted through cultural expectations of thinness. This thin ideal unfortunately leads to body dissatisfaction and the obsessive monitoring of caloric intake, which is linked with not only unhealthy eating, but also binge eating and restrictive dieting (Levine & Piran, 2004). However, research by Anderson (2001) suggests that with proper counsel (from healthcare professionals, friends, family, reading material and the media), seeing the healthy development of a baby may be enough to encourage proper nutrition and lifestyle changes in many women experiencing a pregnancy.

Clinical implications for the previously discussed findings indicate the need for education with regard to normal postpartum changes and expectations. Concurring research by Clark, Skouteris, Wertheim, Paxton and Milgrom (2009), found that pre-natal women would benefit from educational directives with regard to their expectations for pregnancy and the postpartum period. Additionally, Choi, Henshaw, Baker and Tree (2005), report that midwives find opposition when discussing upcoming bodily changes, role transitions and other realities of motherhood with antenatal women. They also suggest that a major concern of pregnant women (with a first pregnancy) is to gain information to assist them with only their impending labor and delivery, because they do not yet know to ask post-birth questions. When planning educational curriculum and interventions these courses should have a greater focus on issues regarding adjustment to motherhood, the demands of a new baby and normal bodily changes. Implications
of the previously listed postpartum issues are of concern to all new mothers, regardless of social status, and could be included in prenatal care curriculum, giving postpartum women a better chance for adjustment to the added demands of motherhood.

Socioeconomic Status (SES)

Researchers cannot overlook the disparities associated with availability and quality of healthcare provided to women categorized with a low socioeconomic status. Low socioeconomic status (SES) has been associated with health disparities and has been identified as a way to study the disparities of individuals characterized by low income, less than a college education, unmarried, unemployed (Goyal, Gay, & Lee, 2010), and other factors depending on the research study. However, with specific regard to postpartum health and wellness, SES has been found to affect the adaptation and transition from pregnancy to postpartum and motherhood (Goyal, Gay & Lee, 2010).

While the birth of a child can be a mixture of joy, new demands and stress for all parents (Muslow, Caldrea, Pursley, Reifman, & Huston, 2002), it is the mother that seems to bear the greatest emotional and physical burden. As a woman begins the transition to first-time mother, her role within the family changes, sometimes with little to no past experience or support system upon which she is able to lean for help. For postpartum women, research has suggested that low SES is “associated with a lack of social support, low self-esteem, younger age, and absence of spousal financial and social support” (Goyal, Gay & Lee, 2010, p. 97). With a lack of support, many postpartum women are less likely to have access to health services, therefore, postpartum affective mood disorders and learning obstacles are more likely to cause ailment (Altshuler et al, 2001).
Additionally, women with lower incomes are less likely to report symptoms to healthcare professionals (Kimmerling & Baumrind, 2005) but are more likely to report unmet learning needs for both maternal and infant care in the postpartum period (Sword & Watt, 2005). Nelson (2003) suggested that changes must be made by healthcare providers so that learning needs would be assessed along with other postpartum issues during all healthcare appointments, including well-baby visits. Making the well-baby visit also about the mother will help to ensure that postpartum obstacles are dealt with as they arise, not when they become problematic. Sword & Watt (2005) confirm the necessity of Nelson’s previous recommendation. They found that women with a low SES categorization, report challenges in obtaining information from a healthcare provider in the postpartum period.

Other issues associated with low SES are unintended pregnancy and shorter hospital stays. As hospital stays become shorter, these postpartum women, pregnant by choice or by chance, are forced to depend on handouts and community groups. However, there is little to no educational information regarding the postpartum period given in the shorter hospital stay (Ruchala, 2000). Ruchala (2000) also suggests that caregivers and educators understand not only the content and timing of the information but also the receiver of the information. As confirmed by qualitative reports from this study, many women will not absorb everything they are told in such a short, and potentially stressful, hospital stay. Therefore, they will be forced to depend on the take-home information and community group support. Women with low SES are not often educated on where and how to get involved with community groups, thus continuing the cycle of low SES disparity with regard to postpartum healthcare.
Internet usage

Previous research has suggested health information to be one of the primary drivers of internet usage (Hurley, Kosenko, & Brashers, 2011), sought by diverse populations online (Zarcadoolas, 2011), and utilized through smart phone access by historically disenfranchised groups. The previously listed research suggests that low SES women do have access to healthcare via the Internet and that they do seek information. A survey done by Declercq, Cunningham, Johnson, and Sakala (2008), found that more than three fourths of childbearing women use the Internet for information regarding pregnancy and birth. They also reported that the internet was rated as the most important source of information for 16 percent of first-time moms and 13 percent of moms of more than one child. The Internet was reported as a location to search for health information by 71 percent of U.S. adults (Harris Interactive, 2007). Additionally, a 2007 Harris Poll reports that Internet users find reliable the health information they obtain online.

The average woman discovers her pregnancy at 5.6 weeks, but she does not see a healthcare provider until the ninth week of pregnancy (Declercq, E., Cunningham, Johnson, & Sakala, 2008). The time in-between the discovery and the first pre-natal visit is spent gaining as much information as possible from internet forums and baby blogs (Larsson, 2007). Because of its convenience and effectiveness as an information seeking tool, women have been found to consult the Internet to find answers to questions that are considered embarrassing to ask a healthcare provider or to avoid the hassle of scheduling a visit to the office (Romano, 2007). Pregnant and postpartum women also use the Internet as a support group. Online birth clubs and forums allow these women to connect with each other and to provide information, assistance and encouragement. While the Internet does not eliminate the need for healthcare providers or for
childbirth educators, it does solidify the need for their understanding of the material available online (Romano, 2007). Researchers, educators and healthcare providers share a responsibility to help childbearing women make sense of the information they find in order to make it to usable, factual and beneficial knowledge regarding pregnancy and the postpartum period.

In order to advance knowledge in the area of the above referenced predictors of postpartum wellness and self-perception, the following research question was designed. As researchers and educators gain more understanding of variables that affect knowledge and expectations of pregnancy on a cultural and personal level, they are better able to help prenatal and postpartum women adjust to their new roles with successful outcomes. Therefore, with regard to self-esteem, exercise and nutrition, SES and the Internet, research question number six was posed:

RQ 6: To what extent do pregnancy-related websites affect the health and wellness of postpartum women?

A review the previous literature (regarding health and wellness, belief and culture, culture in America, cultural expectations for health in America, maternal health in America, female mental and emotional health, body image, media’s role in body image, pregnancy and expectations and predictors of postpartum wellness and self-perception), is important to understand how research can be best used for education and wellness interventions. Knowledge of current pregnancy-related research, combined with an understanding of health beliefs, expectations and educational interventions, is valuable as programs are developed that will instruct and inform women on the realistic expectations and healthy behaviors regarding pregnancy and the postpartum period.
Education and wellness interventions

Educational interventions with regard to health and wellness are necessary and helpful, but they are not always easy to implement due to many different factors. When dealing with prevention or wellness, the results are long-term changes and successes that often do not show immediate benefits. Or, the population will not see any quantifiable benefit other than the absence of sickness, which dilutes belief in the need for continuation along the wellness track. Because American’s do not generally view illness as a need for health behavior change (Northrup, 2010), encouraging the adoption of wellness and prevention strategies are more difficult. Fineberg (2013) found that with regard to culture, prevention is valued. However, this research also suggests that with regard to prevention and wellness, success is invisible, lacks drama, often requires persistent behavior change, and may be long delayed (Fineberg, 2013). Therefore, it is important for educators and researchers to remember that an overnight transformation in beliefs and attitudes should not be expected. Many messages will need to be presented and repeated to become accepted as cultural or even population specific norms.

The presentation of these specific wellness messages could eventually change and update beliefs, behaviors and decisions on the necessity of wellness and prevention. Northrup (2010) suggests that the thoughts and beliefs of an individual or culture are an exceptionally important part of a body’s wisdom because the body has the ability to change its mind as it learns and grows. Additionally, she notes, “a thought held and repeated long enough becomes a belief – and beliefs are heavily influenced by the culture in which an individual lives” (Northrup, 2010, p. 29).

With American culture playing such an important role in wellness and prevention programs, Fineberg (2013, p. 89) suggests that “success will require a sustained effort from
individuals and families in their daily lives; from physicians, nurses, pharmacists, and other health professionals; from cultural, entertainment, and sports celebrities; from employers and insurers; from political, civic, and business leaders; from public agencies at all levels; and from philanthropies”. The key to development and implementation of wellness strategies is to assist the population in understanding that an ounce of prevention really is worth a pound of cure – because in the end, prevention is worth the effort.

Providing assistance and care for prenatal and postpartum women is only successful if the education is designed with an understanding of the needs the individual does have or will potentially have in the future. Therefore, this research sought to further investigate the gaps in prenatal education by specifically assessing postpartum women. Taking a closer look at the needs in current pre-natal education and having the contributions of postpartum women, based on personal opinions and (cultivated) expectations, allows opportunity for educational improvements and updates; thus, research question number seven was offered:

RQ 7: What pregnancy-related education is needed to promote change in health and wellness of postpartum women?

Theoretical framework

Health belief model

The health belief model was developed by Rosenstock and Hochbaum and served as a way of explaining why public health screenings were unsuccessful (Rosenstock, 1974). It is most commonly used today in health education and promotion to explain why people do not engage in screenings. The main underlying concept is that personal beliefs impact health behavior and that health behavior is determined by personal beliefs about a disease/condition and the strategies available to decrease its occurrence.
This model suggests that there are four beliefs that influence a person’s willingness to take action:

1. Perceived threat (susceptibility and severity) – people must believe that they are susceptible to the condition. Being able to show personal risk (susceptibility) is a powerful tool in prompting people to adopt healthier behaviors. Additionally, an individual’s belief about the seriousness (severity) of a disease varies by individual experience, therefore risks and consequences of disease must be clarified. Studies suggest that the greater perceived risk, the greater the likelihood of people altering their behaviors to decrease the risk. It only seems logical that people will be more likely to act in a manner of prevention when they believe they are at risk. However, the opposite can also occur and people could lean towards unhealthy behaviors when they believe they have little to no risk. Perceived severity and perceived susceptibility are referred to as perceived threat, and while perceived threat is a useful predictor of behavior, it is important to remember that perceived threat does not explain behavior in all health situations; therefore, an element of perceived benefits is useful in initiating change.

2. Perceived benefits – people must believe that taking action would reduce their susceptibility to condition or its severity and therefore changing their opinion of the value or usefulness of a new behavior in decreasing risk. People have been shown to adopt new behaviors when they believe the new behavior will decrease negative risk (Weinstein & Nicolich, 1993). Health educators play an important role in clearly defining health behaviors and in a way that will encourage and promote behavior change.

3. Perceived barriers – people must believe that the costs of taking action are outweighed by the benefits of taking action; therefore, perceived barriers are very significant factors in
determining behavior change. An individual will make their own evaluation of the obstacles in their way as they consider adopting the new behavior and research shows that people will weigh the tangible or psychological costs of taking action (Weinstein, & Nicolich, 1993). If health educators are able to identify perceived barriers and provide assistance and new or corrected information, they will have a better opportunity to add reassurance to the newly suggested behavior and therefore potentially overcome the perceived barrier. When barriers are overcome, new behaviors can be adopted.

4. Cues to action – people need to feel an eagerness to change or experience a call-to-action. Cues can come in the form of events, people or things, and will encourage a person to be proactive in changing or modifying their health behavior(s).

5. Self-efficacy – as defined by Albert Bandura, is a means of explaining an individual’s belief in their personal ability to succeed in or accomplish specific goals (Bandura, 1977; Ormrod, 2006). Self-efficacy can also affect how people are motivated to handle goals and challenges (Schwarzer, 2008). Culture, education level, past experiences, skills, motivation, gender and age and individual characteristics have been defined as motivating factors for the health belief model.

This theory also suggests that in order for a person to perform a given health behavior they must believe or perceive one of the following:

1. believe they are at risk
2. believe the condition or disease is serious
3. believe the health behavior is effective in reducing risk/severity of the disease
4. perceive the benefits outweigh the costs of actions
The health belief model is applicable to the present study in that its constructs will help the research to explain current health beliefs with regard to pregnancy and the postpartum period. Constructs of this theory will also explicate the significance of needs (risks) of the postpartum woman which will allow the researcher insights into necessary health behavior change. This study sought to assess the accurate needs of postpartum that could be used to promote and encourage positive health beliefs and behavior change during and after pregnancy.

Because pregnancy is affected by many factors, including perceptions and expectations (both personal and cultural), it is also necessary to examine the variables of this research through the lens of social comparison theory.

Social Comparison Theory

Social comparison theory suggests (Festinger, 1954) that people look to images they perceive to be attainable and realistic and then, make comparisons among themselves, others and the idealized images. His research suggests that these comparisons are made and processed order to determine what is obtainable and realistic. When women determine what is obtainable or realistic, they form opinions regarding their individual body image as related to the ideal images.

There are two main types of comparisons made by individuals: upward and downward. Upward social comparisons occur when individuals compare themselves to others who they perceive to be above them in some way. People make upward comparisons, both consciously and subconsciously, with other individuals they perceive to be better off than themselves in order to improve their views of self or to create a more positive perception of their personal reality. Downward comparisons function in the opposite direction. Downward comparisons are a defensive mechanism that people use as a means of self-evaluation. Individuals will look to
another person or comparison group who are considered to be worse off in order to disassociate themselves from perceived similarities and to make themselves feel better.

Because of a lack of social science research in the area of postpartum health and wellness, as well as mediated effects of prenatal and postpartum experience, there is not enough pertinent information from which the researcher could found specific hypotheses. Based on the previously discussed research and theoretical framework, the seven proposed research questions were constructed to increase knowledge by examining the relationship between cultural and personal health beliefs and expectations regarding pregnancy and the postpartum. Additionally, this study contributes to current knowledge gaps as it increases understanding in the areas of mediated representations of pregnancy, predictors of postpartum wellness and self-perception, pregnancy websites and pregnancy-related education as they affect the personal health and wellness of postpartum women.
CHAPTER THREE

METHODOLOGY

Based on the constructs of the health belief model (perceived threat, perceived benefits, perceived barriers, cues to action and self-efficacy) and social comparison theory (upward and downward comparisons), the research questions were designed to advance previous research regarding expectations and reality. Research questions were also designed to assess the needs of postpartum women in order to support the development of new prenatal curriculum that will address knowledge gaps as related to the postpartum period. The previously discussed research suggests that postpartum women have specific needs; therefore, this study was designed with a quantitative and qualitative portion to better address problem areas and target new educational material. The qualitative responses from this study also serve as a guide for further research in the area of post-natal realities, expectations and educational development. The proposed variables were designed to provide answers to specific questions regarding beliefs, behaviors, intentions and social views. The qualitative portion of the study was designed to follow-up the answers given by respondents to investigate the needs and perceptions of survey participants.

Study Design

Previous research (Beck, 2005) suggests through Internet surveys and questionnaires that women report feelings of belonging, understanding, empowerment and assistance when providing answers to research with which they can associate. Additionally, internet research has been shown to provide participants with anonymity to sensitive topics and allows researchers to
reach vulnerable or hidden populations (Biddix & Park, 2008; Denissen, Neumann, & Van Zalk, 2010). Data collection from the Internet also provides researchers with time and cost-saving benefits (Im & Chee, 2003; Biddix & Park, 2008) and can save hassle with delayed response times and time-zone conflicts (Im & Chee, 2003; Biddix & Park, 2008). For these reasons, as well as convenience and privacy, the survey instruments were administered online and participants for the study were recruited from pregnancy-related websites (babycenter.com, thebump.com), mommy blogs (birminghammommy.com, tuscmoms.com) and Facebook.

“Loyalty to a website is confirmed when a woman signs up to receive weekly e-mails customized to her stage of pregnancy” (Romano, 2007, p. 19). Thebump.com, babycenter.com, Birminghammommy.com and tuscmoms.com were all selected because of their membership opportunities, level of member participation and level of forum activity. Members of these forums are generally information seekers and are active in forum participation; therefore, they are more likely to participate in a survey testing their postpartum needs.

Only U.S. women, who were first-time moms, over the age of 19, were desired as participants of the survey; however, all ranges of ethnicity, education, marital status, and SES were desired. Participants were required to pass two initial screening questions (1. Are you 19 years or older? 2. Did you give birth in the year 2013 or 2014?) before being allowed to participate in the survey. Participants were asked to complete demographic questions and were then screened again at question eight (how many times have you given birth?). All participants that answered with “1” time for giving birth were directed to the complete survey. When asked how many times they had given birth, all participants answering “0” or any number more than 1, were directed to the last five questions, and qualitative portion, of the survey. To protect the anonymity of each participant, no names or identifiers were present on the survey to link the
participants back to their responses. Ethnicity and SES were recorded on a voluntary basis. The survey was created using the Qualtrics program and distributed to respondents using online forums, birth club boards and Facebook.

Understanding the significance of available time to the desired population, the survey instrument was designed with 168 questions, including five open-ended questions (numbers 164-168), and was designed for completion in 25 minutes. The survey was not timed so that each participant could spend as much time as necessary to accurately express their opinions. The average completion time for each participant was 21 minutes.

Data Collection

Data collection took place between March-May 2014. Respondents completed an online survey, which assessed individual opinions and experiences and expectations regarding pregnancy and the postpartum period, as well as factors that influence pregnancy and the postpartum period. The survey was distributed to respondents using pregnancy-related websites (babycenter.com, thebump.com), mommy blogs (birminghammommy.com, tuscmoms.com) and Facebook. The survey measures included: (1) cultural health beliefs (2) personal health beliefs, (3) pregnancy expectations, (4) body image, (5) mediated representations of pregnancy, (6) predictors of postpartum wellness and self-perception, (7) pregnancy-related websites, and (8) pregnancy-related education. There are two outcome variables for the research: (1) health and wellness of postpartum women and (2) expectations for pregnancy. Additional measures on the survey asked about Internet usage, pregnancy-related healthcare, weight gain and birth month.

Pregnancy, childbearing and postpartum research has suggested that, with regard to the Internet, women are more comfortable sharing sensitive information in an anonymous setting.
and comfortable environment (Reddy et al., 2006). Internet research also gives participants time to think about their answers, and provide more specific feedback on open-ended questions. Therefore, this research was designed for participation from any location and device that could be connected to the Internet or Wi-Fi. Although previous research suggests that more than three-fourths of childbearing women use the Internet for information regarding pregnancy and birth (Romano, 2007), Internet survey and questionnaire participation is limited to those who have access to and know how to use a computer or smart phone (Thomas, Stamler, LaFreniere, & Dumala, 2000; Fowler, 2013).

Measures

Participants were screened three times throughout the online survey. The first two questions on the survey were used as initial screening questions in the event that a woman under the age of 19 or who was more than 15 months postpartum attempted the survey. All participants were asked if (1) they were 19 years old or older and if so, (2) did they give birth in the years 2013 or 2014. Question number one was used to screen out participants who would not be able to give personal consent for their participation in the survey. Question number two was used to screen out participants who did not fall into the specific group of first-time moms with a designated postpartum time period of immediately after birth through 15 months. Participants had to answer “yes” to both questions in order to proceed with the survey.

Participants were screened again at the eighth question when they were asked the number of times they had given birth. Screening at the eighth question was done to ensure that women who had given birth only once were directed to the entire survey; women who had given birth more than once were directed to the last five questions of the survey – the qualitative portion of
the survey. The screening of participants was necessary for the purposes of this research in order to establish answers that were not skewed by prior knowledge of a personal birth experience. For the purpose of the survey research, only first-time moms who had gone through a personal birth experience were directed through to the entire survey. Believing that previous birthing and postpartum experiences, as well as adoption, would skew the results away from the newly determined needs of a first-time, postnatal woman, all other postpartum experiences were directed to the last five questions of the survey. The last five questions were designed to elicit open-ended answers regarding postpartum education and decision-making processes about nutrition, physical activity and mental and emotional stability. If participants gave any answer other than the pre-determined “one” when asked how many times they had given birth, they were directed to the open-ended questions.

Because women report appreciation for Internet research in a qualitative format that allows their voice to be heard (Beck, 2005), this study was designed with a quantitative and a qualitative component. In order to benefit from any postpartum woman who was willing to participate, respondents passing the first two screening questions were not turned away from participation at the third screening question, but were merely directed to the qualitative portion where they could express their opinions. These last five, open-ended questions were designed to educate researchers on needs of postpartum women as well as areas of necessary postnatal education. Through the qualitative portion of this research, women were able to express opinions as to how educational curricula presented during prenatal classes could help alleviate postpartum issues.
Predictor variables

There were seven predictor variables for the research study. The variables are defined as: (perceived) cultural health beliefs, personal health beliefs, cultural expectations for pregnancy, body image, mediated representations of pregnancy, pregnancy-related websites and pregnancy-related education. All variables are defined below:

Cultural health beliefs

Health beliefs are operationalized as the beliefs of a culture or individual regarding what causes or prevents illness, how it can be cured, treated or prevented, and who should be involved in the process (Mc Laughlin & Braun, 1998). For the purpose of this research, cultural health beliefs were measured in perceptions of cultural health beliefs. Measures for cultural health beliefs were based on scales adopted from the health belief model (Glanz, Rimer, Lewis, & Jossey-Bass, 2002) and specifically constructed by the researcher in order to relate to the needs of this study. Measures were taken through the constructs of: (1) perceived benefits, (2) perceived threat, (3) cues to action, and (4) self-efficacy. Respondents were asked, regarding their perceptions of cultural health beliefs, to what extent they disagreed or agreed with questions listed on a 6-point Likert scale (i.e., I believe that people view pregnancy as a fragile health condition, I believe that employers are accepting of maternity leave, people expect pregnant women to keep up the pre-pregnancy pace at work).

Personal health beliefs

Health beliefs are operationalized as the beliefs of a culture or individual regarding what causes or prevents illness, how it can be cured, treated or prevented, and who should be involved
in the process (Mc Laughlin & Braun, 1998). Measures for personal health beliefs were based on scales adopted from the health belief model (Glanz, Rimer, Lewis, & Jossey-Bass, 2002) and specifically constructed by the researcher in order to relate to the needs of this study. Measures were taken through the constructs of: (1) perceived benefits, (2) perceived threat, (3) cues to action, and (4) self-efficacy. Respondents were asked, regarding their opinions and perceptions of pregnancy, to what extent they disagreed or agreed with questions listed on a 6-point Likert scale (i.e., exercising on a regular basis enhances the way I feel about my body after having my baby, my ability to connect with my baby will be greatly affected by my physical and emotional health, online birth clubs / forums encourage me to engage in physical activity, I am confident in my ability to make healthy choices when eating after I have my baby).

Cultural expectations for pregnancy

Cultural expectations for pregnancy are conceptualized as perceived expectations regarding culture’s opinions of pregnancy and the pregnant body. In American culture, there is a long-held belief in a “motherhood mystique,” which believes that motherhood is easy, natural, and enjoyable (Hoffnung, 1989). Scales for cultural expectations for pregnancy were newly constructed to fit the research needs. Respondents were asked to what extent they disagreed or agreed with questions, listed on a 6-point Likert scale, regarding their perceived cultural opinions on pregnancy and the pregnant body (i.e., I make decisions about physical activity for myself based on what I believe others expect me to do, I believe that others expect me to get my pre-baby body back).
Body image

Body image is operationalized as the internal feelings or perceptions of one’s outer appearance based on perceived body attractiveness and feelings regarding body shape and size (Thompson, Heinberg, Altabe, Tantleff-Dunn, 1999). Previously validated scales were used for measuring body image. Scales with previously validated reliability ($\alpha = .79$) from McKinley and Hyde (1996) were used to measure body consciousness and self-perception with regard to personal opinions and perceptions of the body before, during and after pregnancy. Participants were asked to what extent they disagreed or agreed with questions listed on a 8-point Likert scale (i.e., I feel ashamed of myself when I haven’t made the effort to look my best, A large part of being in shape is having that kind of body in the first place, I rarely compare how I look with how other people look, I would be ashamed for people to know what I really weigh).

Mediated representations of pregnancy

Mediated pregnancy examples are operationalized as pregnancy-related stories published in an entertainment or pregnancy-related magazine that could potentially affect the way in which an individual views pregnancy experiences. Research suggests that magazines serve as an important source of information for pregnant women (Gow, Lydecker, Lamanna, & Mazzeo, 2012). Because of the lack of research in the area of mediated examples of pregnancy and the effects on postpartum women, new scales were constructed to detail postpartum feelings and opinions on the information related to mediated representations of pregnancy. Because the researcher wanted to measure both entertainment media and informational media sources for mediated representations of pregnancy, separate scales were constructed for each media category.

To measure entertainment media, participants were asked to what extent they disagreed or
agreed with questions listed on a 6-point Likert scale (i.e., the information I read in *People magazine*, regarding other people’s pregnancies, changes the way that I feel about my pregnancy, pregnancy-related stories in *People magazine* are relatable to my life, pregnancy stories in *People magazine* do not affect my pregnancy expectations). Participants were also asked to answer a question regarding their exposure to entertainment media (i.e., how often are you exposed to entertainment media such as *People magazine*) and were given a 4-point scale (daily, weekly, monthly, never).

To measure informational media, participants were asked to what extent they disagreed or agreed with questions listed on a 6-point Likert scale (i.e., the information I read in *Fit Pregnancy magazine*, regarding other people’s pregnancies, changes the way that I feel about my pregnancy, pregnancy-related stories in *Fit Pregnancy magazine* are relatable to my life, pregnancy stories in *Fit Pregnancy magazine* do not affect my pregnancy expectations). Participants were also asked to answer a question regarding their exposure to informational media (i.e., how often are you exposed to informational media such as *Fit Pregnancy magazine*) and were given a 4-point scale (daily, weekly, monthly, never).

**Pregnancy-related websites**

Pregnancy-related websites were operationalized for this research as websites specifically for pregnancy and postpartum information, blogs, message boards and memberships (i.e., babycenter.com and thebump.com). There are many websites devoted to pregnancy-related information and this variable is set to test them as a whole. While it is understood that some websites will be more educational or beneficial for use by a pregnant or postpartum women, assessing these websites as a whole, will allow researchers to provide general information on this
type of educational tool during the pregnancy experience. Before a woman is able to see her health care provider for the first time, she is reported to spend significant time researching and gaining information from the Internet via baby blogs and forums (Larsson, 2007). Additionally, women are suggested to use these websites to gain information regarding questions they are not comfortable asking of their health care provider (Romano, 2007).

New scales were constructed to assess use of pregnancy websites. The author constructed scales that asked the participants questions regarding their usage, findings and feelings about website information. Participants were asked to what extent they disagreed or agreed with questions listed on a 6-point Likert scale (i.e., I use pregnancy-related websites to find answers to the majority of my questions, I believe the information that I find on pregnancy websites to be true and accurate, Pregnancy-related websites provide a network of friends with whom I can exchange information).

Pregnancy-related education

Pregnancy-related education is conceptualized as the education given to a woman during her pregnancy and throughout the postpartum period (immediately after birth through 15 months). This information is designed to assist with the issues, fears and changes she will encounter, and to provide her with a smooth transition because of prior preparation. Midwives and primary care physicians report that women are most concerned about an impending birth; however, the birth is only a small part of what a woman will encounter when she becomes pregnant. Thus, it is most important to ensure that a woman has access to the most accurate and beneficial pregnancy-related education possible.

It has been suggested that the extent to which individuals believe that health education has
relevance to them has a great effect on their willingness to change or alter beliefs (Mc Laughlin & Braun, 1998). In order to provide researchers with the most accurate and beneficial information, the questions regarding pregnancy-related education were presented in both quantitative and qualitative form. Quantitative questions were newly constructed by the author and participants were asked to what extent they disagreed or agreed with questions regarding their pregnancy-related education listed on a 6-point Likert scale (i.e., my OBGYN provided me with useful and beneficial information regarding my pregnancy, my OBGYN provided me with enough pregnancy-related information during my prenatal care visits). Follow-up questions were asked in a qualitative form so that respondents could provide their own thoughts and opinions. The questions asked respondents: (1) What was the content of the postpartum education you received in your prenatal appointments? (2) In your opinion, what constitutes an adequate education on what to expect in the postpartum period? (3) What factors contribute to you making healthy decisions regarding nutrition in the postpartum period (ie: time, money, etc)? (4) What factors contribute to you making healthy decisions regarding physical activity in the postpartum period? (5) What factors contribute to you feeling mentally and emotionally stable in the postpartum period?

In order to assist with generalizations, the survey also requested demographic information: race, age, highest level of education and Internet usage.

Outcome variables

There are two outcome variables for the research study. The variables are defined as: personal health and wellness of postpartum women and expectations for pregnancy. All variables are defined below:
Health and wellness of postpartum women

The health and wellness of postpartum women was operationalized, for this study, as the complete physical, mental and emotional health of the postpartum woman. In order to achieve this outcome variable, scales were constructed by the researcher in order to assess the influence predictors of postpartum wellness and self-perception. The health and wellness of postpartum women conceptualized as self-esteem, exercise and nutrition. Self-esteem during and after pregnancy has been directly related to self-esteem prior to becoming pregnant (Duncombe, Wertheim, Skouteris, Paxton, & Kelly, 2008). Therefore, measuring a woman’ s perceptions of herself both prior to and post pregnancy will allow researchers to understand the effects of self-esteem on health and wellness in the postpartum period. Of additional interest as predictors of postpartum wellness and self-perception are nutrition and exercise habits and their effect on postpartum health and wellness.

Proper nutrition habits have been shown to influence maternal and fetal nutrition, which in turn affects the future of both the mother and baby (Bradley, & Corwyn, 2002; Henriksen, 2006). Proper nutrition has been shown to positively affect energy, blood levels (anemia) and the lactation process (Anderson, 2001). Additionally, research suggests that regular participation in exercise activities is associated with a positive mental and physical state during pregnancy and postpartum (Goodwin, Astbury and McMeeken, 2000; Warburton, Nicol, & Bredin, 2006; Poudeivgne & O’Connor, 2006). Scales were developed by the researcher to properly measure predictors of postpartum wellness and self-perception with specific regard to self-esteem, postpartum nutrition and exercise. Participants were asked to what extent they disagreed or agreed with questions listed on a 6-point Likert scale (i.e., My feelings about my body are the
same now as they were before I became pregnant, I believe that exercise that will lower my risk for postpartum depression, proper nutrition during pregnancy is important for recovery in the postpartum period).

Expectations for pregnancy

The category of expectations for pregnancy was conceptualized, for the purpose of this study, as the cultural and personal expectations for pregnancy as influenced by mediated representations of pregnancy. Cultural expectations for pregnancy was also used as an outcome variable when correlated with mediated representations of pregnancy. As previously discussed, cultural expectations for pregnancy were conceptualized as perceived expectations regarding the culture’s opinions of pregnancy and the pregnant body. Scales for cultural expectations for pregnancy were newly constructed to fit the research needs. Respondents were asked to what extent they disagreed or agreed with questions, listed on a 6-point Likert scale, regarding their perceived cultural opinions on pregnancy and the pregnant body (i.e., I make decisions about physical activity for myself based on what I believe others expect me to do, I believe that others expect me to get my pre-baby body back). Expectations were measured against mediated representations of pregnancy, either through entertainment media or through news media, to determine their impact on women as they go through pregnancy and into the postpartum period.

Reliability

The measurements consist of previously validated scales ($\alpha = .79$) for body image (McKinley and Hyde, 1996), used in conjunction with newly developed scales designed to effectively measure the additional associated variables (See Appendix A for full survey). The
scales used in this study were developed based on the predictor and outcome variables and were determined to be reliable. Reliability for each scale was calculated using Cronbach’s alpha scores. All scales had an appropriate level of reliability. Table 1 summarizes measurement items and scale reliability.

Table 1. Scale Reliability

<table>
<thead>
<tr>
<th>Variable</th>
<th>( \alpha )</th>
<th>( N ) items</th>
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<tr>
<td>Personal health beliefs</td>
<td>.75</td>
<td>23</td>
</tr>
<tr>
<td>Expectations for pregnancy</td>
<td>.71</td>
<td>13</td>
</tr>
<tr>
<td>Body image</td>
<td>.72</td>
<td>14</td>
</tr>
<tr>
<td>Mediated pregnancy examples</td>
<td>.74</td>
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<td>Pregnancy-related websites</td>
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</tr>
<tr>
<td>Pregnancy-related education</td>
<td>.78</td>
<td>6</td>
</tr>
<tr>
<td>The health and wellness of postpartum women</td>
<td>.77</td>
<td>23</td>
</tr>
</tbody>
</table>

Data Analysis

SPSS Statistics 21.0 was used to analyze the data with all data entered in aggregate form. Data was assessed for correlation between interval variables of interest. In order to obtain reliability, two scales were amended from their original survey form: cultural health beliefs and body image. Question numbers 15, 22, 26 and 27 were cut from the cultural health belief scale, increasing reliability from .59 to .77. Although the scales for the body image variable were adopted from and were determined to be validated, questions 104, 110, 113, 116, 117, 118 and 119 were reverse coded, reporting .31 reliability. These questions were recoded and tested, reporting .55 reliability. Questions 104 (rc), 110 (rc), 112, 117 (rc), 119 (rc) and 121 were cut
from the scale, increasing reliability to .72. Upon further examination, it was revealed that participant drop-out or no answer would create unreliable results. Respondents were told that their participation was completely voluntary, and participants were only required to answer questions one, two and eight (screening questions), thus the researcher cleaned the data throughout the responses to account for respondent drop out by assigning the number -99 to any response that was left unanswered. All responses coded with -99 were excluded from analysis. After the categorical data was cleaned, a composite score was calculated for each scale which allows for scales to be analyzed as continuous data.

Once reliability was determined for each set of scales, tests for normality were run. Because all of the variables (IV and DV) were reported in scales, correlation and regression analysis were used. The scale for personal health beliefs did not display normality, therefore a Spearman correlation was used for analysis. Because all other scales displayed normality, Pearson correlations were used for all other scales. Significant findings were determined using tests of correlation and regression. Alpha was set at .05 for all tests. All qualitative research associated with the survey was reviewed, coded and assessed by the researcher for use as support for quantitative research findings.

Sample selection

Participants were recruited using pregnancy-related websites (babycenter.com, thebump.com), mommy blogs (birminghammommy.com, tuscmoms.com) and Facebook. As previously discussed, “loyalty to a website is confirmed when a woman signs up to receive weekly e-mails customized to her stage of pregnancy,” (Romano, 2007, p. 19). Thebump.com, babycenter.com, Birminghammommy.com and tuscmoms.com were all selected because of their
membership opportunities, level of member participation and level of forum activity. Members of these forums are generally information seekers and are active in forum participation; therefore, they are more likely to participate in a survey testing their postpartum needs. While participation rates were high for survey responses, the screening questions designed to filter out anyone who did not have a first-time birth experience reduced the number of complete survey participants.
CHAPTER FOUR
RESULTS

Sample

The goal of this study was to determine factors that affect the health and wellness of postpartum women and to gain information regarding ways to improve the postpartum experience. The previously discussed research suggests that there are many factors mediating the health and wellness of postpartum women. But, in order for medical staff and caregivers to provide proper assistance and postpartum advice, they must have an understanding of the needs of a postpartum woman (Logsdon, Wisner, & Pinto-Foltz, 2006). A large problem with postpartum health and wellness, it has been suggested, lies in the educational focus before and during pregnancy, thus allowing unrealistic expectations to linger. The research questions developed as part of this study were used to examine the relationship between mediating factors and health and wellness, with specific regard to needs and expectations. Because of media’s suggested relationship to beliefs and expectations (Gow, Lydecker, Lamanna, & Mazzeo, 2012), the significant contribution of this study details the effects of media on the health and wellness of postpartum women, giving qualitative suggestions for necessary postpartum education. The research questions regarding cultural and personal beliefs, expectations of pregnancy, body image, mediated representations of pregnancy, pregnancy-related websites and pregnancy-related education will be discussed in the results below.

Using the various websites and a snowball sampling technique, 343 participants started the survey. Of the 343, 170 indicated having their first birth experience within the past 15
months, which means those 170 participants completed the entire survey while all other participants were directed to the final five qualitative questions. Because all 343 total participants were able to answer the final five qualitative questions, it was important to consider the entire population in portions of the results to which they were included (Questions 1-8,164-168). Following a brief review of sample statistics, analysis of results will be detailed.

The mean age of respondents was 30 years old ($SD = 6.305$ years), with a reported range from 19 to 42 years old. The gender of respondents was assumed as female and was not requested as a part of the survey since all participants were screened out at question number two if they did not answer that they had given birth in the years 2013 or 2014.

The race of respondents was as follows: American Indian or Alaska Native ($N = 1, .3$ percent), Asian ($N = 4, 1.2$ %), African American ($N = 7, 2.0$ %), Hispanic ($N = 13, 5.4$ %), Native Hawaiian or Other Pacific Islander ($N = 1, .3$ %), White/Caucasian ($N = 314, 91.5$ %), and 4.7 percent of the sample indicated a race other than listed ($N = 16$). Among the 343 participants, 22 reported Hispanic/Latino heritage (6.4 %). The online pregnancy forums (thebump.com, babycenter.com, birminghammommommy.com and tuscmoms.com) do not release demographic information regarding their members so the researcher was not able to assess demographic equivalencies; however, it is acknowledged that the sample is skewed toward Caucasian participants, and this limitation will be noted further in the dissertation.

Among the women studied, the majority of respondents reported being in a married relationship ($N = 289, 84.3$ %). Other responses were as follows: life partner/significant other ($N = 39, 11.4$ %), single ($N = 12, 3.5$ %), separated ($N = 2, .6$ %), widowed ($N = 1, .3$ %). Respondents were also asked to disclose their highest degree or education level. Thirty-six percent of survey participants report having earned a bachelor’s degree ($N = 123$). Twenty-five
percent report a master’s degree (N = 86), followed by 15.5 percent who report some college credit, no degree (N = 53). Other responses were as follows: associate degree (N = 29, 8.5 %), high school graduate/diploma or equivalent (N = 19, 5.5 %), trade/technical/vocational training (N = 12, 3.5 %), doctorate (N = 10, 2.9 %), professional degree (N = 7, 2.0 %) and some high school/no diploma (N = 4, 1.2 %). In order to follow up on cultural health beliefs regarding nature of delivery and recovery, respondents were also asked whether they had a cesarean delivery and if they received an epidural. Of the 343 respondents, 20.1 percent reported a cesarean (N = 69) and 50.1 percent reported receiving an epidural (N = 172).

To better understand the media and technology use of respondents, questions were included on the survey that asked participants about their internet usage (multiple times/day, daily, weekly, monthly, I do not use the internet). Ninety percent of the 170 first-time moms who completed the entire survey (N = 133) reported that they use the internet multiple times/day.

Regression and correlation results

All of the key variables for the present study were scales used to measure the DV. Given that, Pearson correlation coefficients tests and regression analyses were run. Research question one sought to open the study by giving the researcher insight into perceived cultural health beliefs of the population. Understanding that culture fosters beliefs, habits and expectations (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003), this study designed research question one to provide a framework by which qualitative answers could be examined. Because research suggests that culture guides the framework by which an individual forms beliefs (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003), it was expected that cultural health beliefs would significantly impact the health and wellness of the postpartum woman.
However, no significant relationship was determined. Normal distribution was determined for the cultural health beliefs scale (skewness = -.408, kurtosis = -.293) and for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389); therefore, Pearson correlations were used to examine the relationship between cultural health beliefs and the health and wellness of postpartum women. No significant (α = .05) correlations were made between cultural health beliefs and the health and wellness of postpartum women (r(168) = -.102, p = .346 > .05). Therefore, research question 1 found no significant relationship between the extent to which cultural health beliefs are related to the health and wellness of postpartum women.

Research question 2 sought to determine the relationship between personal health beliefs and the health and wellness of postpartum women. As previously discussed, personal beliefs are said to affect health behavior (Rosenstock, 1974) and have been suggested as useful in explaining differences with regard to individual behaviors (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Thus, health educators agree that health programs (and interventions) will be more effective when they are appropriate in plan and design with regard to the beliefs of the populations they serve (Champion, & Skinner, 2008). Correlation and regression analysis was used to determine the relationship between personal health beliefs and the health and wellness of postpartum women.

Although normal distribution was determined for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389), non-normal distribution was determined for the personal health beliefs scale (skewness = -.1.120, kurtosis = -.2.218); therefore, Spearman correlations were used to examine the relationship between personal health beliefs and the health and wellness of postpartum women. Personal health beliefs was based on a 5-item scale with a range of 2.00 to 4.35 and a mean of 3.52 (SD = .41). The health and wellness of postpartum
women was based on a 5-item scale with a range of 3.09 to 5.00 and a mean of 3.90 (SD = .40). Non-parametric correlations were made between personal health beliefs and the health and wellness of postpartum women. Based on the analysis, there were significant (α = .05) positive correlations between personal health beliefs and health and wellness of postpartum women (r(109) = .487, p = .000 < .05). The results for research question 2 suggested that there was a positive, significant relationship between personal health beliefs and the health and wellness of postpartum women. This finding suggests that, for this study, postpartum women’s personal health beliefs are related to the management of health and wellness after giving birth.

After determining a significant relationship, a univariate linear regression analysis was run to determine if personal health beliefs could be used to predict the health and wellness of postpartum women (β = .510, t(111) = 4.747, p < .05). The regression analysis was significant (p = .000 < .05). The total variance (R²) was explained at 23 percent, with a positive unstandardized coefficient (β = .510). Standard error was reported at .107 and slope at 2.131. Based on results of the regression analysis, personal health beliefs can be used to predict the health and wellness of postpartum women.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE(B)</th>
<th>β</th>
<th>t</th>
<th>Sig. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal health beliefs</td>
<td>.510</td>
<td>.107</td>
<td>.483</td>
<td>4.747</td>
<td>.000</td>
</tr>
</tbody>
</table>

Note. 
R² = .233

Additionally, the researcher found no significant relationship between cultural health beliefs and personal health beliefs. The lack of significance between cultural and personal health beliefs suggests an opportunity for future research in the area of formation of personal health beliefs,
which will be discussed in chapter five.

As previously discussed, cultural expectations are that pregnancy is easy, natural, and enjoyable (Hoffnung, 1989; Nicholson, 1990; Beck, 2002a). Despite the stereotypes or old wives’ tales about pregnancy being easy, most women who have had a baby understand that the experience is not always smooth or easy. However, many women start their pregnancy with this cultural belief or expectation about the process. Given that, research question 3 examines how these cultural expectations regarding pregnancy are related to an individual’s health and wellness.

A correlation analysis was used to examine the relationship between perceived cultural health beliefs and the health and wellness of postpartum women. Normal distribution was determined for the cultural expectations for pregnancy scale (skewness = -.447, kurtosis = -.004) and for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389), therefore Pearson correlations were used to examine the relationship between cultural expectations for pregnancy and the health and wellness of postpartum women. No significant (α = .05) correlations were made between cultural expectations for pregnancy and the health and wellness of postpartum women (r(125) = -.159, p = .131 > .05); thus, research question 3 suggests that, with regard to the present sample, there is not a significant relationship between a woman’s perceptions of cultural expectations for pregnancy and her health and wellness. This finding concurs with previous literature regarding American culture, which suggests that adoption of new beliefs and ideas is a possibility; however, it is the implementation of those new beliefs that will actually create new perceptions and expectations that will evoke change.

Research question 4 sought to determine what role body image played in the health and wellness of postpartum women. According to the National Organization on Women and Body
Image, American women get an average of forty negative messages a day about their bodies (Northrup, 2010), and many women have come to believe that their bodies are objects by which they are evaluated (Muehlenkamp & Saris-Baglama, 2002). Jones (2001), suggests that women feel pressure by their peers to conform to thin ideals; however, previous research by Jordan, Capdevila, and Johnson (2005) suggested that while body image is one concern, there are other issues (i.e., new stress, greater importance of children and family and lack of personal space) that cause body image to become of unpredictable importance for many new mothers. Research question 4 was posited for the purpose of clarification on body image and pregnancy in order to strengthen the educational support for postpartum women.

Correlation and regression analysis were used to examine the relationship between body image and the health and wellness of postpartum women. Normal distribution was determined for the body image scale (skewness = .088, kurtosis = .345) and for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389); therefore, Pearson correlations were calculated to examine the relationship between body image and the health and wellness of postpartum women. The body image scale was based on a 7-item scale with a range of 1.00 to 5.69 and a mean of 3.29 (SD = .80), with a higher number representing more positive or favorable body image. The health and wellness of postpartum women was based on a 5-item scale with a range of 3.09 to 5.00 and a mean of 3.90 (SD = .40). Significant (α = .05) negative correlations were found between body image and the health and wellness of postpartum women (r(129) = -.227, p = .028 < .05); therefore, research question 4 suggests that there was a significant (negative) relationship between body image and the health and wellness of postpartum women.
Additionally, a univariate linear regression analysis was run to determine if body image could be used to predict the health and wellness of postpartum women ($\beta = -0.109$, $t(131) = -2.237$, $p < .05$). The regression analysis showed significance ($p = .028 < .05$). The total variance ($R^2$) was explained at five percent with a negative unstandardized coefficient ($\beta = -0.109$). Standard error was reported at .049 and slope at 4.261. Based on results of the regression analysis, body image can be used to predict the health and wellness of postpartum women. And, as confirming support for the correlation analysis, body image is a significant, negative predictor of the health and wellness of postpartum women.

Research question 5 was composed with the intent to gauge the effects of mediated representations of pregnancy on expectations for pregnancy. Current entertainment media and entertainment media research often inundate pregnant women with information regarding celebrity pregnancies and recovery. This type of media content could lead a pregnant woman to feel less positive about her own pregnancy-related experience, if the celebrity pregnancies seem glorified or more positive. Additionally, these images and messages assist in creating unrealistic expectations for pregnancy and the postpartum period. Current media and body image research reports that women compare themselves with body image or appearance standards presented in the media (Strahan, et al., 2008). These findings are attributed to the fact that magazines, advertisements, movies and television series are filled with images of (ultra-thin, young, attractive) women (O'Brien, 2012). These comparisons flow into the realm of pregnancy and body image where current research suggests that postpartum expectations – on a personal and cultural level – are influenced by mediated representations of pregnancy (Gow, Lydecker, Lamanna, & Mazzeo, 2012).

A correlation analysis was used to examine the relationship between mediated
representations of pregnancy and cultural expectations for pregnancy. Normal distribution was
determined for the cultural expectations for pregnancy scale (skewness = .088, kurtosis = .345)
and for the scale of mediated representations of pregnancy (skewness = -.612, kurtosis = -.078);
therefore, Pearson correlations were calculated. No significant (α = .05) correlations were made
between mediated representations of pregnancy and cultural expectations for pregnancy (r(127)
= .137, p = .168 > .05) which suggests that cultural expectations for pregnancy were not
significantly related to mediad portrayals of pregnancy. The results of the non-significant
relationship between mediated representations of pregnancy and cultural expectations for
pregnancy will be discussed in chapter five.

Although cultural expectations for pregnancy were not significantly related to mediated
representations of pregnancy, the researcher found that the variable of health and wellness of
postpartum women was significantly related to mediated representations of pregnancy. Tests of
correlation and regression were used to examine the relationship between mediated
representations of pregnancy and the health and wellness of postpartum women. Normal
distribution was previously determined for the scales (mediated representations of pregnancy:
skewness = -.612, kurtosis = -.293; health and wellness of postpartum women: skewness = .142,
kurtosis = -.389); therefore, Pearson correlations were calculated to examine the relationship
between mediated representations of pregnancy and the health and wellness of postpartum
women. The mediated representations of pregnancy scale was based on a 5-item scale with a
range of 1.50 to 4.14 and a mean of 3.05 (SD = .52). The health and wellness of postpartum
women was based on a 5-item scale with a range of 3.09 to 5.00 and a mean of 3.90 (SD = .40).
Significant (α = .05) correlations were found (r(127) = .230, p = .039 < .05). Results from this
test found that mediated portrayals of pregnancy were a significant predictor of (positive) health
and wellness in the postpartum women in this sample, suggesting greater exposure to mediated portrayals of pregnancy is related to more positive/favorable health and wellness. A univariate linear regression analysis reported a significant relationship between mediated representations of pregnancy and the health and wellness of postpartum women ($\beta = .190$, $t(129) = 2.098$, $p < .05$). A regression analysis showed significance ($p = .039 < .05$) between the two variables with a total variance ($R^2$) explained at 5 percent and a positive unstandardized coefficient ($\beta = .190$). Standard error was reported at .091 and slope at 3.319. Based on results of the regression analysis, mediated representations of pregnancy can be used to predict the health and wellness of postpartum women.

Additionally, the researcher found significant relationships between mediated representations of pregnancy and body image. Tests of correlation and regression were used to examine the relationship between mediated representations of pregnancy and body image. Normal distribution was previously determined for the scales (mediated representations of pregnancy: skewness = -.612, kurtosis = -.293; body image: skewness = .088, kurtosis = .345); therefore, Pearson correlations were calculated to examine the relationship between mediated representations of pregnancy and body image. The mediated representations of pregnancy scale was based on a 5-item scale with a range of 1.50 to 4.14 and a mean of 3.05 ($SD = .52$). The body image scale was based on a 7-item scale with a range of 1.00 to 5.69 and a mean of 3.29 ($SD = .80$). Significant ($\alpha = .05$) correlations were found ($r(129) = .305$, $p = .002 < .05$).

A univariate linear regression analysis reported a significant ($p = .002 < .05$) relationship between mediated representations of pregnancy and body image ($\beta = .506$, $t(131) = 3.230$, $p < .05$). The total variance ($R^2$) was explained at 9 percent with an unstandardized coefficient ($\beta = .506$). Standard error was reported at .157 and slope at 1.752. Based on results of the regression
analysis, mediated representations of pregnancy can also be used to predict body image.

Health information not only comes from doctors, books, friends, family or media, it also comes from the Internet. As previously discussed, current research suggests that health information is one of the primary factors driving internet usage (Hurley, Kosenko, & Brashers, 2011) and that a large majority of childbearing women use the Internet for information, questions and opinions (Romano, 2007). Additionally, the Internet was rated as the most important source of information for 16 percent of first-time moms and 13 percent of moms of more than one child (Romano, 2007). Thus, research question 6 was developed to examine the relationship between pregnancy-related websites and the health and wellness of postpartum women.

A correlation analysis was used to examine the relationship. Normal distribution was determined for the pregnancy-related websites (skewness = -1.031, kurtosis = 1.749) and for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389); therefore, Pearson correlations were calculated to examine the relationship between pregnancy-related websites and the health and wellness of postpartum women. No significant ($\alpha = .05$) correlations were found between pregnancy-related websites and the health and wellness of postpartum women ($r(126) = .023, p = .825 > .05$). Although current research suggests that more than three-fourths of childbearing women use the Internet for information regarding pregnancy and birth, the correlation analysis suggests that pregnancy-related websites do not have a significant relationship on the health and wellness of postpartum women in this sample.

Research question 7 was designed to be answered with qualitative and quantitative responses in order to most effectively bring awareness to the pregnancy-related education that is needed to promote change in the health and wellness of postpartum women. The researcher began by conducting tests of correlation and regression to determine what role and relationship
pregnancy-related education plays in the health and wellness of postpartum women. Previous results from research question two suggest that there was a significant relationship between personal health beliefs and health and wellness. Additionally, previous literature suggests that it is the implementation of new beliefs that will actually evoke change; therefore, it was central to the study to determine not only the relationship between pregnancy-related education and health and wellness, but to also define specific needs in pregnancy-related education material as indicated by postpartum women.

Correlation and regression analysis were used to examine the relationship between pregnancy-related education and the health and wellness of postpartum women. Normal distribution was determined for the pregnancy-related education scale (skewness = -.762, kurtosis = .382) and for the scale of health and wellness of postpartum women (skewness = .142, kurtosis = -.389); therefore, Pearson correlations were calculated to examine the relationship between pregnancy-related education and the health and wellness of postpartum women. The pregnancy-related education scale was based on a 5-item scale with a range of 1.17 to 5.00 and a mean of 3.74 (SD = .82). The health and wellness of postpartum women was based on a 5-item scale with a range of 3.09 to 5.00 and a mean of 3.90 (SD = .40). Significant (α = .05) correlations were made between pregnancy-related education and the health and wellness of postpartum women (r(127) = .310, p = .002 < .05); therefore, research question 7 suggests that there is a significant relationship between pregnancy-related education and the health and wellness of postpartum women.

Additionally, a univariate linear regression analysis was run to determine if pregnancy-related education could be used to predict the health and wellness of postpartum women (β = .149, t(129) = 3.141, p < .05). The regression analysis showed significance (p = .002 < .05). The
total variance ($R^2$) was explained at 10 percent with an unstandardized coefficient ($\beta = .149$). Standard error was reported at .047 and slope at 3.339. Based on results of the regression analysis, pregnancy-related education can be used to predict the health and wellness of postpartum women. Even if an individual is fairly set in his/her ways or mindset, previous literature regarding American culture suggests the adoption of new ideas or beliefs is possible (Sniehotta, Scholz, Schwarzer, 2005). Subsequently, it is important to examine what postpartum women think and believe regarding the need for pregnancy-related education. Therefore, conveying the importance for the qualitative component of research question 7 – what education is needed to promote change?

From the 343 total participants in the survey, 164 women responded to the qualitative portion (questions 164-168) of the survey. All five of the qualitative questions were used for analysis as support for research question seven. The questions asked respondents to report their opinions on the content of their postpartum education and give suggestions for improvement. They were also asked to give their opinions on factors contributing to them making healthy decisions in the postpartum period. The responses were reviewed by the researcher and codes were then created to characterize major themes. Each response was assigned a code based on content. Statements with similar codes were gathered together, and major themes were derived. A total of four major themes were identified: how information was presented, information needs, postpartum depression (PPD), and factors involved in postpartum health.

When asked about the content of their postpartum education, the participants, for the most part, noted a lack of information regarding what to expect following the birth of their child. Several participants noted there was little discussion about the postpartum period, especially PPD, while several others noted their education or information was received via a pamphlet or
brochure but not through a conversation with their healthcare provider. Additionally, a few participants noted that the extent of the postpartum conversation they had with their healthcare provider was based around insurance forms for the hospital, and the needs of the healthcare provider.

When asked their opinions on the information they feel women should receive before the postpartum period, the majority of respondents noted that they needed more information about what to expect from their body with regard to weight loss, bleeding, healing from tears or cesarean delivery, PPD, hemorrhoids, mastitis, breastfeeding and exercise. Many participants noted that they did not even know what to expect immediately after birth and felt lost when it was time to breastfeed or to go home and care for themselves in addition to a new baby. The discussion of PPD was prevalent in most responses as a much-needed addition to the pre-delivery conversation with a healthcare provider.

Participant: “It isn't anything cute like 'weepies' or "baby blues": it is full on depression. Women should know this.”

Respondents also noted that, although the hospital provided them with some information before they checked-out, it was not appropriate in time or situation with regard to what they were experiencing two/three days post-birth.

When discussing the factors involved in postpartum healthy decision making, the majority of the sample noted that time was the main problem they found that kept them from being able to successfully make healthy decisions. Time was closely followed by money and support. Most of the participants noted that the help of friends, family or co-workers was needed to get through the postpartum period and adjustment to changes for the mother and also for the new family unit. Respondents also noted that expectations played a large role in their perceptions
of the postpartum period. These women felt that if they had been given information regarding what to expect, they would not have been so surprised when things did not go as planned. The main request that most every respondent noted was knowledge. These women asked for knowledge of the postpartum period, knowledge of symptoms of concern and knowledge of the reality of motherhood, changes and care.

Table 3 displays the correlation matrix and descriptive statistics for all of the variables in the study. A Pearson correlation was used to assess the relationship among variables. Previously discussed findings suggested that pregnancy-related websites were not significantly related to the health and wellness of postpartum women. However, as noted in table 3, findings for pregnancy-related websites become significantly related to the health and wellness of postpartum women when controlling for other variables. This finding suggests that pregnancy-related websites do have a positive relationship with the health and wellness of postpartum women when examined with mediating variables. Reasons for this change of significance when controlling for other variables will be further discussed in chapter five.
The goal of this study was to determine factors that affect the health and wellness of postpartum women. As previously discussed, research suggests that proper maternal care should be given prior to, during and after pregnancy (Northrup, 2010). However, in order for medical staff and caregivers to provide proper assistance and postpartum advice, they must not only have an understanding of the needs of a postpartum woman (Logsdon, Wisner, & Pinto-Foltz, 2006), they must also understand the effects of expectations for pregnancy and the drivers of those expectations.

Post hoc test of regression analysis were run for each dependent variable (individually) to determine the relationship to the independent variables related to the study. This was done in order to determine if, when examined as a group, additional predictability would result. When

<table>
<thead>
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<th>Variables</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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<td>.223*</td>
<td>.014</td>
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<td>.022</td>
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<td>.230*</td>
<td>-.227*</td>
<td>.023</td>
<td>.310**</td>
<td>.483**</td>
<td>.159</td>
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<tr>
<th>M</th>
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<td>SD</td>
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<td>.52</td>
<td>.80</td>
<td>.75</td>
<td>.82</td>
<td>.41</td>
<td>.48</td>
<td>.40</td>
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</table>

**Correlation is significant at the 0.01 level (2-tailed)  
*Correlation is significant at the 0.05 level (2-tailed)
examined with cultural expectations for pregnancy, significant findings were reported for cultural health beliefs ($p = .002 < .05$) and for body image ($p = .044 < .05$). When examined with the health and wellness of postpartum women, significant findings were reported for personal health beliefs ($p = .000 < .05$), pregnancy-related websites ($p = .040 < .05$) and for pregnancy-related education ($p = .003 < .05$). Table 4 and 5 below illustrates the findings of the regression analysis by dependent variable.

Table 4. Post Hoc Regression Analysis: Cultural Expectations for Pregnancy

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE(B)</th>
<th>$\beta$</th>
<th>$t$</th>
<th>Sig. ($p$)</th>
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</thead>
<tbody>
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<td>.101</td>
<td>.385</td>
<td>3.183</td>
<td>.002</td>
</tr>
<tr>
<td>Body image scale</td>
<td>.183</td>
<td>.089</td>
<td>.260</td>
<td>2.062</td>
<td>.044</td>
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</tbody>
</table>

Note.  
$R^2 = .255$

Table 5. Post Hoc Regression Analysis: Health and Wellness

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE(B)</th>
<th>$\beta$</th>
<th>$t$</th>
<th>Sig. ($p$)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>.453</td>
<td>3.920</td>
<td>.000</td>
</tr>
<tr>
<td>Pregnancy-related websites</td>
<td>.136</td>
<td>.065</td>
<td>.257</td>
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<td>.040</td>
</tr>
<tr>
<td>Pregnancy-related education</td>
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<td>.051</td>
<td>.360</td>
<td>3.185</td>
<td>.003</td>
</tr>
</tbody>
</table>

Note.  
$R^2 = .471$

Although previous findings related to this study did not suggest a relationship between cultural health beliefs, cultural expectations and pregnancy-related websites on the health and wellness of postpartum women, when examined together with all variables related to the study, these findings suggest that cultural health beliefs and body image could be used to predict cultural
expectations for pregnancy. Additionally, these findings suggest that personal health beliefs, pregnancy-related websites and pregnancy-related education could be used to predict the health and wellness of postpartum women.

A large problem with postpartum health and wellness, it has been suggested, lies in the educational focus before and during pregnancy. This lack of education is suggested to contribute to false expectations regarding many factors related to pregnancy and the postpartum period. Whether related to expectations or realities, a better understanding of factors affecting postpartum health and wellness will help guide pregnancy-related education, beliefs and behaviors.
CHAPTER FIVE
DISCUSSION

‘Whether your pregnancy was meticulously planned, medically coaxed, or happened by surprise, one thing is certain - your life will never be the same.’

- Catherine Jones, (Eating for Pregnancy, 2009)

The goal of this study was to determine factors that affect the health and wellness of postpartum women and to report relevant information regarding postpartum needs for the development of necessary pregnancy and postpartum education. Through six carefully crafted research questions, this study sought to verify previous claims regarding postpartum health and to also bring awareness to postpartum needs not yet discussed in communications literature. Because research suggests that media fosters beliefs, opinions and expectations (Yanovitzky & Stryker, 2001; Lapinski & Rimal, 2005), it is important to understand the role of media in the development or influence of personal health beliefs. These personal health beliefs have been found by this study, as well as previous research, to play a role in health behaviors and healthy outcomes.

Some U.S.-based research suggests that Americans do not see (or report) themselves as being affected by culture. As Hofstede found, Americans generally think of themselves as highly individualistic and without need for approval by the whole (Jetten, Postmes & McAuliffe, 2002). This individualism suggests that personal health beliefs are the best way to influence an
individual in order to alter health behaviors. However, research has found that while Americans feel that they are highly individualistic, their version of individualism revolves around the cultural (or societal) norm.

Because media have been suggested as a cultivator of societal norms and expectations, it is important to study the influence of media on cultural and personal expectations. While communications literature has been devoted to this topic (Yanovitzky & Stryker, 2001; Lapinski & Rimal, 2005), minimal research has studied the effects of media as it relates to pregnancy and the health and wellness of postpartum women. This study contributes to communications research by gaining knowledge of media effects as they pertain to cultural and personal pregnancy-related expectations, and increases knowledge by addressing the needs in postpartum education that will influence and potentially change expectations and behaviors.

Based on the research questions, factors considered in this study were: (1) cultural health beliefs, (2) personal health beliefs, (3) postpartum women’s perceived cultural expectations of pregnancy, (4) body image, (5) mediated representations of pregnancy, (6) pregnancy-related websites, and (7) pregnancy-related education.

The review of current literature began with research in the area of defining health and wellness because of the myriad of definitions and descriptions offered for each. While there are many definitions of health and wellness, the WHO definition is still widely used and accepted as a primary definition. The WHO declared that health is the, “state of complete mental, physical and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1948). The Department of Health and Human Services Healthy People (2020) provides a national framework for promoting health and a more positive quality of life for all members of society. They suggest that an individual’s health status falls within five dimensions of health: physical,
mental, emotional, social and spiritual. These dimensions are easily connected to an individual’s beliefs about health. As previously discussed in the literature review, individual beliefs are reportedly fostered by culture (Becker & Murphy, 2009) and have also been suggested as a useful tool for explaining differences with regard to individual behaviors. More simply, an individual’s belief system about a health issue such as pregnancy may certainly be related to the way the same individual manages his/her health. Therefore, research questions 1 and 2 were developed to investigate cultural and personal health beliefs and their effect on postpartum health and wellness. Cultural health beliefs can be developed in many ways, and this is one of the places where the media component is crucial. Given the current media landscape, it is difficult to extract media from any type of issue, especially health, with the number of mediated messages about health that are disseminated. From fictional stories found in entertainment media about a woman’s pregnancy to (potentially) scarier news stories about complications related to pregnancy or social media forums used by individuals seeking out specific information, we are bombarded with messages about health.

The results of this study suggested that there was no significant relationship between cultural health beliefs and the health and wellness of postpartum women, but the results did report a strong significant relationship between personal health beliefs and the health and wellness of postpartum women. An additional test of regression analysis found that personal health beliefs are a moderately strong predictor of the health and wellness of postpartum women. Personal health beliefs are all of the beliefs that an individual has regarding their personal health and their personal health behaviors. These beliefs will not only affect current and future health behaviors, but the outcome of an individual’s health and wellness. Therefore, understanding the
formation of these beliefs will be of benefit to researchers as they explore pregnancy and postpartum health and wellness.

As previous research has reported, a postpartum woman’s beliefs are fostered by culture; however, for women of this study, those cultural health beliefs do not reportedly relate to their health and wellness as do their personal health beliefs. This could be due to the individualistic nature of American culture, as Hofstede found, or because the definition of cultural health beliefs is continuously evolving; therefore, this finding calls for future research in the area of cultural health beliefs and will be addressed later in chapter five. It is important for researchers to understand what cultivates personal health beliefs and is also the reason for the selection of the health belief model as a theoretical component of this study.

Much of the research in the area of pregnancy and postpartum is found in health journals, but in order to look at the relationship from a different perspective, it was important to consider the way postpartum women felt culture influenced their own behavior as it related to health. Cultural and personal health beliefs were followed by research examining cultural expectations for pregnancy and the postpartum period in order to provide verification for previous findings regarding expectations for pregnancy and the postpartum period.

Hofstede’s research on culture suggests that when comparing the United States with other cultures, Americans, as a culture, ranked themselves very high (91/100) in Individualism – meaning Americans are not necessarily concerned with what others around them are doing. This suggestion supports findings from research question 1 that reports no significance between cultural health beliefs and the health and wellness of postpartum women. Because Americans seem to think that they are individualistic, results from this study suggest that these women do not associate cultural health beliefs with their health and wellness. The results of research
question 2 suggest that these women do consider their personal health beliefs to influence their health and wellness; therefore, maintaining an individualistic influence in personal health behaviors. Additionally, results of research question 3 suggest that there is no significance in perceived cultural expectations and the health and wellness of postpartum women. This finding simply agrees with research question 1 in finding that these women do not believe that culture, or cultural expectations, has an effect on their health and wellness.

While differences in expectations and realities have long been a suggested problem with pregnancy and the postpartum period (Nicholson, 1990), many women report that there is a level of expectation that is always different from what becomes a reality with motherhood (Beck, 2002a). Additionally, previous research suggests that women report feeling disillusioned with new motherhood when they feel that they have failed to fulfill personal expectations (Buultjens, & Liamputtong, 2007). With regard to pregnancy and the postpartum period, the questions now become, what influences personal expectations and what makes them different from cultural expectations. These questions will be addressed later in chapter 5 under future research.

In keeping with the role of culture and health beliefs, research question 4 examined the relationship between body image and the health and wellness of postpartum women. Previous research suggests a significant relationship between media and cultural expectations for body image, as well as a relationship between media and pregnancy-related body image. Research findings from this study suggested an interesting, negative relationship between body image and the health and wellness of postpartum women. This research implies that as body image increases, the health and wellness of postpartum women decreases. As a woman feels better about her body, or as she begins to see her body image in a more positive manner, her health and wellness is found to be on the decline. For example, a woman could be decreasing her nutritional
intake or increasing her exercise routine beyond what is healthy in order to meet or maintain a body image she deems appropriate; therefore, causing a decrease in her health and wellness. A significant, negative correlation confirms previous pregnancy and postpartum body image research suggesting that there is great pressure in Western society to be and remain slim (Muehlenkamp & Saris-Baglama, 2002), and this pressure has been determined to reach into pregnancy-related body image as well (Lederman, 1996). Dissatisfaction with body image has been associated with self-esteem issues, depression, anxiety and unhealthy eating habits, all of which could negatively affect a pregnant or postpartum woman (Green & Pritchard, 2003; Stice & Whitenton, 2002). Findings related to this study confirm that body image and body image concerns remain in the forefront of the mind of many postpartum women. When asked about the content of their postpartum education, participants of this study reported wanting to know more about their postpartum body, understanding physical changes, healthy expectations about weight loss and getting their pre-pregnancy body back, as evidenced by the following quote from one of the respondents:

Respondent: “My doctor told me not to gain too much weight because it would be hard to get off.”

American culture tells women that they cannot gain weight, regardless of the circumstances. Even though it is natural and expected to gain weight while pregnant, women are still cautioned about the consequences of weight gain. This leads some pregnant women to worry more about the number on the scale than the nutrients that their unborn baby may be receiving. Current research in the area of media and body image demonstrates that women compare themselves with the (unrealistically high) standards presented in the media (Strahan, et al., 2008). Additionally, studies have shown a direct relationship between media exposure and body
dissatisfaction (Levine, & Murnen, 2009), which has been suggested to affect pregnancy and postpartum body image. Because of the role that media plays in the development of positive or negative body image, research question 5 sought to examine the relationship between exposure to mediated representations of pregnancy and women’s expectations for pregnancy.

A recent content analysis (of three celebrity magazines) suggests that postpartum expectations – on a personal and cultural level – are influenced by mediated representations of pregnancy (Gow, Lydecker, Lamanna, & Mazzeo, 2012). However, since 1996, there has been very little research, and almost nothing found in social science journals using empirical methods, regarding perceptions and expectations of pregnancy and the postpartum period. The role of media in shaping a woman’s self-perception has been substantiated, yet no literature exists in mass communication or communication journals with regard to pregnant or postpartum women. Correlation and regression analysis from this study suggest no significant relationship between mediated representations of pregnancy and expectations for pregnancy. Participants were asked questions regarding celebrity and entertainment media (i.e., People) and informational media (i.e., Fit Pregnancy) to confirm the source of their mediated representations of pregnancy.

Although cultural expectations for pregnancy were not significantly related to mediated representations of pregnancy, a correlation and regression analysis reported significance when mediated representations of pregnancy were compared with the health and wellness of postpartum women. Albeit the regression analysis reports a weak influence, the significance suggests that mediated representations of pregnancy or postpartum celebrity women do play a role in the health and wellness of postpartum women – most likely as related to an additional finding of this study which links mediated representations of pregnancy and body image.
Current research suggests that pregnancy-related expectations and perceptions are not just formed through media usage but also from the Internet, which has been found as an important variable when researching health information (Hurley, Kosenko, & Brashers, 2011) because of its broad usership and ability to reach diverse populations (Zarcadoulas, 2011). And, as previously discussed, more than three-fourths of childbearing women reportedly use the Internet for information regarding pregnancy and birth (Romano, 2007). Additionally, findings suggest that the time in-between a discovered pregnancy and the first pre-natal visit is reportedly spent gaining information from internet forums and baby blogs (Larsson, 2007). Because much of the current research with regard to Internet and pregnancy ends with the pregnancy period, research question 6 examined the relationship between the Internet and the health and wellness of postpartum women.

This study found no significant correlation between pregnancy-related websites and the health and wellness of postpartum women. While Internet usage is not reported to affect the health and wellness of postpartum women, qualitative responses from this study reveal potential reasons why. Before the first baby is born, a woman will have plenty of questions (whether or not she asks her healthcare provider) and will also have a considerable amount of time that she can more freely devote to pregnancy and birth research than after the baby is born. The majority of respondents answering the open-ended questions revealed that time was a major factor during the postpartum period. Additionally, the lack of postpartum education presented during the prenatal appointments regarding what to expect leaves women at a loss for specific recovery research. Many respondents reported needing support of family, friends, co-workers and mommy groups (which are also offered online); however, many of the women reporting this as a need also suggested that they wished they had found a support group earlier in their postpartum
period, and that they will be better prepared to look for support in future pregnancies and postpartum experiences. The findings from research question 6 could merely be respective of this particular sample, or a product of the individualistic feelings that were suggested from the previous research, or even due to a lack of time for Internet research during the postpartum period. However, table 3 (above) reported correlation coefficients for all variables when examined together and suggested that pregnancy-related websites do have a significant relationship on the health and wellness of postpartum women. Finding that pregnancy-related websites do have a significant relationship to the health and wellness of postpartum women when mediating variables are considered suggests that things such as body image, mediated representations of pregnancy, pregnancy-related education and health beliefs could indirectly influence the way that pregnancy-related websites are used and internalized by pregnant and postpartum women. In a direct correlation, pregnancy-related websites are not related to the health and wellness of postpartum women because these websites are used for reasons that many women would consider as informational and not as a factor in their health and wellness. It stands to reason that women believing that they are individualistic by nature, reporting that cultural health beliefs do not affect their health and wellness, would also believe that their personal health beliefs are not influenced by pregnancy-related websites. However, when mediated by concerns that influence the health and wellness of postpartum women, these pregnancy-related websites not only disseminate information, but also potentially influence health beliefs and behaviors. The findings related to this study indicate the need for more research in the area of postpartum Internet usage, which will be discussed later in chapter 5 under future research.

From a review of the previous six research questions regarding factors that affect the health and wellness of the postpartum woman, it is evident that there are outside influencers
affecting postpartum perceptions and expectations. Additionally, there seems to be a gap in the postpartum education given to prenatal women, therefore enlarging the disparity between postpartum perceptions and realities. Educational interventions, both necessary and helpful, are more easily implemented when specific factors related to beliefs (perceived threat, benefits, barriers and cues to action) are considered. The creation and continuous presentation of messages regarding postpartum health and wellness could eventually change and update beliefs, behaviors and decisions (both culturally and individually) on the necessity of wellness and prevention. If an ounce of prevention really is worth a pound of cure, then providing information, assistance and care for prenatal and postpartum women should be of great importance to medical educators and professionals. With the current literature in mind, this study sought to answer research question 7 – What pregnancy-related education is needed to promote change in health and wellness of postpartum women?

The researcher conducted correlation and regression analyses to first examine the relationship between pregnancy-related education and the health and wellness of postpartum women. Significant findings suggested a positive correlation as well as predictive ability for pregnancy-related education on the health and wellness of postpartum women. The results of this research question suggest the importance for the qualitative component of research question 7 as it examined the specific education needed to promote positive change in the health and wellness of postpartum women. Figure 1 below was designed for this study to illustrate how the postpartum factors associated with this study are potentially related to the health and wellness of postpartum women.
From the 343 total participants in the survey, 164 women responded to the qualitative portion (questions 164-168) of the survey. All five of the qualitative questions were used for analysis as support for research question seven. Participants were candid and open with their experiences as they conveyed information that could have helped to create a more positive postpartum experience. The majority of participants reported receiving little to no postpartum education in their prenatal visits with their healthcare provider. Some reported receiving brochures or pamphlets with some information, and few reported having an actual conversation with their healthcare provider regarding the postpartum period. When asked what constitutes an adequate education regarding the postpartum period, participants reported wanting to know more about: body changes, time period for healing (from both vaginal and cesarean deliveries), PPD, expectations of motherhood, bleeding and breastfeeding, along with a number of other individually addressed issues or complications.

Based on a first-time postpartum experience, respondents indicated suggestions for positive changes in the postpartum period. The majority of women associated with this study reported that they needed more knowledge regarding the myriad of factors surrounding the
postpartum period. The sample associated with this study mostly consisted of Caucasian, educated, married women. If these women felt that they did not have the proper knowledge to most successfully navigate the postpartum period, what does that mean for other populations? Additionally, what does that say about the nature of postpartum healthcare in the United States?

This lack of preparation or sense of false expectations for the postpartum period could be largely attributed to the cultural picture that is painted of pregnancy and the postpartum period, through media, cultural expectations and passed down cultural health beliefs. It is possible that whether or not they understand the influence, there is some outside influencer that helps shape and guide personal health beliefs and behaviors and expectations. These beliefs, behaviors and expectations potentially translate to the health and wellness of the postpartum woman creating a potentially negative experience. As one respondent put it:

“I believe that your OBGYN should have a visit to discuss only what to expect after delivery. I woke up very anxious 2 days after delivery and couldn't stop crying, I had no idea that this was normal. I didn’t expect the baby blues or PPD to be so bad! Nor did I expect being a mom to be so tough--it took me longer than I thought to adjust properly.”

Many of the women associated with this study expressed common concerns as it relates to postpartum health and wellness—lack of time, lack of sleep, lack of support from family and friends and lack of understanding of what to do. Additionally, many of the respondents noted symptoms of PPD or diagnosed PPD but reported having a lack of knowledge regarding symptoms and care. In our culture, it does not seem acceptable to suffer from depression, it does not seem acceptable to have issues with mental health following the birth of your baby, and it is not (socially) acceptable to experience feelings that maybe you do not like your baby or you resent your baby. PPD does affect many women, but like depression and related mental health
issues, women are told to remain quiet on the topic. The same could be said about body image. Women feel pressure to look perfect all the time, and there is a misleading expectation that a woman’s pregnancy and postpartum body will look just like a thin-ideal celebrity body as seen on TV or in entertainment magazines. The women associated with this study report having false expectations as to recovery period, postpartum body, and PPD. There seems to be a disconnect between expectations and reality potentially based on the entertainment news that is seen on an almost daily basis. Respondents noted that they felt pressure to be a new mother who looked like she had it all together (with regard to body image, breastfeeding, mental health and completing daily tasks) but they noted that they didn’t even begin to understand how to handle all of the challenges, therefore, creating feelings of failure, sadness and disappointment. This study confirms the need for advancing knowledge and research in the area of postpartum health and wellness. If women have these perceptions and expectations, research needs to focus on where they originate.

Based on the results of a post hoc linear regression analysis to determine the relationship of each independent variable in the study to both dependent variables of this study (respectively), the “Big Picture” model illustrated below in figure 2, conveys the importance of research concerning the media’s relationship to the “big picture” of the health and wellness of postpartum women. Each factor surveyed regarding the health and wellness of postpartum women is presented with its personal relationship value to the whole.
For the future, we need to consider how these factors and a lack of knowledge shape women’s postpartum health and wellness as well as their expectations for the postpartum period. This knowledge that they desire has the potential to filter into most every factor affecting postpartum health and wellness, and it is knowledge that will help guide beliefs, expectations, and outcomes. Previous research suggests that knowledge will affect an individual’s beliefs and behaviors (Weinstein & Nicolić, 1993; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). And, if knowledge will affect beliefs and behaviors, previous research by Northrup (2010) confirms predictive change, because the body (individual) has the ability to change as it learns and grows.
Theoretical and practical implications

Constructs of the health belief model (HBM) and social comparison theory (SCT) were selected for explaining this study and furthering knowledge in the area of media effects with regard to the health and wellness of postpartum women because of their practical implications from both a health and media perspective.

The HBM is most commonly used today in health education and promotion to explain why people do not engage in healthy behaviors. As previously discussed, this model suggests that personal beliefs impact health behavior and that health behavior is determined by personal beliefs about a disease/condition and the strategies available to decrease its occurrence. The HBM suggests that there are five beliefs that influence a person’s willingness to take action: (1) perceived threat, (2) perceived benefits, (3) perceived barriers, (4) cues to action and (5) self-efficacy.

*Perceived threat* (susceptibility and severity) suggests that individuals must believe that they are susceptible to the condition, and that they are at risk. In the case of health and wellness of postpartum women, healthcare providers need to spend time ensuring that a pregnant woman has a good general understanding of what to expect in the postpartum period. The lack of postpartum understanding, as reported by participants in this study, further complicates expectations for the postpartum period and in turn affects preparations, behaviors, and ultimately the health and wellness of the postpartum woman.

*Perceived benefits* means that people must believe taking action would reduce their susceptibility to a condition or its severity, therefore, changing their opinion of the usefulness of a new behavior in decreasing risk. With regard to the health and wellness of postpartum women, health educators play an important role in clearly defining health behaviors (nutrition, exercise).
that affect not only the mother, but also the child and family unit. For most of the participants, time was reported as the main factor in their ability to make healthy decisions. While healthcare professionals cannot change the time requirement after giving birth, they can offer suggestions to make other areas of adjustment easier, so that time might be freed for the mother. Participants also conveyed “money” as a factor that contributes to them making healthy decisions (with regard to nutrition); therefore it is important to educate postpartum women on cost-effective, nutritional choices.

*Perceived barriers* suggest that an individual must believe that the costs of taking action are outweighed by the benefits of taking action; therefore, perceived barriers are very significant factors in determining behavior change. If healthcare providers can educate prenatal women on the benefits of healthy behaviors with regard to postpartum health and wellness, it will be easier for these women to understand the need for behavior change. Healthy habits regarding exercise (and nutrition) have been suggested to reduce not only PPD, but also to provide benefit to post-birth recovery, milk production and body image (Northrup, 2010). When barriers are overcome, new behaviors can be adopted.

*Cues to action* suggests that an individual needs to feel an eagerness to change or experience a call to action. Cues can come in the form of events, people or things, and will encourage a person to be proactive in changing or modifying their health behavior(s). Healthcare providers have numerous opportunities to create a call to action for the prenatal woman through their monthly/weekly appointments.

*Self-efficacy* is the belief that individuals have it in themselves to complete the desired outcome (goals and challenges) (Schwarzer, 2008). With regard to the health and wellness of postpartum women, there are many factors that not only influence the ability to complete
outcomes, but that also influence the belief in ability to complete outcomes. From lack of support, time, money to a myriad of other factors, postpartum women report needing the knowledge regarding experiences, encouragement to make healthy decisions and support to complete those decisions.

The HBM has very practical implications for researchers and educators as they seek to gain knowledge of the health and wellness of the postpartum woman. Because the constructs of HBM suggest that personal beliefs impact behavior it is important to understand the factors that shape and influence personal beliefs. With regard to the postpartum period, this study found significant correlation and predictability between personal health beliefs and the health and wellness of postpartum women. Additionally, this study found significance between mediated representations of pregnancy and the health and wellness of postpartum women.

Previous research has suggested a relationship between mediated representations of pregnancy and personal beliefs about pregnancy and the postpartum period (Gow, Lydecker, Lamanna, & Mazzeo, 2012). This research suggests that mediated versions of acceptable pregnancy and postpartum issues help to create a skewed version of reality for the average American woman and the culture in which she lives, therefore, creating behaviors based on a false expectation.

Through maternal care, healthcare providers have a great opportunity to touch all five constructs of the health belief model in an effort to eliminate false expectations and construct a more positive reality. As they provide prenatal care, these professionals can evaluate the five beliefs associated with this model that are suggested to influence a person’s willingness to take healthy action: (1) perceived threat, (2) perceived benefits, (3) perceived barriers, (4) cues to action and (5) self-efficacy.
The constructs of the HBM can be used in conjunction with SCT as a means to better understand the beliefs that shape false expectations because these false expectations, in turn, shape health behavior. In order to positively impact the postpartum period, this study sought to determine the needs of the postpartum woman. Many suggestions were made for “needs”; however, the main request was a better knowledge of postpartum reality.

SCT suggests that people look to images they perceive to be attainable and realistic and then, make comparisons among themselves, others and the idealized images (Festinger, 1954). When women determine what they perceive to be obtainable or realistic, they form opinions regarding their individual body as related to the ideal images. For this reason, mediated representations of pregnancy were studied. As previously discussed, current research in the area of media and body image demonstrates that women compare themselves with the unrealistically high standards presented in the media (Kim, & Lennon, 2007; Strahan, et al., 2008). Print and online magazines frequently cover celebrity pregnancies, using these women as examples for what to expect regarding pregnancy and the postpartum period. When used as an example of pregnancy and postpartum experiences, women began making comparisons (both consciously and sub-consciously) to the example as they form (potentially false) expectations and foster (potentially unhealthy) beliefs.

Although this study did not confirm previous research suggesting that postpartum expectations – on a personal and cultural level – are influenced by mediated representations of pregnancy (Gow, Lydecker, Lamanna, & Mazzeo, 2012), this study did report a significant relationship between mediated representations of pregnancy, therefore suggesting a need for future research in this area. It is important for postpartum researchers and educators to gain knowledge in the area of media effects as it specifically related to pregnancy and the postpartum
period because body dissatisfaction has been associated with depression, anxiety and unhealthy eating habits, all factors that could negatively affect pregnancy and the postpartum period (Green & Pritchard, 2003; Stice & Whitenton, 2002). This study considered media effects as related to magazine depictions of pregnancy and the postpartum, but perhaps a larger implication of this research suggests that effects are not entirely based on media format (such as magazines) but more on the media content consumed with regard to pregnancy and the postpartum period. It stands to reason that the more media to which an individual is exposed, the greater potential for cultivated belief in that reality. Subsequent research would benefit from this implication and will be further discussed in chapter five under future research.

As an extended part of SCT, individuals are suggested to make two main types of comparisons: upward and downward. Upward social comparisons occur when individuals compare themselves to others who they perceive to be above them, or better off than them, in some way as they work to create a more positive perception of reality. Downward comparisons serve as a defensive means of self-evaluation based on comparison to a person, image or group considered to be in worse condition. Practical implications from this study with regard to SCT come from the qualitative component of research question seven. Even though many women report similar needs with regard to postpartum health and wellness, respondents suggest that it is very important to remember that comparisons cannot be made because every woman and every situation is different. As one respondent noted, “I think it's a bit too individualized for it to be 'adequate'. A general list of maybes is really all a doc can do because every woman and experience is different.”

Comparing a personal postpartum experience to that of another woman has the potential to make an individual feel happy, sad or confused. Constructs of the HBM used in conjunction
with knowledge of SCT and an individual’s innate desire to make comparisons will allow healthcare providers the opportunity to reach prenatal women at the onset of pregnancy and correct false expectations, negative health beliefs and unhealthy comparisons with unrealistic ideals.

Limitations and directions for future research

Although this study does provide insight into the factors affecting the health and wellness of postpartum women, there are some limitations for this study. Additionally there are many opportunities for future research.

This research study was envisioned as an online survey taken from a baby forum birth month club such as thebump.com or babycenter.com because of their high level of membership and of forum participants. With this type of survey, there are limitations regarding online bias, and diversity of sample. Internet survey and questionnaire participation is limited to those who have access to and know how to use a computer or smart phone (Thomas, Stamler, LaFreniere, & Dumala, 2000; Fowler, 2013). Therefore, participant diversity is a limitation.

Participant dropout is an additional limitation of internet survey research. Although 400 women began the survey, 57 participants dropped out before answering the first non-screening question, leaving only 343 total participants. Because of the tight screening process for respondents – to only include women, over 19 years of age, with only one birth experience (within the past 15 months) – the total number of participants completing the entire survey was approximately 170. Length of survey seemed to be an issue and therefore dropout occurred within the total 170 taking the complete survey. Because this was not a probabilistic sample, and was largely homogenous and low in number, generalization to the population is a limitation of
this survey. The sample population of predominantly Caucasian, educated women in their 30’s, should be noted as a study limitation and should also be used as a directive for future research.

Time constraints and privacy policies of thebump.com and babycenter.com created the need for snowball sampling in order to obtain data. While demographic information was collected, this study reports a significantly educated, white, middle aged woman and is not representative of the population. Another limitation to this study is recall bias. Because many times the baby becomes more of the focus than the birth or postpartum experience, it is possible that participants do not accurately remember the complete experience. Also a limitation is the definition of cultural health beliefs for this study. Cultural health beliefs are continuously evolving; therefore, the definition as outlined for this study may not align with every participant’s definition of cultural health belief and the survey items designed to measure cultural health beliefs may not accurately display an individual participants true perceptions regarding cultural health beliefs. Additionally, this study would be best served in a longitudinal research project spanning pre-conception to the postpartum period in order to accurately evaluate health beliefs and behaviors and as they span pregnancy and into the postpartum period. Additionally, considering expectations before and after an educational stimulus would provide knowledge for healthcare providers.

Addressed as a limitation, this study displays results as generated by a predominantly Caucasian sample; therefore, the sample population is an opportunity for future research. This study would benefit from further exploration of additional populations, specifically, Hispanic and African American populations. Future research would benefit from greater knowledge of participant media use.
A better understanding about the television, magazine and Internet usage of the sample would benefit the research as it seeks to determine the effects of media on pregnancy and postpartum expectations. As a previously discussed limitation, subsequent research studies should look at the health and wellness of postpartum women from a longitudinal study beginning pre-conception, following the participant through pregnancy and the postpartum period.

Due to the lack of quantitative research stemming from the field of communications, this research study was designed to cover a number of factors affecting the health and wellness of postpartum women. Many of these factors (personal health beliefs, mediated representations of pregnancy, body image and pregnancy-related education) showed significant relationships with the health and wellness of postpartum women and confirmed previous research. However, cultural health beliefs and cultural expectations for pregnancy contradicted previous findings as they reported no significant relationship with the health and wellness of postpartum women. Previous research found that postpartum expectations – on a personal and cultural level – are influenced by mediated representations of pregnancy (Gow, Lydecker, Lamanna, & Mazzeo, 2012); therefore, future research should focus on the effects of media on culture and of culture on health beliefs. Additionally, it would provide better understanding of pregnancy and the postpartum period if research more thoroughly investigated the relationship between cultural expectations and personal expectations. If cultural expectations are different than an individual’s personal expectations for themselves, researchers should continue to examine the cause of the variance and the formation of personal expectations. There are many communication theories suggesting that media cultivates society and influences beliefs, the contradictory findings related to this research suggest that further examination is necessary, possibly with a larger, more diverse, sample size.
In order to determine the effect of mediated messages and images on pregnant and postpartum women, future research should measure perceptions and beliefs of pregnant and postpartum women regarding what is realistic and obtainable when exposed to mediated pregnancy stories. Determining the perceived level of obtainability regarding pregnancy expectations will give insight as the researcher seeks to understand formed health beliefs and health behaviors. This study considered media effects as related to magazine depictions of pregnancy and the postpartum, but future research would benefit from a better knowledge of quantity of media content over media format. Exploring the difference in media content over format will better detail the greater potential for cultivated belief in a false (or mediated perception) of reality.

It would also be of benefit for researchers to examine the difference in postpartum expectations between women who attend optional hospital courses offered to prenatal women and women who choose not to attend. Hospitals often offer courses in the areas of delivery, breastfeeding, infant care, etc. Having more information regarding the women who attend those courses and their perception of postpartum education would benefit researchers and educators as they work towards the development of new (beneficial) postpartum education.

Lastly, this exploratory study was done with a qualitative and quantitative component due to the lack of research in the discipline of communication. Future research should explore how structural equation modeling (SEM) would benefit communications research in the area of pregnancy and the postpartum period by analyzing the data for direct and indirect relationships among variables.

It is evident that there are many factors influencing and affecting postpartum health and wellness. Because these factors can inhibit a postpartum woman’s ability to properly recover,
perform daily tasks, and make healthy decisions, this study suggests confers with previous research in suggesting that proper maternal care should be given during and after pregnancy. In order to provide proper maternal care, participants of this study suggest that healthcare providers be more forthcoming with postpartum reality during pre-natal appointments. Postpartum reality has been distorted by media’s effects on health beliefs and behaviors. These beliefs foster misleading expectations for pregnancy and the postpartum period, causing additional stress for new mothers. As a sample, pregnant women are largely under-represented because their status as pregnant is relatively short. However, most women will attest to the fact that life changes after having a baby. In some cases, women suffer severe PPD, which can lead to many bigger issues related to caring for the child, interpersonal interactions with other family members, a slow return to work, etc. Results here suggest that some women in the present sample could even be experiencing PPD and it could very well be going untreated. From an applied perspective, this is an area where healthcare initiatives can improve the mother and infants qualify of life. From a theoretical perspective, it suggests that we need to dig deeper into the self-beliefs and self-perception of this niche group to better understand why help may not be sought or understand why women feel they must remain (largely) silent on the issue. Increasing research in the area of needs specific to the health and wellness in the postpartum period will assist healthcare providers as they work to motivate change in health and wellness behaviors – moving postpartum women move from the perceived to the realistic.
REFERENCES


APPENDIX A

1. Are you 19 years old or older?
   Yes    No

2. Did you give birth in the years 2013 or 2014?
   Yes    No

I would like to ask you a few questions about yourself. Please answer each question honestly as no identifying information will be linked to your answers.

3. Please list your age: ________

4. Race / Ethnicity:
   American Indian or Alaska Native
   Asian
   Black or African American
   Native Hawaiian or Other Pacific Islander
   White/Caucasian
   Other

5. Are you Hispanic or Latino?
   Yes    No

6. Marital Status:
   Single
   Life partner / Significant other
   Married
   Separated
   Divorced
   Widowed
   Other
7. Highest degree or level of school completed:
   - Some high school, no diploma
   - High school graduate, diploma or the equivalent (for example: GED)
   - Some college credit, no degree
   - Trade/technical/vocational training
   - Associate degree
   - Bachelor’s degree
   - Master’s degree
   - Professional degree
   - Doctorate degree

8. How many times have you given birth?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - More than six

9. How many babies were delivered during the birth?
   - 1
   - 2
   - 3
   - 4
   - More than four

10. Did you have a cesarean delivery?
    - Yes
    - No

11. Did you receive an epidural?
    - Yes
    - No

12. In what year did you give birth?
    - 2013
    - 2014

13. In what month did you give birth:
    - January
    - February
    - March
    - April
    - May
    - June
    - July
    - August
    - September
    - October
    - November
    - December

From your experience with pregnancy, the following questions will ask your perceptions of society’s beliefs about pregnancy and pregnant women.

(Cultural health beliefs):

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15. Society believes that pregnancy is an easy experience for the average woman.

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17. Society believes that weight gained during pregnancy is acceptable.

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18. Society believes that weight gained during pregnancy must be lost after delivery.

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19. Society believes that carrying a baby during pregnancy is an easy process.

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20. Society believes that delivering a baby is an easy process.

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21. Society views a cesarean section (c-section) as an emergency procedure.

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22. Society views a cesarean section (c-section) as an effortless delivery procedure.

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23. Society believes that pregnancy makes a woman less able to complete household related tasks.

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24. Society believes that pregnancy makes a woman less able to complete work related tasks.

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25. Society expects that a woman will have less physical strength during pregnancy.

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26. Society believes that proper nutrition will positively affect the progress of the pregnancy.

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27. Society believes that proper exercise habits will positively affect the progress of the pregnancy.

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28. Society believes that pregnancy-related depression is a real health condition.

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29. Society believes that pregnancy-related depression is a preventable health condition.

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Media exposure has been shown to affect beliefs and opinions. The following questions ask your beliefs on how the media has affected your opinions of pregnancy.

(Mediated pregnancy examples):

30. When I read stories in celebrity and gossip magazines, such as People magazine, US Weekly or similar entertainment magazines, about other people’s pregnancy, I feel like it affects the way I have thought about my own pregnancy.

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31. When I read stories in celebrity and gossip magazines, such as People magazine, US Weekly or similar entertainment magazines, about other people’s pregnancy, I feel like it affects the way I have acted while pregnant.

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32. Pregnancy-related stories in celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines, are relatable to my life.

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33. Pregnancy stories in celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines, do not affect my expectations of pregnancy.

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34. How often do you read to celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines or digital copies?

- Daily
- Weekly
- Monthly
- Never

35. Do you subscribe to celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines – through either hard copy or digital version?

- Yes
- No

36. When I read stories in pregnancy-specific magazines, such as *Fit Pregnancy magazine or Pregnancy and Newborn magazine* about other people’s pregnancy, I feel like it affects the way I have thought about my own pregnancy.

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37. When I read stories in pregnancy-specific magazines, such as *Fit Pregnancy magazine or Pregnancy and Newborn magazine* about other people’s pregnancy, I feel like it affects the way I have acted while pregnant.

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38. Pregnancy-related stories in pregnancy specific magazines, such as *Fit Pregnancy magazine or Pregnancy and Newborn magazine* are relatable to my life.

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</table>
39. Pregnancy stories in pregnancy specific magazines, such as *Fit Pregnancy magazine or Pregnancy and Newborn magazine* do not affect my expectations of pregnancy.

   1  2  3  4  5

   Completely disagree  Somewhat disagree  Neutral  Somewhat agree  Completely agree  I don’t know agree

40. How often do you read informational media such as *Fit Pregnancy magazine, Pregnancy and Newborn magazine* or other pregnancy specific magazines or digital copies?

- Daily
- Weekly
- Monthly
- Never

41. Do you subscribe to informational media magazines, such as *Fit Pregnancy magazine, Pregnancy and Newborn magazine* or other pregnancy specific magazines?

- Yes
- No

42. I believe that people accept what they read in celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines, to be true.

   1  2  3  4  5

   Completely disagree  Somewhat disagree  Neutral  Somewhat agree  Completely agree  I don’t know agree

43. I believe that people accept what they read in informational media such as *Fit Pregnancy magazine, Pregnancy and Newborn magazine* or other pregnancy specific magazines, to be true.

   1  2  3  4  5

   Completely disagree  Somewhat disagree  Neutral  Somewhat agree  Completely agree  I don’t know agree

44. I read celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines to escape my reality.

   1  2  3  4  5

   Completely disagree  Somewhat disagree  Neutral  Somewhat agree  Completely agree  I don’t know agree

45. I read celebrity and gossip magazines, such as *People magazine, US Weekly* or similar entertainment magazines, with the belief that they contain accurate information.

   1  2  3  4  5

   Completely disagree  Somewhat disagree  Neutral  Somewhat agree  Completely agree  I don’t know agree
46. I read informational media such as *Fit Pregnancy magazine, Pregnancy and Newborn magazine* or other pregnancy specific magazines, with the belief that they contain accurate information.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

47. I read magazines to stay up-to-date on popular information.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

*Based on your personal experience with pregnancy, the following questions will ask your beliefs regarding pregnancy, exercise and nutrition.*

(Personal health beliefs):

48. I believe that postpartum depression is worsened by a mother’s lack of attention to personal health after giving birth.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

49. I believe that a postpartum woman should begin an exercise routine as soon as she is cleared by her OBGYN.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

50. I believe that exercising on a regular basis improves the way I feel about my body after having my baby.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
51. I believe that exercising on a regular basis (4-5 times per week) will reduce my risk of depression after having a baby.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

52. I believe that eating more healthy foods (fruits and vegetables) will reduce my risk of depression after having my child.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

53. I believe that eating more healthy foods (fruits and vegetables) will enhance the way I feel about my body after having my child.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

54. I believe that my ability to connect with my baby will be greatly affected by my physical and emotional health.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

55. Encouragement from online pregnancy-related forums encourage me to engage in physical activity.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

56. I am confident in my ability to make healthy choices when eating now that I have given birth to my baby.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
57. I believe that pregnancy is an easy experience for the average woman.

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58. I view pregnancy as a beautiful time in a woman’s life.

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59. I believe that gaining weight during pregnancy is acceptable.

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60. I believe that weight gained during pregnancy must be lost after delivery.

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61. I believe that carrying a baby during pregnancy is an easy process.

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62. I believe that delivering a baby is an easy process.

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63. I view a cesarean section (c-section) as an emergency procedure.

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64. I view a cesarean section (c-section) as an effortless delivery procedure.

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</table>
65. I believe that pregnancy makes a woman less able to complete household-related tasks.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

66. I believe that pregnancy makes a woman less able to complete work related tasks.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

67. I believe that proper nutrition will positively affect the progress of the pregnancy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

68. I believe that proper exercise habits will positively affect the progress of the pregnancy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

69. I believe that proper nutrition will increase my chances for a healthy baby.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

70. I believe that proper exercise will increase my chances for a healthy baby.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

71. I believe that pregnancy-related depression is a real health condition.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
72. I believe that pregnancy-related depression is a preventable health condition.
1   2   3   4   5
Completely disagree   Somewhat disagree   Neutral   Somewhat agree   Completely agree   I don’t know

73. Please write in your pre-pregnancy weight: ________

74. How much weight did you gain during your pregnancy? ________

75. Please write in your current weight: ________

76. Please write in your height ________

77. Please choose your body frame:
   Small frame
   Small-medium frame
   Medium frame
   Medium-large frame
   Large frame

*Because pregnancy has been determined to affect self-perception, the following questions will ask you to give your perceptions of self. There is no right answer for any statement. Please answer as honestly as possible.*

(Self-perception and self-esteem):

78. I feel satisfied with the way my body looks right now.
1   2   3   4   5
Not at all   A little bit   Somewhat   Very much   Extremely

79. I am worried about whether I am regarded as a success or failure.
1   2   3   4   5
Not at all   A little bit   Somewhat   Very much   Extremely

80. I feel that others respect and admire me.
1   2   3   4   5
Not at all   A little bit   Somewhat   Very much   Extremely

81. I am dissatisfied with my weight.
1   2   3   4   5
Not at all   A little bit   Somewhat   Very much   Extremely
82. I feel self-conscious.  
Not at all    A little bit    Somewhat    Very much    Extremely

83. I feel displeased with myself.  
Not at all    A little bit    Somewhat    Very much    Extremely

84. I feel good about myself.  
Not at all    A little bit    Somewhat    Very much    Extremely

85. I am pleased with my appearance right now.  
Not at all    A little bit    Somewhat    Very much    Extremely

86. I am worried about what other people think of me.  
Not at all    A little bit    Somewhat    Very much    Extremely

87. I feel inferior to others at this moment.  
Not at all    A little bit    Somewhat    Very much    Extremely

88. I feel unattractive.  
Not at all    A little bit    Somewhat    Very much    Extremely

89. I feel concerned about the impression I am making.  
Not at all    A little bit    Somewhat    Very much    Extremely

90. I am worried about looking foolish.  
Not at all    A little bit    Somewhat    Very much    Extremely
Because beliefs are suggested to influence expectations, the following questions will ask your opinions of cultural expectations regarding pregnancy and the expectations that might have influenced your personal pregnancy prior to carrying and delivering your baby.

(Cultural expectations for pregnancy):

91. Cultural expectations for pregnancy are formed through magazine stories related to pregnancy.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

92. Cultural expectations for pregnancy are formed through television representations of pregnancy.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

93. Cultural expectations for pregnancy are formed through the opinions of friends and family.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

94. There are cultural expectations for the amount of weight a woman should gain.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

95. There are cultural expectations for the rate in which a woman should lose pregnancy-related weight.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

96. Cultural expectations regarding a woman’s weight gain during pregnancy are unhealthy.
   1 2 3 4 5
   Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
97. Cultural expectations regarding the rate in which a woman should lose weight after delivery are unhealthy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

98. Cultural expectations for pregnancy affected the way I felt about my pregnant body.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

99. Culture expects women to take a full maternity leave.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

100. Culture expects the birth of a baby to change the way a woman prioritizes work responsibilities.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

101. Culture expects the birth of a baby to change the way a woman prioritizes home responsibilities.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

102. Cultural expectations for pregnancy are unrealistic.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

103. Cultural expectations for postpartum women are unrealistic.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
Pregnancy has been determined to affect body image. Based on your perceptions of your body at this moment, please answer the following questions.

*(Body image):*

104. I rarely think about how I look.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

105. When I can’t control my weight, I feel like something must be wrong with me.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

106. I think it is more important that my clothes are comfortable than whether they look good on me.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

107. I think a person is pretty much stuck with the looks they are born with.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

108. I feel ashamed of myself when I haven’t made the effort to look my best.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

109. A large part of being in shape is having that kind of body in the first place.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply

110. I think more about how my body feels than how my body looks.
   1  2  3  4  5  6  7  NA
   Strongly disagree
   Disagree
   Neither agree nor disagree
   Strongly agree
   Does not apply
111. I feel like I must be a bad person when I don’t look as good as I could.

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<td>Neither agree nor disagree</td>
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112. I rarely compare how I look with how other people look.

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<td>Strongly agree</td>
<td>Does not apply</td>
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113. I think a person can look pretty much how they want to if they are willing to work at it.

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<td>Strongly agree</td>
<td>Does not apply</td>
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114. I would be ashamed for people to know what I really weigh.

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115. I really don’t think I have much control over how my body looks.

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<td>Strongly Disagree</td>
<td>Neither agree nor disagree</td>
<td>Strongly agree</td>
<td>Does not apply</td>
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116. Even when I can’t control my weight, I think I’m an okay person.

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<td>Strongly Disagree</td>
<td>Neither agree nor disagree</td>
<td>Strongly agree</td>
<td>Does not apply</td>
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117. During the day, I think about how I look many times.

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<td>Neither agree nor disagree</td>
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<td>118.</td>
<td>I never worry that something is wrong with me when I am not exercising as much as I should.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
<td></td>
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<td>119.</td>
<td>I often worry about whether the clothes I am wearing make me look good.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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<td>120.</td>
<td>When I’m not exercising enough, I question whether I am a good enough person.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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<td>121.</td>
<td>I rarely worry about how I look to other people.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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<td>122.</td>
<td>I think a person’s weight is mostly determined by the genes they are born with.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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<td>123.</td>
<td>I am more concerned with what my body can do than how it looks.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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<td>124.</td>
<td>It doesn’t matter how hard I try to change my weight, it’s probably always going to be about the same.</td>
<td>Strongly agree, Neither agree, Strongly disagree, Nor disagree, Does not agree, Does not disagree, NA</td>
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Based on your experience with pregnancy and the postpartum period, please answer the following questions about postpartum health and self-perception.

(Predictors of postpartum wellness and self-perception):

125. I felt comfortable with the way my body looked before pregnancy.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

126. I felt comfortable with the way my body looked during pregnancy.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

127. I felt comfortable with the way my body looked after giving birth.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

128. My feelings about my body are the same now as they were before I became pregnant.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

129. I believe that my body is more powerful after giving birth.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

130. I believe that I am a stronger person after carrying a baby.
  1  2  3  4  5
Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
131. I believe that I make healthy decisions regarding nutrition.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

132. I believe that I make healthy decisions regarding exercise.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

133. I believe that being a mother is a great responsibility.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

134. I believe that being a mother changes the way that others view me.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

135. I make decisions for my health because others need me to be healthy.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

136. I make decisions for my health because others look to me as an example.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

137. I exercise because I believe that I am expected to look a certain way.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

138. I believe that exercise that will lower my risk for postpartum depression.
1 2 3 4 5
Completely disagree  Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
139. I believe that exercise will help me to get back my pre-baby body.

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140. I believe that exercise will help me to feel better about myself.

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141. I believe that exercise will change the way that others view me.

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142. Proper exercise during pregnancy is important for recovery after giving birth and throughout the postpartum period.

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143. I believe that proper nutrition will help me to get back my pre-baby body.

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144. I believe that proper nutrition will help me to feel better about myself.

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145. I believe that proper nutrition will change the way that others view me.

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146. Proper nutrition during pregnancy is important for recovery in the postpartum period.

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<th>Agree</th>
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147. I am confident in my ability to make healthy choices for myself.

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<th>Agree</th>
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<th>Somewhat Disagree</th>
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148. I am confident in my ability to make healthy choices for my baby.

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<th>Agree</th>
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<th>Somewhat Disagree</th>
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149. I am in better physical condition than most women who have had a child in the last year.

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150. I am more emotionally stable than most first-time mothers with a child the same age as mine.

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<th>Agree</th>
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<th>Somewhat Disagree</th>
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**Based on your Internet usage, please answer the questions below in regard to pregnancy-related websites.**

(Pregnancy-related websites):

151. How often do you use the Internet?

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<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Completely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>I do not use the Internet</td>
</tr>
</tbody>
</table>

152. I use pregnancy-related-websites to find answers to the majority of my questions.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Completely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>I don’t know</td>
</tr>
</tbody>
</table>
153. I believe the information that I find on pregnancy websites to be accurate.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

154. Pregnancy-related websites provide a network of friends with whom I can exchange information.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

155. I feel confident in my ability to find reliable information (support groups) I need related to pregnancy on the internet.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

The following questions ask you to give your opinions of the pregnancy and postpartum-related education you received from your OBGYN.

(Pregnancy-related education):

156. My OBGYN emphasized weight gain during my pregnancy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

157. My OBGYN emphasized proper nutrition during my pregnancy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know

158. My OBGYN emphasized beneficial exercise habits during my pregnancy.

1 2 3 4 5

Completely disagree Somewhat disagree Neutral Somewhat agree Completely agree I don’t know
159. My OBGYN provided me with useful information regarding my pregnancy.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely disagree</td>
<td>Somewhat disagree</td>
<td>Neutral</td>
<td>Somewhat agree</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

160. My OBGYN provided me with enough pregnancy-related information during my prenatal care visits.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely disagree</td>
<td>Somewhat disagree</td>
<td>Neutral</td>
<td>Somewhat agree</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

161. My OBGYN provided me with sufficient information regarding what to expect during the postpartum period.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely disagree</td>
<td>Somewhat disagree</td>
<td>Neutral</td>
<td>Somewhat agree</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

162. From a postpartum perception, please rate your pre-natal education.

<table>
<thead>
<tr>
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<th>2</th>
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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Unsatisfactory</td>
<td>Moderately Unsatisfactory</td>
<td>Neutral</td>
<td>Moderately Satisfactory</td>
<td>Extremely Satisfactory</td>
</tr>
</tbody>
</table>

163. Please fill in any information you wish you had received from your OBGYN regarding the pregnancy and birthing experience?

___________________________________________________________________________
___________________________________________________________________________

Finally, I would like to ask you a few questions regarding your experience with pregnancy and give you the opportunity to share additional information for the purpose of enhancing pre-natal education to benefit women during the postpartum period.

**Qualitative Questions:**

164. What was the content of the postpartum education you received in your pre-natal appointments?

165. In your opinion, what constitutes an adequate education on what to expect in the postpartum period?
166. What factors contribute to you making healthy decisions regarding nutrition in the postpartum period (i.e., time, money, etc.)?

167. What factors contribute to you making healthy decisions regarding physical activity in the postpartum period?

168. What factors contribute to you feeling mentally and emotionally stable in the postpartum period?
February 20, 2014

Rachael Smallwood
College of Communication & Information Sciences
The University of Alabama
Box 870172

Re: IRB # 14-OR-044, “A Needs Assessment for the Overall Health and Wellness of the Postpartum Woman based on Cultural and Personal Perceptions Regarding Mediated Representations of Pregnancy”

Dear Ms. Smallwood:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on February 19, 2015. If your research will continue beyond this date, please complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, please complete the Modification of an Approved Protocol form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Request for Study Closure form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

Carpentier T. Mykles, MSM, CLM, CIP
Director & Research Compliance Officer
Office for Research Compliance
The University of Alabama