

NURSING STUDENTS' KNOWLEDGE OF OBSTETRICAL
FOLK BELIEFS AND SUPERSTITIONS

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We hereby recommend that the Thesis prepared under
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Dedicated to my family and Rick Sim. Thank you
for our reciprocal love.

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CHAPTER I

INTRODUCTION

Every known society has developed methods for coping with threats to health and well being. Folk beliefs and superstitions have been the primary coping methods to threats against health and well being since primitive man appeared on earth. Folk beliefs and superstitions help man to explain the vast world around him and eliminate the feeling of total helplessness in the face of nature (Bauer 1969; Camp 1974; Simons 1973).

Folk beliefs and superstitions are still prevalent today (Denton 1978; Killion and Waller 1972). Many folk belief practices and superstitions are based, at least in part, on religion, superstition, or social customs. The specific cultural background often makes it difficult for people outside the particular culture to understand the concepts prevalent in the folk beliefs. Conflict and confusion often result because people outside of a particular culture are not knowledgeable of beliefs and superstitions of other cultural societies. Conflicting cultural beliefs create dissonance which reduces therapeutic interpersonal interaction within the health care setting.

The nurse needs to acquire an understanding of folk beliefs and superstitions so rapport can be established and dissonance reduced. This study is not suggesting that nurses must believe in folk practices, but instead that they should be aware of the existence of these practices and respect the importance these beliefs have for some patients. Knowing and understanding cultural beliefs, other than one's own, could be achieved by teaching nursing students about various folk beliefs and superstitions as part of the nursing educational curriculum. The students would be better able to relate to patients as holistic beings in body, spirit, cultural, and traditions. This study assessed the knowledge of obstetrical folk beliefs and superstitions among senior nursing students in accredited baccalaureate nursing programs.

Statement of the Problem

The problem of this study was:

What is the level of knowledge of baccalaureate senior nursing students regarding obstetrical folk beliefs and superstitions?

Statement of Purposes

The purposes of this study were:

1. To assess the knowledge level of baccalaureate senior nursing students regarding obstetrical folk beliefs and superstitions
2. To determine if subjects who were aware of folk beliefs and superstitions related these beliefs to a particular ethnic group
3. To determine the number of students who had learned of the folk belief and superstition questionnaire items while in nursing school
4. To determine the number of students who had learned of the folk belief and superstition questionnaire items outside of the school of nursing
5. To compare subjects' knowledge of folk beliefs and superstitions learned in nursing schools to subjects' knowledge who attained this information outside the school of nursing
6. To present item responses with subjects' age, religious preference, geographical area of residence in which the subjects spent most of their life, and geographical location of school of nursing in which they were enrolled

Background and Significance

Folk beliefs and superstitions continue to exist in the twentieth century (Denton 1978; Dorson 1972; Killion and Waller 1972). The lack of an adequate educational knowledge base of cross cultural medical beliefs may create dissonance among nurses and patients who have folk beliefs and superstitions. The tendency of modern medical institutions and their personnel to scorn folk concepts of illness and treatment has delayed the much needed perspective of the holistic therapeutic process (Hand 1976). Cultural traditions must be considered if the total person concept of care is to be provided by the health-care community (Neuman 1974).

Nurses are interacting with many different cultural groups more than any other time in history (Leininger 1967). The flow of cross-cultural patients is partly due to new modes of communication, travel, and foreign trade (Leininger 1976). Nursing serves an active part in giving health care to patients from diverse cultures. To meet the nursing care needs of patients with diverse cultural backgrounds, the nurse needs to be aware and understand cultural factors that influence the interpersonal process (Pasquali 1974). Cultural backgrounds influence

life styles, value systems, attitudes, and responses to illness and treatment (Pasquali 1974).

To meet the nursing care needs of patients with diverse cultural backgrounds, the nurse needs to understand that all people are products of cultural differences as well as cultural similarities (Koshi 1976). Culture develops by the process of socialization (Bandura 1969). It is not adequate that cultural stereotyping be taught in the nursing curricula. Nursing care deals with the individuals of various cultures, not only the traits inherent within a cultural group (Koshi 1976). Koshi assumed that unless a nursing curriculum includes both the cultural variations among groups and individuals, it would still be deficient and inappropriate. Koshi (1976) contended that one of the persisting barriers to the inclusion of cultural differences in nursing curriculum and instruction was the myth that the American culture is basically a monolithic culture. Nursing has not dealt with cultural diversity, but rather treated all patients as a "cultural melting pot" (Koshi 1976: 16). Koshi pointed out that under this myth of assimilation, nursing curricula have been projected to develop skills to provide care for the model patient, "the white, middle class homogenized United States American" (Koshi 1976: 16). An objective look at American culture would clearly indicate

that America is a multicultural society, rather than the monolithic myth culture previously taught in nursing schools (Koshi 1976). The acceptance of multi-racial students, faculty, and total hospital integration have helped open nurses' eyes that cultural differences do exist. "No longer may we have a lofty contempt for people whose culture is different or seems strange" (Leininger 1967: 27).

Nurses working on a ward occupied by ethnic minorities would surely recognize the cultural differences of each patient, even though each had been born in the United States. This explains how subcultures exist within a culture. Each patient may be an American citizen and yet retain traditional cultures valued by their subculture (Koshi 1976; Leininger 1967).

Koshi (1976) explained that a more precise awareness and understanding of cultural diversity in our own society would provide better nursing care to all patients. Nursing cannot continue to disregard the factors of race, color, creed, and national origin in the professional educational programs (Koshi 1976).

The goal of the nursing profession is that all people receive better nursing care. deTornyay (1976) cited the American Nurses' Association Affirmative Action Programming for the Nursing Profession to describe the goal.

Inherent in the goal is a system of values that includes respect for oneself and others, respect for cultural differences, respect for the economic, political, and social rights of others, and respect for the rights of all persons to seek and maintain their own identities (deTorneyay 1976, p. 3).

Nurses take an active part in providing health care to individuals from different diverse cultures. It is essential that nurses make a conscious effort to increase their scientific knowledge about various cultural groups and individuals (Leininger 1967). Superficial knowledge, a rigid ethnocentric position, and false assumptions about different cultures are not sufficient if health workers are to be successful in nursing people from other cultures. Leininger (1976) asserted that nursing can no longer be perceived in the traditional sense of an activity based only on knowledge of man's physical and emotional needs. Cultural and social behavior should be taken into consideration. Health services may be rejected, sabotaged, or severely criticized by the patient if the staff is antagonistic to the norms and health values of a cultural group (Leininger 1967). The result could be patient non-compliance with the medical regimen.

Culture is a universal and significant concept that has relevance to nursing. Culture is tightly interwoven into the life of socialized man and continually pervades his thinking, actions, feelings, and particularly

his health status (Branch and Paxton 1976; Leininger 1970). The nurse needs to be aware and understand the cultural factors that influence the interpersonal process of communication with patients from diverse cultures (Pasquali 1974). To achieve the understanding of cultural factors and improve nursing care to all people, deTornyay (1974) suggested strengthening the cultural component of the nursing curricula.

The need for an educational knowledge base in the area of cultural beliefs and superstitions was regarded as important by the numerous authors cited in this section of the study. This study examined if nursing in the area of obstetrical folk beliefs and superstitions provided such knowledge to senior nursing students in the four baccalaureate programs sampled.

Definition of Terms

For the purpose of this study, the following terms were defined:

Baccalaureate nursing students--senior nursing students in an accredited National League for Nursing four year nursing program leading to a baccalaureate degree in nursing

Delimitations

For the purposes of this study, the delimitations that were observed were:

1. The sample consisted of baccalaureate nursing students enrolled as seniors in accredited schools of nursing in four southwestern universities
2. Only four programs of nursing were sampled
3. Only one metroplex was sampled

Assumptions

For the purpose of this study, the assumptions were:

1. Pregnancy and childbirth are natural states of health
2. People are open systems in contact with their environment
3. People are influenced by their cultural environment
4. Folk beliefs are a part of people's cultural influence
5. Folk beliefs and practices have value to those who believe in them
6. Nurses need to know folk beliefs and superstitions to enhance interpersonal communications with

patients who have such beliefs and to reduce nurses's ethnocentrism

Summary

Chapter I presented the statement of the problem and the purposes of this study. Chapter I also consisted of the background and significance, definition of terms, limitations, delimitations, and assumptions. A review of the literature pertinent to the inclusion of cultural folk beliefs and superstitions into nursing curricula follows in Chapter II. This review also explains the significance of folk beliefs and superstitions that had been utilized in the questionnaire tool used for this study. Chapter III then explains how the data were collected and treated. A description of the sample, setting, tool, and human rights aspects are explained in Chapter III. Chapter IV consists of tables and explanations of the analysis of the data gathered for the purpose of this study. In closing, Chapter V offers a summary of the findings and conclusions derived from the study. This chapter also contains implications and recommendations for further research in relation to this thesis.

CHAPTER II

REVIEW OF LITERATURE

The review of literature includes material relevant to the importance of incorporating cultural and ethnic teachings within the nursing curricula. The review of literature also demonstrates obstetrical folk medical beliefs and superstitions that are the basis for the questionnaire tool utilized in this study.

Incorporating Cultural and Ethnic Teachings

Within the Nursing Curricula

This section of the review of literature answers the question of why include ethnic teachings into the nursing curricula. The content submits that the incorporation of cultural content would enhance the holistic approach of patient care and improve physical assessment among ethnic people.

Culture is a universal concept that has relevance to nursing. Every human being has a culture (Branch and Paxton 1976). Culture is tightly interwoven into the life of socialized man and continually pervades his thinking, actions, feelings, and particularly his health status (Leininger 1976). Culture includes diet, language,

interpersonal, intrapersonal, and social patterns, including values and concepts of health and illness (Branch and Paxton 1976). Culture is dynamic and has evolved out of man's life experiences. Culture has served as an effective adaptive process throughout the history of man (Paxton, Ramirez, and Walloch 1976). Adaptive culture resulted from man's reaction and interaction with his environment (Branch and Paxton 1976).

Culture refers to a way of life belonging to a designated group of people. Culture serves as our social legacy transmitted from one generation to the next (Leininger 1970). Cultures act as dynamic and stabilizing qualities that permit people to live together in a society. The stabilizing effect is provided by the ability to anticipate the behavior of others and predict many future events which would follow the social norm. Culture provided solutions to life problems. The cultural norms were the stable rules of behavior that prescribed the behavior to be followed for the social members. Every society has its own particular culture, and yet the concept of culture is universal to all people. Many factors influence culture. Among these factors are society and its norm, economics, education, experience, and values (Branch and Paxton 1976).

Folk medicine and superstitious beliefs are still prevalent today (Killian and Waller 1972). Many folk

remedies were the precursors of modern medical practices (Leininger 1976). Folk medical practices are coexisting with modern medical treatment in the twentieth century (Branch 1976; Leininger 1976). The cultural factors of norms, economics, education, values and experiences are again responsible. Today in many areas indigenous folk medicine and professional health systems coexist in communities. Leininger (1976) concluded that there was generally a valid reason why the two exist side by side. She believed that the modern professional neglects the persons cultural needs in health care. The indigenous folk system is available and ready to offer help to the person in distress. Folk medicine is less expensive and usually readily available, unlike most professional systems. Until the professional system becomes more culturally aware to local people's needs and can provide less costly services and more personal services, folk medicine serves a valuable service and will continue to exist (Leininger 1976).

Folk medicine and naturalism are undergoing a rebirth among members of the dominant anglo society in the Western culture (Branch 1976). A current trend exists to get back to nature through the use of herbs, diets, and natural curative measures (Branch and Paxton 1976).

This is in contrast to the previous philosophy that considered health and illness strictly the result of germs and microorganisms (Branch and Paxton 1976). This renewed interest may help span the gap which exists today cross-culturally, especially between patients and nurses from different cultures.

The goal of incorporating ethnic teaching to nurses is not to prepare culturally traditional healers. It should stimulate nurses' awareness of alternative healing methods currently in practice by ethnic groups (Branch and Paxton 1976). These alternative healing methods include herbology, biofeedback, hypnosis, acumassage, relaxation, and exercises such as yoga. A challenge for nurses results when patients desire to use both culturally traditional and Western healing practices in conjunction (Branch and Paxton 1976).

The holistic approach to patient care has been impeded by theories taught in nursing school curricula based on the white middle-class norm (Adams et al. 1976). The myth that the United States is a homogenous society continues to exist. This is known as the melting pot theory or the theory of assimilation (Branch and Paxton 1976). According to this theory, all immigrants relinquished their cultural heritage when they came to America and became Americanized. This is not true since we still have active

the holistic study of man. The holistic approach considers all aspects of the individual (Osborne 1976; Brink 1976). Nursing deals with the holistic approach by the concept of total patient care. Nursing and anthropology are similar in the respect to the holistic approach and the massive data necessary for study and practice. The blend of nursing and anthropology has resulted in a new field called transcultural nursing (Brink 1976).

Transcultural nursing is interested in comparative nursing (Brink 1976). This includes comparing communication systems, anatomy and physiology, and cultural health norms for different cultures (Brink 1976; Leininger 1976).

Transcultural nursing is based on providing nursing care to patients based on the patient's culture. This requires that the nurse realize the differences between her beliefs and the patients, and be sensitive to those needs (Brink 1976). Transcultural nursing requires assessment of both nurse and patient cultural beliefs since both have their own preconceived ideas of health, illness, roles, and total cultural concepts. If the differences between expectations and interventions are not realized, conflicts can occur which can result in noncompliance with the medical regimen (Brink 1976; Sackett and Haynes 1976; Leininger 1976).

When conflicts occur it is the nurses position to adapt her behavior to that of the patient since the patient is

already stressed by his illness. By the nurse being sensitive to patient values, attitudes towards illness, hospitalization and treatment, she can provide better patient care and reduce her own nursing frustration (Brink 1976).

Transcultural nursing was initiated into nursing in 1959 by pioneer nurse researchers such as Madeleine Leininger. Transcultural nursing is now established as a legitimate area of nursing study and practiced as a sub-field of nursing. Incorporating ethnic teaching into nursing curricula could help reduce patient-nurse dissonance created by ethnocentrism. Ethnocentrism is the belief that an individual's beliefs and values are the best available (Branch and Paxton 1976; Koshi 1976; Leininger 1970). Ethnocentricity exists strongest in middle class Americans (Branch and Paxton 1976). Professional ethnocentrism could be reduced if the nurse were more sensitive to the cultural differences of people and respected their culture (Leininger 1976).

Another area of need for ethnic teachings into nursing curricula exists in the need to improve physical assessment among people of color (Branch and Paxton 1976). Branch and Paxton (1976) declared that until nurses can physically assess cyanosis, jaundice and skin rashes in people of all colors (from the lightest to the blackest

complexions), nursing care cannot be considered safe nor effective.

The need to incorporate ethnic cultural concepts into the nursing curricula is gaining support and interest among nurses, nursing schools, and professional organizations. Adams et al. (1976) defined the preliminary curriculum goals involved in teaching cultural and racial diversity to nursing students. These five goals are:

1. The curriculum should produce a nurse who recognizes the existence of racial and cultural diversity in American society.
2. The curriculum should produce a nurse who is knowledgeable of health practices of ethnic peoples of color.
3. The curriculum should produce a nurse who recognizes the influence on the nursing process of culturally determined values and behaviors of the nurse and the patient.
4. The curriculum should produce a nurse whose nursing practices maintains and fosters the ethnic identity and cultural practices of her patients.
5. The curriculum should produce a nurse who is able to make nursing assessments and interventions appropriate to the culture of the client (Adams et al. 1976: 211).

Branch and Paxton (1976) also suggested integrating ethnic teachings as an incorporated portion of classes rather than as a specific one hour lecture. The authors believed that if folk beliefs and cultural differences were seen as a basic part of a person, rather than a special lecture on social deviance, the students would retain the information as having relevance and value.

In conclusion, culture is a universal and significant concept that has considerable relevance to nursing. Culture is tightly interwoven into the life of socialized man and continually pervades his thinking, actions, feelings, and particularly his health status (Leininger 1967). The nurse needs to be aware and understand the cultural factors that influence the interpersonal process of communication with patients from diverse cultures (Pasquali 1974; Snow 1978). To achieve the understanding of cultural factors and thereby improving nursing care to all people, deTornyay (1974) suggested strengthening the cultural component of the nursing curricula.

Obstetrical Folk Medical Beliefs and Superstitions

This section of the review of literature expounds on the obstetrical folk medical beliefs and superstitions used in the questionnaire tool. The questionnaire tool consisted of ten questions that reflected common folk medical beliefs and superstitions which are prevalent in many various cultures. The ten folk medical beliefs and superstitions were chosen because of their cross-cultural consistency. Each folk medical belief and superstition was dealt with under a separate subheading.

Most societies believed that a pregnant woman was in a particularly vulnerable state of health (Johoda 1969). Every culture had strong beliefs about factors which influenced the danger or enhancement of the outcome of pregnancy and childbirth (Chinn 1971). The kind of experience a woman had during pregnancy was thought to influence the offspring in various ways. Common obstetric folk beliefs and superstitions involved strict limitations (taboos) of certain types of behavior or exposure to certain specified influences (Chinn 1971). These influences could be either external or internal. External influences could be the ingestion of food, exposure to some form of "evil eye", or participation in some specific activity. Internal influences (from within the mother herself), could result from sudden fright, anger, frustrations, or peace and tranquility (Chinn 1971).

In some modern cultures the spiritual reasons for the attitudes and beliefs toward external influences of folk medicine and superstition have been lost, but the practice continues to exist (Chinn 1971). Often the individual who practiced folk medical beliefs and superstitions was not fully convinced of their effectiveness, but was afraid to break taboos just in case they should turn out to be valid (Chinn 1971; Simon 1973). In many cases where no harm is done, the belief is important

to the mental health or social well-being of the pregnant woman and her family (Chinn 1971). To attempt to omit or ignore the folk medical beliefs and/or superstitions may possibly create cultural dissonance and result in patient noncompliance with the medical regimen.

Pregnancy, menstruation, and childbirth continue to be regarded by many cultures as unsuitable for open discussion. While this attitude lingers on in modern society, superstition and old wives' tales will continue to exist and exert their influence to create confusion (Camp 1974). Until individuals understand the female phenomenon of pregnancy, menstruation, and childbirth, the concepts of superstition and folk medicine will continue to prevail. As stated earlier, superstition is man's coping method for explaining the unknown forces of nature (Bauer 1969; Camp 1974; Simons 1973).

Children Born or Conceived During a Full Moon
Will Be Stronger and/or More Muscular
Than Those Not Born During
A Full Moon

In many societies the moon was called the great midwife (Leach 1961). Numerous folk beliefs and superstitions were related to the moon. Many cultures believed the moon to be a feminine entity. The Greek deity Diana was patron of the moon (Hamilton 1942).

A common cross-cultural folk belief was that children conceived or born at a full moon would be stronger and/or more muscular than those not born during a full moon (Harley 1969; Jacob 1967; Randolph 1947; Simons 1973). This belief placed emphasis on the time of month conception and/or birth occurred. Similiar beliefs served as the basis for astrology. The time of birth (such as during a full moon) had many common maxims. One maxim most people are familiar with is:

Monday's child is fair of face,
 Tuesday's child if full of grace,
 Wednesday's child is loving and giving,
 Thursday's child must work for a living,
 Friday's child is full of woe,
 Saturday's child has far to go,
 But the child that is born on the Sabbath day
 Is blithe and bonny and good and gay (Emrich 1972; 636).

The rationale for the birth and/or conception during a full moon relating to the size and strength of the offspring was explained by a Mississippi Negro prophetess:

...the bes' time fer birthin' chillun, 'ca'se de moon's gedderin' strengt' t' come new, en de baby is gittin' strengt' t' come wid it. En ef it comes jes atter de new moon, dat's jes ez good, 'ca'se de Bible say 'ez de moon wax strong in de heb'm so will de young on de ye'th' (Botkin 1971: 627).

The belief that things increased and decreased with the moon indicate that the days just before and after the new moon were the best days to have a big strong healthy baby.

During this time the moon had all of it's strength and therefore, the baby should have all of it's strength. "The moon has a special hand in the birth of children" (Harley 1969; 193).

Lifting of the Arms Over One's Head
Will Cause the Umbilical Cord
To Wrap Around the
Baby's Neck

This folk belief (or superstition) was also found cross-culturally. In many cultures women were forbidden to make nets for fishing, plait ropes, or even braid their hair for fear of causing the umbilical cord to strangle the baby. It was also a taboo for a pregnant woman to raise her arms above her head for the same fear of strangulation of the fetus (Bauer 1969; Boegehold et al. 1978; Camp 1974; Hand 1976; Kennett 1976).

In many cultures this served as a reduction in the daily duties normally performed by the pregnant woman and allowed for more rest. In some of the more primitive cultures, breech of this taboo (like many other taboo breeches) was grounds for death.

Frightened Women Have Babies With
Birthmarks Resembling the
Object That Frightened
the Mother

A common folk belief was that birthmarks were caused by a pregnant woman witnessing an unpleasant or

frightening sight (Boegehold 1978; Boegehold et al. 1978; Botkin 1971; Camp 1974; Chinn 1971; Emrich 1972; Hand 1976; Jacob 1967; Randolph 1947). The birthmark on the baby would supposedly resemble the object that frightened the mother during her pregnancy. An example of this belief was about a woman who had been frightened by a mouse during her pregnancy. The woman had thrown her hand up to her forehead in fear, and as a result the son was born with a mouse birthmark on his forehead (Emrich 1972). Another pregnant woman burned her fingers while cooking. She immediately withdrew her hand and touched her breast-- on her newborn daughter's chest there appeared the impression of the five fingers (Emrich 1972). These examples may sound ridiculous to some readers, but to the believers in folk medicine and superstition many such stories are considered logical.

Folk medicine also provides for the prevention and 'cure' of birthmarks. To avoid facial birthmarks on the unborn child, the pregnant woman was advised not to touch her face during the entire pregnancy (Emrich 1972). If a woman accidentally touched her face while pregnant, she was instructed to immediately cross herself in the name of the trinity. Numerous 'cures' for the removal of birthmarks exist. Rubbing the birthmark with the hand of a corpse was thought to be effective (Bauer 1969; Coffin 1976).

An English belief was to lick the birthmark for nine successive mornings for removal (Camp 1974). The American Negroes added fasting and silence to this ritual of licking for removal of a birthmark (Emrich 1972). These folk medical 'cures' are similiar to the common expression, "kiss the place and make it well" (Camp 1974: 53). Another cure for birthmark removal was to rub the birthmark with a fresh hen's egg at 9 A.M. or just prior to sunrise for nine mornings, and then to bury the egg under the doorstep. Rubbing the birthmark with a duck's foot was also thought to be effective (Emrich 1972).

Blair (1976) explained why folk remedies for birthmark removal continue to be used today. She surmised that newborns sometimes develop a rash, erythem toxicum or mongolian blue patches which may be found on the back or buttocks which do fade and become lighter with time. Hemangioma, more commonly known as stork bites, appear as mauve blotches which are often present at birth and do gradually disappear by themselves. These instances of skin discoloration are what probably reinforced the traditions of treating birthmarks by folk beliefs. These practices could be explained as a Skinnerian causal connection (Lefrancois 1972).

Foods Craved During Pregnancy Cause the
Baby to be Born With a Birthmark
Resembling the Craved Food

Another common folk belief was that a pregnant woman's cravings for some particular food should be satisfied. If the pregnant woman's cravings were not satisfied, the child might be born with a birthmark resembling the craved food item (Anderson 1970; Bauer 1969; Chinn 1971; Emrich 1972; Hand 1976; Randolph 1947).

The inordinate cravings a pregnant woman may have for a certain food had no dietary meaning in folk beliefs (Emrich 1972; Snow 1978). In the review of literature, the only relationship with foods craved during pregnancy was that of birthmarks. An example of this folk belief was an incident where a pregnant woman desired blackberries. She did not receive the blackberries, and the child happened to be born with a birth mark resembling a bunch of blackberries on his forehead (Emrich 1972). This same example could have used the variety of foods craved which resemble birthmarks, such as strawberries or ginger snap cookies.

To prevent this type of birthmark, the folk community strived to provide the foods craved by pregnant women in the hope of preventing birthmarked children. The 'cure' for this type of birthmark was to rub the birthmark with an

object closely resembling the birthmark. For example, a strawberry type birthmark should be rubbed with strawberries. Another 'cure' was for the person pigmented with the birthmark to eat as much of the item resembling the birthmark until their body was tired of the item. The rationale was that the body's craving that was denied during pregnancy had now been appeased (Puckett 1968).

More Babies are Born During A Full Moon

Once again the moon is believed to be related to childbirth. This was a common cross-cultural folk belief with little documentation of facts.

Leach (1961) observed that hospital births showed a significant trend for maximum births at a new moon. Leach also declared that sixty percent of births begin at night regardless of the season, peaking about 3 A.M. and labor pains were twice as prevalent at midnight as at noon. No definite rationale could be offered other than folk cultures may have thought the moon's pull affected labor as it affected the tides.

Survival Rate for Seventh Month Babies Is Greater Than For Eighth Month Babies

A popular belief was that seventh month babies survival rate was higher than eighth month babies (Aldous

1978; Camp 1974; Randolph 1947). It was believed that the fetal position moved in utero like the hand of a clock. Each month the baby's position changed to prepare for the proper birthing position. The seventh month gestation position was believed to be better aligned with the birth position than the eighth month gestation position. Birth during the eighth month was believed to result in complications such as breech births. The complications of the eighth month positioning were thought to reduce the survival rate of eighth month babies (Aldous 1978).

Placing a Sharp Object Under the Bed
Or House Steps Will Reduce the
Intensity of Labor Pains and
Make Delivery Easier

The practice of placing sharp objects under a laboring woman's bed or house steps to reduce the intensity of labor pains was widespread (Bauer 1969; Botkin 1971; Camp 1974; Coffin 1976; Emrich 1972). In many cultures the sharp object was left in place to reduce the incidence of afterbirth pains. The sharp object could be an ax, plowshare, knife, or razor blade. The rationale for the sharp object was to "cut" the pains, thereby reducing the intensity (Botkin 1971:627).

The act of placing sharp objects near the laboring woman offered a form of family involvement. The moral support from family and friends served as a reduction of the fear-tension-pain cycle which usually increased fear and pain.

Lactating Mothers Cannot Conceive

A cross-cultural belief was that lactating mothers could not conceive (Boegehold 1978; Camp 1974; Erickson 1963; Kippley 1974; Simons 1973; Topkins 1958). Many cultures imposed man-made taboos regarding sexual intercourse with a lactating woman. Breach of this taboo could result in disaster. To avert such disaster, a complex ritual which included the cutting off of a dog's ear was sometimes used (Simon 1973). The man-made taboo against intercourse with lactating mothers resulted in a widespread custom of nursing infants for two or even three years. This was the only form of community approved sexual abstinence available to women in many cultures. The abstinence was folk women's method of birth control. Complete breast feeding was a fairly effective method of decreasing ovarian function and consequently decreased conception in the event of intercourse (Camp 1974).

Udesky (1950) studied 121 nursing mothers to determine the effectiveness of lactation as a method of

birth control. The results revealed that about 3 1/2 percent of nursing mothers became pregnant before menstruation returned following childbirth. The 3 1/2 percent result was recognized as evidence that there was considerably less risk of conception among nursing mothers (Kippley 1974; Topkins 1958).

Control of Excessive Bleeding
Could be Achieved by
the Use of Cobwebs
and/or Soot

Excessive bleeding is considered a medical emergency cross-culturally. Many treatments to control bleeding exist, but the most common practices in the review of the literature centered around the use of cobwebs and/or soot (Anderson 1970; Bauer 1969; Coffin 1976; Hand 1976; Kennett 1976; Killion 1972; Paredes 1971; Puckett 1968).

The bleeding area was packed with cobwebs or soot to seal the wound. The cobwebs and soot would become tenacious and conform to the shape of the wound providing a sealing effect. Soot offered an effective sealing effect with slight chance of infection since it is the result of fire which sanitizes. In 1882 a substance called arachnidin was isolated from spider webs (cobwebs) which proved to be a remarkable fever reducer (Leach 1961). The arachnidin in spider webs and soot being a sanitized by-product of fire resulted in decreased bleeding with minimal inflammation.

Never Bathe or Wash Hair During Lochia
As This May Cause Coughs, Colds,
Or Respiratory Distress

The belief that a woman is unclean during menses continues to be prominent today.

Among the taboos connected with illness the 'uncleanness' of the woman during menstruation or pregnancy is by far the commonest. From Alaska to Africa, Europe to Australia, taboos are found forbidding association with, or even touching a woman during childbirth or while having a menstrual flow (Camp 1974; 34).

The attitude of "uncleanness" has created a multitude of folk beliefs regarding menstruating women. A common belief was that these women should not bathe nor wash their hair while menstruating as it could result in coughs, colds, or respiratory distress (Camp 1974; Randolph 1947). A similar belief was that pregnant women should avoid baths since the water may get up to the baby and create problems (Bauer 1969).

Another folk belief was that women should never be bathed all over or her bedding completely changed for nine days postpartum. This was similar to the belief that no sweeping of rooms was permissible after childbirth or when the newborn was asleep (Puckett 1968). The rationale for both beliefs stemmed from the idea that at birth the baby's body and spirit were not fully united. To create unnecessary drafts or movements could blow the

spirit away from the baby's body. If the spirit (soul) portion of the newborn was lost, the baby would die (Puckett 1968). The spirit/soul could not be hastened in the joining process. After an allocated period of time, it was assumed that the spirit/soul was ready to be joined with the baby's body to be made complete. This joining process between body and soul was performed by baptism.

...baptism illustrates a curious mixture of pagan and Christian beliefs. Both the Druids and the Norsemen held naming ceremonies, which not only protected the child from disease but also legalized its existence and gave it the right of inheritance. Even today, in some areas, when an unbaptized child is taken ill the mother will send to the church for a supply of 'christening water' in an attempt to cure it (Camp 1974: 50).

The beliefs of bathing also applied to women's hair. Beliefs such as permanents received while pregnant would not take curl (Paredes 1971). Pregnant women were advised not to comb their hair for ten days before delivery in the belief that it would turn gray or fall out (Puckett 1968). Hair was not to be combed for a month postpartum or it would fall out and never grow back again (Puckett 1968).

Conclusion

The review of literature has included material germane to the importance of incorporating cultural and

ethnic teachings within nursing curricula. Included was a review of literature to elucidate the folk beliefs used in the tool for the thesis. The review of literature was to inform the reader of the background, rationale, and importance of folk beliefs and superstitions to people whose traditional cultural heritage is based on such beliefs. Dorson (1972) stated the signs seem to be pointing to the need for re-examining the folk medical heritage. "The history of folk medicine is the history of medicine: a long drama of trial, error, and dedication" (Leach 1971: 699).

Reaching patients from other cultures requires understanding and acceptance of their way of thinking (Glittenberg 1974). Many folk cultural people distrust medical strangers and may find modern medical practices to be in violation of their cultural beliefs. Culture not only influences man's life style and value systems, it also differentiates his attitudes and responses to illness and treatment (Pasquali 1974). Ignoring cultural differences may interfere with nurse-patient interactions and patient compliance. "Social science concepts, especially those related to ethnic and cultural diversity are--or should be--an important part of nursing curricula" (Kotchek 1978:5).

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This chapter presents the methodology used in the study to assess the knowledge among senior baccalaureate nursing students regarding obstetrical folk beliefs and superstitions. The first section deals with the setting for the study. The second section includes the population from which the sample was derived and the method for selection of the sample. The third section consists of information regarding human rights. The final sections discuss the tool used in this study and the collection and treatment of the data.

Setting

The setting for this study included four universities located in a southwestern urban setting with a population of over one million. Each university selected for the study has within it an accredited baccalaureate program of nursing. The urban area has multiple hospital complexes which serve the city with a large county hospital serving all races and cultures of people.

Population and Sample

The sample used for this study consisted of 106 senior nursing students enrolled in accredited baccalaureate schools of nursing within the metroplex. Four of the five baccalaureate nursing programs in the metroplex agreed to participate in the study. Subjects from each of the four universities were tested using the same questionnaire tool and demographic data sheet. All subjects sampled had completed a clinical rotation in the obstetrical area prior to this study.

The subjects were selected by a convenience sample. The convenience sample resulted from the Dean of each participating university selecting classrooms of senior nursing students attending their program of nursing to participate in this study. The students were informed in writing that participation in the study was voluntary. The nursing instructors of the selected classrooms administered the consent forms and questionnaires to the student subjects in the classroom setting. The investigator had no contact with the subjects other than the written contents of the questionnaire, consent form, and letter of explanation of the study.

Thirty-three questionnaires with written explanations attached were left with the Dean of each participating university. The number thirty-three was chosen to insure the proposed sample size of at least one hundred student responses to the questionnaire. Of the thirty-three questionnaires left at each of the four universities, the sample results were: 31 subjects out of a possible 116 senior nursing students (26 percent) responded to the questionnaire from University W; 31 subjects from University X out of a possible 155 (20 percent) responded to the questionnaire; 19 subjects from University Y out of a possible 101 nursing seniors (18 percent); and 25 subjects from University Z out of a possible 35 seniors (71 percent) participated in the study by responding to the questionnaire. A total of 106 senior nursing students of accredited baccalaureate nursing programs in the metroplex comprised the study sample.

Human Rights

Permission to conduct this study was received from the Texas Woman's University Research Review Committee using the appropriate procedures outlined by the University. The facilities where data were collected were contacted and permission obtained to use their students for sample

subjects according to procedures outlined by Texas Woman's University (Appendix A).

Each subject in the study was presented with a written explanation of the study and consent form (Appendix B). The participants were assured anonymity by the fact that no signatures were required on the questionnaires. The subjects were informed that they could decline to participate in the study and could withdraw from the study at any time.

Tool

The questionnaire (Appendix C) was developed by the investigator based on the purposes of the study and a review of the literature. The tool consisted of ten items which reflected obstetrical folk beliefs and superstitions which are prevalent in various cultures. The cultures included Black, American Indian, Mexican-American, and European influences. The ten items reflected common folk beliefs relating to obstetrics cross-culturally. The same tool was used by all senior nursing students sampled.

Panel

The questionnaire was examined by a panel of four experts to verify that the folk beliefs and superstitions were broadly cross-cultural and to assess the tool's

clarity of expression. One of the experts was a certified midwife. The nurse midwife received her registered nurse license from Louisiana in 1972. She has been a nurse midwife in Mississippi since 1975.

The second expert on the panel was a medical anthropologist with a degree in Philosophy at the doctoral level. She is a professor and coordinator of the Master's and Doctoral programs in medical anthropology at a nearby university. This expert co-authored a 1978 book, Medical Anthropology.

The third member on the panel of experts was a cultural anthropologist. This member has a Doctor of Philosophy degree and teaches anthropology at a nearby university.

The fourth member on the panel of experts was a full-time faculty member at Texas Woman's University. This member was a Master's prepared registered nurse teaching nursing administration in the graduate school of nursing. Her expertise was used to assess the tool's clarity of expression. Suggested modifications made by the panel of experts were implemented within the tool.

A pilot study was conducted with the tool to substantiate its clarity by administering it to different group of students than those in the study. The pilot study

sample consisted of fourteen students similar to the subjects sampled. The findings from the pilot study were supportive of the adequacy of the tool.

The demographic data sheet included age, ethnic background, religious preference, geographical area of residence in which the subject spent most of their life, and geographical location of the program of nursing in which the subjects were enrolled.

Data Collection

Thirty-three questionnaires with written explanations attached were left with the Dean of each participating nursing program. The Dean of each participating nursing program gave the questionnaires to teachers who distributed the questionnaires to the subjects while they were in their usual classroom setting. The data were then returned to the investigator via the Dean's office. A total of 106 senior nursing students in four baccalaureate programs participated in the study.

Treatment of Data

The treatment of the data included frequency distribution and descriptive statistics. The six purposes of the study were discussed individually in Chapter IV to

explain the treatment of the data. Six tables were created to enhance understanding of the narrative findings reported.

Conclusion

The study was concerned with assessing the knowledge of senior baccalaureate nursing students regarding obstetrical folk beliefs and superstitions. The O'Leary Questionnaire on Folk Beliefs and Superstitions was designed by the investigator for data collection. The questionnaire was reviewed by a panel of experts to verify that the folk beliefs and superstitions in the questionnaire were cross-cultural. One member of the panel of experts evaluated the questionnaire for clarity of expression. A pilot study was conducted with subjects similar to the 106 senior nursing students who comprised the sample for this study. The findings of the pilot study supported the adequacy of the tool. The treatment of the data included frequency distribution and descriptive statistics.

CHAPTER IV

ANALYSIS OF THE DATA AND FINDINGS OF THE STUDY

One hundred and six senior baccalaureate nursing students from four National League for Nursing accredited programs in the metroplex took part in this study by responding to the questionnaire developed by the investigator. Each subject had three possible responses; A, B, or C (response D was optional) to each of the ten questionnaire items, making a total of thirty possible responses per subject.

Questionnaire response A indicated that the subject had learned the folk belief or superstition in the nursing program. Questionnaire response B indicated that the subject had learned the folk belief or superstition outside the nursing program. Questionnaire response C indicated that the subject had never heard of the folk belief or superstition. Response D indicated the culture the subjects attributed this belief to if they were familiar with the folk belief or superstition. Each of the purposes of the study was dealt with individually to explain the data analysis and findings.

Purpose Number One

Purpose number one was to assess the knowledge which senior baccalaureate nursing students possessed regarding the ten obstetrical folk beliefs and superstitions. This included responses A and B on the questionnaire tool. Less than 43 percent of the subjects sampled had knowledge of folk beliefs and superstitions as measured by the O'Leary Questionnaire. The findings showed that the least familiar of the folk beliefs and superstitions was item number one which referred to children born or conceived during a full moon being stronger and/or more muscular than those not born during a full moon. The most familiar item on the questionnaire tool was item number seven which referred to a woman becoming pregnant while breast feeding an infant. The responses to each item on the questionnaire for each of the four participating baccalaureate programs of nursing are depicted in Table 1.

Purpose Number Two

Purpose number two determined if subjects who were aware of folk beliefs and superstitions related these beliefs to a particular ethnic group. This data were based on the number of responses to response D on the questionnaire. No pattern prevailed in the findings. The responses

TABLE 1
FREQUENCY DISTRIBUTION OF NUMBER OF A* AND B**
STUDENT RESPONSES TO QUESTIONNAIRE ITEMS 1 - 10

Program of Nursing Sampled	Questionnaire Items									
	1	2	3	4	5	6	7	8	9	10
University W (n = 31)	3	17	15	6	17	16	24	5	18	10
University X (n = 31)	0	19	18	7	12	20	25	8	17	10
University Y (n = 19)	2	4	5	3	8	5	11	1	10	1
University Z (n = 25)	10	13	6	1	13	2	18	1	14	6

*Response A was learned in nursing program.

**Response B was learned elsewhere (outside of or prior to entrance to nursing program).

included fifty five Whites; forty-four Black; forty Mexican; five Indian; seven classified as other; and twenty-six responses referred to the beliefs being present in all ethnic groups of people. There were no correct answers since the questionnaire items were cross-cultural and reflective of many cultures.

Purpose Number Three

Purpose number three determined the number of students who had learned of the folk belief and superstition questionnaire items while in nursing school (response A on the questionnaire). Thirty-one subjects from University W responded to the questionnaire. The findings revealed forty-nine (15 percent) out of 310 possible A responses (learned in nursing school) from University W. University X also had thirty-one subjects participate in the study. Subjects from University X responded with fifty-four (17 percent) out of 310 possible A responses. Nineteen subjects participated from University Y. The subjects from University Y responded with sixteen (8 percent) out of the 190 possible A responses. University Z was represented by twenty-five students participating in the study. The subjects from University Z responded with eight (3 percent) out of the 250 possible A responses. University Z had the least amount of

A responses (learned in nursing school) than the other three universities sampled.

The findings revealed that subjects from Universities W and X appeared to receive more folk belief and superstition instruction in their nursing curriculum than did the subjects from Universities Y or Z. These findings were suggestive of the cross-cultural ethnic teachings in the curriculum of the programs of nursing sampled. The findings were included in Table under the heading of Response A.

Purpose Number Four

Purpose number four was to determine the number of students who had learned of the folk belief and superstition questionnaire items outside the school of nursing (response B on the questionnaire). Thirty-one subjects from University W responded to the questionnaire. The findings revealed that subjects from University W responded with eighty-two (26 percent) out of the 310 possible B responses.

University X also had thirty-one subjects participate in the study. Subjects from University X responded with eighty-two (26 percent) out of a possible 310 B responses (the same as University W).

University Y had nineteen subjects participate in the study. The subjects from University Y responded with thirty-four (17 percent) out of a possible 190 B responses.

TABLE 2

FREQUENCY DISTRIBUTION COMPARISON OF STUDENT QUESTIONNAIRE RESPONSES
A AND B REPRESENTING THE FOUR PROGRAMS OF NURSING SAMPLED

Program of Nursing Sampled	Response A--Acquired Knowledge in Nursing School		Response B--Acquired Knowledge Outside Nursing School	
	Number of Responses	Percentage	Number of Responses	Percentage
University W (n = 31)	49	15%	82	26%
University X (n = 31)	54	17%	82	26%
University Y (n = 19)	16	8%	34	17%
University Z (n = 25)	8	3%	56	22%

University Z was represented by twenty-five students participating in the study. The University Z subjects responded with fifty-six (22 percent) out of the possible 250 B responses.

The findings revealed that 17 to 26 percent of the subjects sampled had heard of the folk beliefs and superstitions outside the school of nursing they were attending. Subjects from University Y were the least familiar with the folk beliefs and superstitions. The findings from University W and X were identical for response B. These findings were depicted in Table 2 under the heading Response B.

Purpose Number Five

Purpose number five compared subjects' knowledge of folk beliefs and superstitions learned in nursing programs (questionnaire response A) to subjects' knowledge attained outside the college of nursing (questionnaire response B). The findings revealed that more students sampled from each of the four programs of nursing had attained more folk knowledge outside of the nursing curricula than within the school of nursing.

The findings revealed that 17 to 26 percent had become knowledgeable of the folk belief and superstition

outside of the nursing program. Three percent to 17 percent of the students became knowledgeable of the folk beliefs and superstitions as a result of nursing school education. These findings are depicted in Table 2.

Purpose Number Six

Purpose number six compared the subjects' questionnaire responses with the subjects' demographic data. The subjects' demographic data included age, ethnic background, religious preference, and geographical area of residence in which the subjects spent most of their lives. Geographical locations of the nursing programs were not a variable in this study since all four programs of nursing sampled were located within the same metroplex in the southwestern United States.

Among the 106 subjects sampled, ninety-two were White with 109 A responses (learned in nursing school) and 240 B responses (learned outside of the nursing school). The findings represent 11 percent and 26 percent of A and B responses respectively. Seven subjects sampled were Black with fifteen A responses and fifteen B responses (21 percent and 21 percent respectively). Five subjects sampled were classified as others and responded with three A responses and six B responses (6 percent and 12 percent

respectively). Due to the limited variations in ethnic background of the subjects sampled, no inferences regarding this variable of ethnic background could be made. These findings are depicted in Table 3.

Findings of the variable regarding religious preference revealed eighty-one (76 percent) of the 106 subjects were Protestants. The figures reflect ten opportunities for each of the eighty-one subjects to respond to responses A or B, or 810 possible A or B responses. Out of the eighty-one Protestant subjects, eighty-seven (10 percent) responded A (learned in nursing school) with 217 (26 percent) responding B (learned outside of nursing school).

Fifteen subjects' religious preference was Catholicism. Twenty-six Catholic subjects (17 percent) responded to response A (learned in nursing school), while thirty-two (21 percent) responded to response B (learned outside of nursing school). Ten subjects were classified as others. These ten subjects responded fourteen times to response A (14 percent) and twenty-five times to response B (25 percent). Due to the limited number of responses regarding this variable, no inferences regarding the variables of religious preference could be made. These findings are depicted in Table 4.

TABLE 3
SUBJECTS' ETHNIC RESPONSES* TO
QUESTIONNAIRE ITEMS 1-10

	Response A Learned in Nursing School		Response B Learned Outside Nursing School		Response C Never Heard of it	
	Number of Responses	Percentage	Number of Responses	Percentage	Number of Responses	Percentage
Black (n=7)	15	21	15	21	25	35
White (n=92)	109	11	240	26	538	58
Others (n=5)	3	6	6	12	23	50

*Two subjects did not respond to this item.

TABLE 4
SUBJECTS' RESPONSES TO QUESTIONNAIRE
ITEMS 1-10 BASED ON
RELIGIOUS PREFERENCE

	Response A Learned in Nursing School		Response B Learned Outside Nursing School	
	Number of Responses	Percentage	Number of Responses	Percentage
Protestant (n=81)	87	10	217	26
Catholic (n=15)	26	17	32	21
Others (n=10)	14	14	25	25

Findings regarding the geographical area of residence in which the subjects spent most of their lives revealed that eighty-one of the 106 subjects sampled spent the majority of their lives in the southwestern United States. The eastern border of Texas was used to differentiate southwest from the southeast. Ninety-seven (11 percent) responded A (learned in nursing school) and 211 (20 percent) responded B (learned outside of nursing school).

Fourteen subjects lived the majority of their lives in the southeast. Nine (6 percent) responded A and forty (28 percent) responded B.

Eleven subjects had resided the majority of their lives in the northern United States. The geographical areas were divided north and south by a line drawn on the southern borders of Oregon, Idaho, Wyoming, Nebraska, Iowa, Illinois, Indiana, Ohio, Pennsylvania, and New Jersey. Twenty-one (19 percent) responded A, while twenty-three (20 percent) responded B (learned outside of nursing school). The findings revealed that subjects from the Southeast had learned 8 percent more regarding folk beliefs and superstitions than subjects from the North or Southwestern United States. These findings are depicted in Table 5.

TABLE 5

SUBJECTS' RESPONSES TO QUESTIONNAIRE
ITEMS 1-10 BASED ON GEOGRAPHICAL
AREA OF RESIDENCE

	Response A Learned in Nursing School		Response B Learned Outside Nursing School	
	Number of Responses	Percentage	Number of Responses	Percentage
Southeast U.S. n=4	9	6	40	28
Southwest U.S. n=81	97	11	211	20
Northern U.S. n=11	21	19	23	20

Data regarding subjects' ages were classified as 21 to 25; 26 to 29; and 30 years or older. Eighty-three of the 106 subjects fell within the 21-25 year old bracket. Ninety-six (11 percent) responded to A (learned in nursing school). Another 196 (23 percent) responded to B (learned outside of nursing school). Response C (never heard of it) received 472 (56 percent).

There were fourteen subjects in the 26-29 age bracket. Nineteen (13 percent) responded A, while thirty-nine (27 percent) responded B. Response C had seventy-five (53 percent).

There were nine subjects in the thirty years or older age bracket. The findings showed twelve (13 percent) A responses; thirty-nine (43 percent) B responses; and forty-two (46 percent) C responses. The findings revealed that senior nursing students 30 years and older were more knowledgeable of folk beliefs and superstitions and that they had attained this knowledge outside of the nursing program. The findings are depicted in Table 6.

Summary

The six purposes of this study have been presented to explain the findings regarding senior nursing students' knowledge of obstetrical folk beliefs and superstitions.

TABLE 6

SUBJECTS' RESPONSES TO QUESTIONNAIRE
ITEMS 1-10 BASED ON SUBJECT AGE

Age in Years	Response A Learned in Nursing School		Response B Learned Outside Nursing School		Response C Never heard of it	
	Number of Responses	Percentage	Number of Responses	Percentage	Number of Responses	Percentage
21 to 25 n=83	96	11	196	23	472	56
26 to 29 n=14	19	13	39	27	75	53
30 and over n=9	12	13	39	43	42	46

The analysis of the data collected using the O'Leary Questionnaire on Folk Beliefs and Superstitions has been presented. The findings will be reiterated in Chapter V under the heading, Summary.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Culture is a universal concept. Folk beliefs and superstitions are an integral part of any culture known to man. Folk beliefs exist in man's attempt to understand nature and the world around him. Cultural beliefs and superstitions especially influence people's perception of health and illness. Cultural concepts affect the nurse as a health care provider. If the nurse cannot accept the cultural diversity of her patients, dissonance may occur. To reduce this dissonance, the authors cited in this study have recommended that a stronger cultural component be included in the nursing curricula. This study assessed the level of knowledge among senior baccalaureate nursing students regarding obstetrical folk beliefs and superstitions.

Summary

The problem of this study was to determine what the level of knowledge was among baccalaureate senior nursing students regarding obstetrical folk beliefs and superstitions. Knowledge of obstetrical folk beliefs and

superstitions may reduce conflicting cultural beliefs between patients who have folk beliefs and nurses who care for such patients.

The sample in the study was comprised of 106 senior baccalaureate nursing students from four National League for Nursing accredited programs of nursing located in a southwestern urban setting. The subjects were selected by a convenience sample. The convenience sample resulted from the Dean of each program of nursing selecting the classrooms of students in the nursing program to be sampled.

The data were collected using a questionnaire designed by the investigator. The questionnaire was examined by a panel of four experts in the fields of nursing and anthropology. The panel of experts verified that the folk beliefs and superstitions in the questionnaire were cross-cultural and that the questionnaire had clarity of expression. A pilot study was conducted with subjects similar to the 106 senior nursing students who comprised the sample for this study. The findings of the pilot study were supportative of the adequacy of the tool. The data were analyzed using frequency distribution and descriptive statistics.

A summary of the study findings are listed below:

1. Less than 43 percent of the senior nursing students sampled had knowledge of folk beliefs or

superstitions as measured by the O'Leary Questionnaire (learned either in the program of nursing or outside the program of nursing)

2. The subjects sampled did not attribute the obstetrical folk beliefs and superstitions to any particular ethnic group (there was no correct response since each questionnaire item was broadly cross-cultural and reflective of many cultures)

3. Subjects sampled from four programs of nursing revealed 3 percent, 8 percent, 15 percent, and 17 percent had acquired this knowledge within the nursing program

4. Subjects sampled from four programs of nursing revealed 17 percent, 22 percent, 26 percent, and 26 percent had acquired this knowledge outside the nursing program

5. Subjects attained more knowledge regarding folk beliefs and superstitions outside the nursing program than within the nursing curricula

6. No inferences regarding the ethnic background of the subjects could be made due to the limited variation in ethnic backgrounds of subjects

7. Religious preference of subjects sampled did not appear to be a significant variable

8. Subjects from the Southeastern United States were 8 percent more knowledgeable of folk beliefs and

superstitions than were subjects from the Northern or Southwestern United States (indicating geographical area of residence to be a significant variable)

9. Senior nursing students thirty years or older were more knowledgeable of folk beliefs and superstitions than the younger subjects, and they had attained this knowledge outside the nursing program indicating age to be a significant variable

Conclusions

The following conclusions resulted from the study:

1. Less than 18 percent of the senior baccalaureate nursing students had become knowledgeable of folk beliefs or superstitions as part of their nursing curricula. This suggested a deficiency in cross-cultural ethnic teaching. Ethnocentrism among nurses will continue to exist unless the nurse is cognizant that cultural differences do not necessarily mean social deviance in a negative sense of the word.

2. An increased knowledge base of folk beliefs and superstitions would enhance interpersonal communications between nurses and patients who have folk beliefs and superstitions. Enhanced interpersonal communications may result in reduced dissonance among patients and nurses who have idiosyncratic cultural beliefs. All geographical

areas of the United States lack sufficient knowledge of folk beliefs and superstitions despite the Southeast scoring 8 percent higher than the Southwestern or Northern United States.

Recommendations

The following areas are recommended for further study:

1. The validity and reliability of the O'Leary Questionnaire on Folk Beliefs and Superstitions should be determined
2. A similar study should be done to assess the knowledge of obstetrical folk beliefs and superstitions among nurses in programs of nursing in other areas of the United States since geographical area of residence was shown to be a significant variable
3. The investigator recommends that cross-cultural ethnic teachings be included as an integral part of nursing program curricula to enhance patient-nurse interpersonal communications and reduce ethnocentrism among nurses

Appendix A

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Baylor College of Nursing

GRANTS TO Maureen Kathleen O'Leary

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To evaluate the level of knowledge of baccalaureate senior nursing students regarding obstetrical folk medicine and superstition.

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date

1/24/79

Maureen K. O'Leary
Signature of student

Debbie M. Laughlin
Signature of Agency Personnel

Cheryl Anderson
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Participating Agency

GRANTS TO Maureen Kathleen O'Leary

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To evaluate the level of knowledge of baccalaureate senior nursing students regarding obstetrical folk medicine and superstition.

The conditions mutually agreed upon are as follows:

1. The agency (~~may~~) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (~~may~~) (may not) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date January 22, 1979

Maureen K. O'Leary
Signature of student

Detty H. Underwood
Signature of Agency Personnel

C. H. Anderson
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
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Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Texas Christian University-Harris College of Nursing

GRANTS TO Maureen Kathleen O'Leary

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (~~wants~~) (~~does not want~~) ^{does not want} a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date 1-31-79

Maureen K O'Leary
Signature of student

Deanna Garrett
Signature of Agency Personnel

Ch Anderson M.D.
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.S. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Dallas Baptist College of Nursing

GRANTS TO Maureen Kathleen O'Leary

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To evaluate the level of knowledge of baccalaureate senior nursing students regarding obstetrical folk medicine and superstition.

The conditions mutually agreed upon are as follows:

1. The agency (may) ~~(may not)~~ be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) ~~(may not)~~ be identified in the final report.
3. The agency ~~(wants)~~ ~~(does not want)~~ a conference with the student when the report is completed.
4. The agency is (willing) ~~(unwilling)~~ to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date Feb. 2, 1979

Sandra Blasingame (Harmon)
Signature of Agency Personnel

Maureen K. O'Leary
Signature of Student

Carol Anderson
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy - agency; second copy - T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Maureen O'Leary Center: Dallas
Address: 1810 Inwood Road, #214 Date: 12/19/78
Dallas, Texas 75235

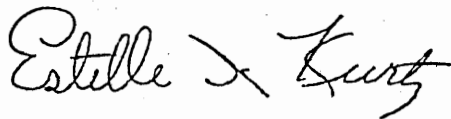
Dear Ms. O'Leary:

Your study entitled Senior Nursing Students' Knowledge of Obstetrical Folk Medicine and Superstition has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,



Chairman, Human Research
Review Committee

at Dallas.

APPENDIX B

TEXAS WOMAN'S UNIVERSITY

(Form A - Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

(The following information is to be read to or read by the subject)

1. I hereby authorize Maureen O'Leary
 (Name of person(s) who will perform
 procedure(s) or investigation(s)).
 to perform the following procedure(s) or investigation(s):
 (Describe in Detail) To request subjects to fill out a questionnaire
 tool and demographic data sheet regarding obstetrical folk medicine and
 superstition. See attached letter explaining the study to subjects.
2. The procedure of investigation listed in Paragraph 1 has been explained
 to me by Maureen O'Leary
 (Name)
3. I understand that the procedures or investigations described in Para-
 graph 1 involves the following possible risks or discomforts:
 (Describe in detail) No physical discomfort is expected from filling out
 the questionnaire. Potential risks to human subjects may include
 embarrassment and accidental improper release of data.
4. I understand that the procedures and investigations described in
 Paragraph 1 have the following potential benefits to myself and/or others:
 It is postulated that increased knowledge of obstetrical folk medicine
 and superstition will enhance nursing care to multi-ethnic patients.
5. An offer to answer all of my questions regarding the study has been
 made. If alternative procedures are more advantageous to me, they have
 been explained. I understand that I may terminate my participation in
 the study at any time.

Subject's signature_____
Date

A BRIEF EXPLANATION OF STUDY TO SUBJECTS

I am a graduate nursing student at Texas Woman's University conducting a research investigation to assess the knowledge among senior baccalaureate nursing students regarding obstetrical folk beliefs and superstitions. I would appreciate your participation in this study. Participation involves filling out a brief questionnaire and demographic data sheet. This will take approximately five minutes of your time. If you agree to participate in the study, please read and sign the attached consent form which will be kept on file by the investigator. You have the right to refuse to participate in this study and the right to withdraw from the study at any time. No physical discomfort is expected from filling out the questionnaire. All data will remain confidential to protect subjects from risks of embarrassment and improper release of data. Your identity will remain anonymous since no name will appear on the questionnaire. It is postulated that increased knowledge of obstetrical folk beliefs and superstition will enhance nursing care to multi-ethnic patients.

Maureen Kathleen O'Leary, R.N.

APPENDIX C

DEMOGRAPHIC DATA FOR QUESTIONNAIRE

_____ Age

_____ Ethnic Background

_____ Religious Preference

_____ Geographic area where you spent most of your life
(city and state)

_____ Name of school of Nursing (include city and state)

O'LEARY QUESTIONNAIRE ON FOLK
BELIEFS AND SUPERSTITIONS

Directions: Circle the appropriate number according to the following key.

- A. Learned in nursing program.
 - B. Learned elsewhere (outside of or prior to entrance to nursing program).
 - C. Never heard of it.
 - D. If you have heard of this belief, to what culture do you relate it to (Black, Mexican-American, etc.)
-
- 1. Children born or conceived during a full moon will be stronger and/or more muscular than those not born during a full moon.
A B C D _____
 - 2. A pregnant woman will cause the umbilical cord to wrap around the baby's neck if the pregnant woman lifts her arms over her own head while pregnant.
A B C D _____
 - 3. A woman frightened during her pregnancy will have a baby with a birthmark resembling the object that frightened the pregnant woman.
A B C D _____
 - 4. If foods craved by a pregnant woman are not supplied, the baby will be born with birthmarks resembling the food items the mother craved (but did not eat) during pregnancy.
A B C D _____

5. More babies are born during a full moon than at other times during the month.
A B C D _____
6. Placing a sharp object (such as an ax, plowshare, or razor) under the bed or house steps will reduce the intensity of labor pains and make delivery of the baby easier.
A B C D _____
7. A woman cannot become pregnant while breast feeding an infant.
A B C D _____
8. Control of excessive bleeding postpartally can be achieved by the use of cobwebs and/or soot.
A B C D _____
9. A woman should not bathe and/or wash her hair during menstruation as this may cause coughs, colds, or respiratory distress.
A B C D _____
10. The survival rate for babies born at 7 months of pregnancy is greater than for babies born at 8 months of pregnancy.
A B C D _____

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