1987

The Effects of Psychological Intervention on Primiparous Career Women's Adjustment to Motherhood after the Age of Thirty

Beth Schiff
Loyola University Chicago

THE EFFECTS OF PSYCHOLOGICAL INTERVENTION ON PRIMIPAROUS CAREER WOMEN'S ADJUSTMENT TO MOTHERHOOD AFTER THE AGE OF THIRTY

by

Beth Schiff

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

August

1987

ACKNOWLEDGMENTS

The acknowledgments which follow express my gratitude for the personal and professional support I received throughout the conception and labor pains of this dissertation. I sincerely thank the chairperson of this dissertation, Dr. Marilyn Susman, for her interest, concern, dedication, and constructive criticism. I also thank her for the trust and confidence she had in me which enabled us to exchange ideas in the most fruitful and productive ways. I am grateful to Dr. Gloria Lewis for her unfailing encouragement and support. I appreciate the gentle persevering challenges by Dr. Carol Harding related to the qualitative integrity of the research project.

I am most grateful to my parents, Joseph and Gladys Stein, who have supported me in this and all my endeavors.

Thanks go to all the women who participated in my study. They started out simply as subjects, but soon became friends.

Special thanks go to- Anne Jacobson, Kathy Kahn, Lynn Borenstein, Tina Ziegler, Missy Fleming, Michael Tobin, Fran Moore, Marla Richardson, Jill Stein, Nan Stein- my

friends, fellow students, and sisters for their support, encouragement, ideas, and criticism.

Finally, to my husband Alan and children Adam and David for their assistance and love during the pain of the process so that we could enjoy the pleasure of the end.

VITA

The author, Beth Schiff, is the daughter of Joseph and Gladys Stein. She was born September 22, 1948, in Chicago, Illinois.

She received her elementary and secondary education in Highland Park, Illinois, graduating from Highland Park High School in 1966. She attended Bradley University in Peoria, Illinois from 1967-70. She completed her Bachelor of Science Degree in Education in 1970 with a major in elementary education.

After graduating from college, she taught in the Chicago public school system from 1970 through 1981. In 1975 she began attending Northeastern Illinois University where she received a Master's of Education in Guidance and Counseling in 1978. Immediately thereafter, she began her doctoral studies in guidance and counseling at Loyola University of Chicago. In 1983 she was inducted into Loyola's chapter of Alpha Sigma Nu- the National Jesuit Honor Society. Concurrent with completing her doctoral program, she and her husband have been raising two young children. Currently she is employed as a psychologist for the Chicago Public Schools.

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CHAPTER I

INTRODUCTION

The sociological revolution of the past two decades has had particular impact on the structure of the family. Changes in values have led to alternate family arrangements: single parent families, blended families, joint-custody families, many couples choosing not to have children, and couples choosing to delay having children until their thirties and forties (Daniels & Weingarten, 1982). According to national fertility statistics, the birth rate rose dramatically in the late 1970s among women in their thirties delivering their first children (Bryant & Collins, 1985; Daniels & Weingarten, 1982). However, having one's first child at age thirty and older is still a "nontraditional" pattern. There are few precedents for becoming a parent in the middle rather than at the beginning of adult life. No traditional wisdom is available; and models and mentors are few. (Bryant & Collins, 1985; Cutrona, 1984; Leifer, 1980).

The view that parenthood is an option and that one can control the timing of prenancy has forced a shift in

the established progression of adulthood. Marriage is no longer automatically followed by parenthood. Some women are now choosing to work after marriage (Bryant & Collins, 1985). When these older, educated career women make this decision to become mothers they face unique stressors (Knaub, Eversoll & Voss, 1983). They have had time to complete their educations and to establish meaningful careers. They develop an independent identity which removes them from the traditional model of entering motherhood in the early twenties. When they do become mothers, self-image and identity reformulation are major problems for them to overcome (Bryant & Collins, 1985; Dubin, 1982; Pickens, 1982).

The trend to delay parenting has been attributed to such variables as educational level, career orientation, and feminist ideology (Knaub, Eversoll & Voss, 1983; Yogev & Vierra, 1983). These older, educated career women bring new attitudes, expectations, experiences, and needs with them as they enter motherhood. They are having fewer children; they are placing a high premium on the experience of producing and nurturing each child.

Because of this unique blend of circumstances, preparation for parenthood becomes critical (Morsbach & Gordon, 1984). However, obstetrical practice has changed little in the last twenty-five years. The major focus of prenatal and postnatal care continues to be physiology and nutri-

tion, although the actual childbirth experience has recently been given considerable attention (Eiser & Eiser, 1985). Women who desire preparation for labor and delivery can now receive courses in prepared childbirth through their hospitals. However, the experience of the older, career woman during the antenatal and postpartum period continues to be neglected by health care providers. Little attention has been paid to the mother as a human being (Eiser & Eiser, 1985).

One reason for this is that a mother's function has been seen exclusively as caring for her child. Her importance has been determined by how well she deals with her child. Her psychological well-being while preparing for and dealing with her child has been seen as unimportant. (Dubin, 1982; Grossman et al, 1980; Leifer, 1980; Shereshefsky & Yarrow, 1973.) All this seems inexcusable in the face of the current literature attesting to the real need older career women have as they enter this transition.

Need for the Study

It is evident from current research that more women are postponing motherhood until their thirties and beyond. This is particularly the case among career women who use the decade of their twenties to establish their work identities (Colman, 1978; Bryant & Collins, 1985; Daniels & Weingarten, 1982). Although psychological and emotional readiness greatly influences the timing of the transition to

adulthood, environmental and life experiences such as establishing an independent residence, beginning a career, defining secure relationships, and sexual experimentation are milestones that women strive to achieve during their twenties. Researchers have also identified several factors that influence the decision to postpone pregnancy and childbearing, including freedom and identity issues, desire for economic security, and increased career and educational opportunities for women (Frankel & Wise, 1981; Pickens, 1982; Wilkie, 1981). Relinquishing all of this presents unique stresors for the woman to overcome. As it appears that more women will be following this pattern in the future, it seems valuable for health care professionals to help these older, educated career women cope during this period (Bryant & Collins, 1985).

The importance of pregnancy as a preparation period is clear from the research that links psychological stress at this time to prematurity, spontaneous abortion, excessive vomiting, delivery room difficulties, and the physical status of the newborn (Heinstein, 1967). Researchers found evidence that even for women who optimally use their pregnancies to prepare for motherhood and who establish satisfying relationships with their infants, the transition to motherhood is difficult and the role of mother creates severe stress (Leifer, 1980; Shereshefsky & Yarrow, 1973). Holmes and Rahe (1967) listed forty-three life-changing

events in order of the amount of stress they provoked. Death of a child and spouse were cited as being the most stressful life events, with marriage, birth of a child, and starting a new job also very significant. Evidence supporting the notion that the way in which a prospective mother's environment is managed by those who care for her affects the way she adapts to her new role has been documented by researchers (Broussard, 1976; Eiser & Eiser, 1985; Gordon & Gordon, 1959; Klaus & Kennell, 1976). Caplan (1960) noted that during significant transitional periods of life, such as pregnancy, individuals often experience a heightened desire for help and may be more open to receiving help.

A growing body of theoretical and empirical literature attests to the importance of this social support for psychological adjustment and health. Social support can moderate depression (Billings, Cronkite & Moss, 1983), stress (Cobb, 1976), birth complications (Nuckolls, Cassel & Kaplan, 1972), and can ease difficult life transitions (Hirsch, 1980). Observations of people in mutual help groups reflect the epidemiological finding that individuals who form intimate relationships tend to be less affected by stress-related illnesses. Adler and Hamet (1973) cited the importance of participation in a shared cognitive system and of access to key relationships as two relevant factors in support groups. Backalenick (1974) attributed the beneficial aspect of affiliation with others to the sharing of

mutual problems and the opportunity for expression of feelings, while Ablon (1974) emphasized the identification with others. Barish (1971) thought the major function of affiliation was to counteract isolation and alienation. Hochschild (1973) felt it was the fostering of a "we" feeling that was the most comforting process of all. All concurred that the use of groups as a vehicle for the establishment of relationships that were beneficial to coping and adapting to the particular stress was advantageous.

Recently, researchers have suggested that social support would be an appropriate method of easing the transition to motherhood (Cronenwett, 1980; Cutrona, 1984; Power & Parke, 1984). However, the few previous studies (Kahn, 1978; Cutrona, 1984; Levitt, Weber & Clark, 1986; Tietjan & Bradley, 1985) are marked by diverse definitions, measurements, and agents of social support. They have primarily addressed the role of spousal support in the adjustment to motherhood. These studies have highlighted the need for an experimental study addressing the issue of whether social support would ease the transition to motherhood.

Purpose of the Study

The purpose of this study, then, is to evaluate the effectiveness of a social support group in easing the adjustment to motherhood. More specifically, this research will investigate the efficacy of psychological intervention in the form of an organized social support group in smooth-

ing the adjustment to motherhood for primiparous career women who have chosen to delay childbearing until their thirties, and who intend to stop working for at least six weeks after the birth of their children. This will be accomplished by quantitatively and qualitatively comparing a group of women participating in the support groups to a similar sample of women who do not participate. The intervention consists of weekly group sessions beginning in the ninth month of pregnancy and continuing through the first eight weeks postpartum. The topics to be covered each week are ones that are relevant to prospective and new mothers.

The primary question to be addressed is whether psychological intervention begun during the later part of pregnancy and continued through the first eight weeks postpartum will alter the adjustment to motherhood. Specifically, the study will attempt to answer the following questions:

1) Will postpartum adaptation be better for women who participate in the support groups than for those who do not?

2) Will anxiety be lower for women who participate in the support groups than for those who do not?

3) Will depression be lower for women who participate in the support groups than for those who do not?

To answer these questions, three standardized instruments will be used. Lederman's Self-Evaluation Question-

naire will be used to measure postpartum adaptation; the Depression Adjective Checklist will measure depression; and anxiety will be gauged by the State-Trait Anxiety Inventory. Further, qualitative analysis will be employed. The standardized instruments listed above are not ideal for examining the nuances of individuals' attitudes and reactions. Particularly in a study such as this, where new ground is being explored, it is valuable to take a closer look at these questions. Thus, qualitative analyses designed by the researcher will be used to investigate certain patterns relating to participation in support groups.

Definition of Terms

Adjustment to motherhood: For this study, adjustment to motherhood is operationally defined to include anxiety, depression, and adaptation. Adjustment to motherhood is a process influenced by many different factors. The psychology of the woman, the woman's physiology, the quality of the marriage, the life stressors, the sources of support, and the characteristics of the infant all influence one's adjustment to motherhood.

Career: In the current literature (Herr & Cramer, 1979), the term career is used to connote an extremely broad conception of a person's vocational behavior throughout one's lifespan. In this study, career encompasses the vocation in which the woman has been involved for the past 2 to 12 years. A career, as opposed to a job, implies a

commitment to the profession which is not easily put aside.

Crisis: It should be made clear that definitional differences of crisis persist not simply for semantic reasons, but because of differing theoretical or professional biases and practical concerns. However, for the purposes of this study, crisis is defined as a syndrome marked by a more or less protracted period of emotional upsets. It is an "emotionally significant event or radical change of status in a person's life" (Webster's New World Dictionary, 1966). The crisis is produced by the individual having to face important problems which she cannot immediately solve. Crises can occur at transitional points in the life cycle- for example, adolescence, marriage, first pregnancy, and mid-life (Schulberg & Sheldon, 1968).

Older Mothers: In the current literature, the term is used to connote women who postpone motherhood until their late twenties or early thirties (Daniels & Weingarten, 1982; Leifer, 1980; Russell, 1974). The average age of older mothers in January 1980 was thirty and one-half years (Daniels & Weingarten, 1982).

Primiparous: The term primiparous is used to describe a woman who is full-term pregnant for the first time or who has born only one child.

Postpartum: This is the term used to describe the period subsequent to childbirth.

Support group: This is defined as the resources,

assistance, and information provided by other people. Support involves both the perception that others are available in times of need and satisfaction with the available support (Sarason, Levine, Bacham, & Sarason, 1983).

Hypotheses

The hypotheses tested in this study are stated in the null form:

1. There will be no significant difference between the experimental and control groups in terms of postpartum anxiety as determined by the scores on the State-Trait Anxiety Inventory.

2. There will be no significant difference between the experimental and control groups in terms of postpartum depression as determined by the scores on the Depression Adjective Checklist.

3. There will be no significant difference between the experimental and control groups in terms of postpartum adaptation as determined by the scores on the Postpartum Self-Evaluation Questionnaire.

In addition to the statistical analyses related to the null hypotheses stated above, qualitative analysis will be used to examine opinions and feelings expressed by the subjects both in conversation and on the questionnaire (see Appendix B). This qualitative analysis is expected to reveal patterns relating to participation in support groups

and valuable information concerning the women's adjustment to motherhood that are not easily measured by standardized instruments.

Limitations of the Study

The study was conducted among primiparous career women approximately thirty years of age and older who had chosen to delay motherhood, so the results may or may not apply beyond this narrow population. The participants were volunteers; therefore, this sample cannot be considered random even from this population. The selection process necessarily limits the external validity of the study. The sample is drawn from the Chicago urban area, and consists of middle-class, Caucasian women. Thus, the results may or may not be pertinent to other demographic groups.

Because the support groups shared one leader (the researcher), it is difficult to separate the content of the group sessions from the personal attractiveness of the leader. It is also difficult to identify all of the distinct characteristics of each group; therefore, it is the total effect of the groups that is to be considered as the independent variable. A check was made for equivalence between the control and experimental groups on the dependent variables.

Organization of the Study

This study is organized under five major headings. Chapter I introduces the research problem and states the

need for the study, the purpose of the study, the hypotheses, the definitions of terms, and the limitations imposed by its design. Chapter II reviews the literature as it pertains to: the psychology of pregnancy; the transition as a crisis; older, career women entering the transition to motherhood and handling the stress of the transiiton; postpartum adjustment; and empirical research in the field. Chapter III provides the methodology of the study, including a review of the subjects, procedures, instruments, treatment, hypotheses, and methods of data analysis. The data is analyzed with respect to the study's hypotheses in Chapter IV; and Chapter V examines the results for their implications and offers recommendations for future research.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

The purpose of this chapter is to review the literature related to the transition to motherhood of primiparous career women over thirty. There are seven sections. The first is a brief introduction. The second section reviews the literature regarding the psychology of pregnancy. The third section defines the term "crisis" as it pertains to pregnancy and motherhood. The intent of the fourth section is to describe the older, career woman as she enters this role transition. In the fifth section, stress theory is examined as it relates to women during a first pregnancy and birth. Section six focuses on postpartum adjustment. Section seven examines the empirical research in the field.

Introduction

The sociological revolution of the past two decades has had particular impact on the structure of the family. Change in values has had many consequences on the family structure. One change is couples delaying starting families until their thirties. This decision to delay parenthood attaches a premium to producing and nurturing each

child.

Women entering motherhood after thirty experience varied reactions. Some savor the experience of motherhood because they realize this may be their only child. However, there is evidence that many others are angered by the reality of pregnancy and motherhood (Barber & Skaggs, 1975). Yogev and Vierra (1983), in their interviews of forty women faculty members at Northwestern University in Evanston, Illinois, found that the women in their study were not confident of their ability to mother.

Eiser and Eiser (1985) interviewed sixty primiparous women about their experiences pertaining to: prenatal care, labor and delivery, and education concerning childcare they received prenatally and during their hospital stay. The results indicate that many had misgivings and unanswered questions. The women felt that the information provided about childcare was unsystematic at best. Many sociologists have noted that parenting is a role for which our society offers little preparation (Barber & Skaggs, 1975; Dubin, 1982; Pickens, 1982). Because of the different stresses and strains on women in today's world, mastery of pregnancy and motherhood is often difficult to attain.

Psychology of Pregnancy

Much of the early work on women's psychological health and its relation to motherhood comes from the psychoanalytic literature (Benedek, 1970; Bibring, 1961). These psy-

choanalytic theorists tend to view adaptation to pregnancy and motherhood as an intrapsychic task. Prevalent in the psychoanalytic literature on pregnancy is the notion that this event causes both intrapsychic and interpersonal turmoil (Gladieux, 1978).

Psychoanalytic theorists recognize the importance of childbearing in the emotional lives of women and believe that motherhood is an essential experience of an emotionally mature woman. This concept originated with Freud, who espoused the belief that the most important task for a woman was the renunciation of her wish for a penis and the substitution of the more realistic and attainable wish for a child (Grossman, Eichler & Winickoff, 1980). He did not, however, examine the actual experiences of pregnancy and motherhood. It remained for later theorists to focus on the specific psychology of pregnancy and childbirth. Deutsch (1945) postulated that pregnancy is the natural fulfillment of the deepest most powerful wish of women and that healthy ego development is closely related to the development of the "motherly ego". She emphasized the enormity of the psychological task involved in successfully navigating the mothering role. Benedek (1970) acknowledged both the calm, narcissistically gratifying element of pregnancy as well as the anxieties, regressive tendencies, and psychological challenge inherent in the process.

Although the psychoanalytic theorists made significant

theoretical contributions to the understanding of the psychological processes involved in pregnancy, it was left for other theorists to focus more specifically on the pregnancy and childbirth experiences. Two theoretical orientations are found in the literature regarding the pregnancy experience of a primiparous woman. The first views pregnancy as a transition or normative crisis period (Bibring, 1961). The second orientation views pregnancy as a normal developmental event (Leifer, 1980).

The Transition as a Crisis

After surveying the literature in this field, it is clear that definitional differences of crisis persist not simply for semantic reasons, but because of differing theoretical or professional biases and practical concerns. The manner in which crisis is defined may depend upon whether it is being viewed as a clinical syndrome, a theoretical prototype of the interaction between the individual and his environment, a normative experience, or a change tactic.

Crisis has been viewed as an environmentally produced situation to which the individual must respond. It has also been understood as the individual's perception of an event. Further, it is described as the interaction between a subjective state and an objective environment. However, most frequently it has been defined as a characteristic clinical syndrome marked by a more or less protracted period of emotional upsets. The crisis is produced by the

individual having to face important problems which she cannot immediately solve. A more recent formulation of crisis is that of the critical role transition occuring at varying points in the life cycle (Schulberg & Sheldon, 1968).

Melchior (1975) categorizes crises into two types: developmental or maturational and situational or accidental. The developmental crises are stages of the normal life cycle and are periods of physical, psychological and social changes that are accompanied by disturbances of thought and feeling. Bibring (1961) came to regard pregnancy, like puberty and menopause, as a period of crisis involving endocrine, somatic, and psychological changes. In all these psychobiological transitions unique changes occur- adulthood from puberty, aging from menopause, and motherhood from pregnancy. She viewed the crisis of pregnancy as basically a normal and essential part of female growth and maturation.

The emotional turbulence of pregnancy may be viewed as a positive phenomenon within a developmental framework (Caplan, 1960). From a developmental perspective, emotional changes such as increased anxiety or emotional lability are seen as reflecting significant reorganization in personality as a woman moves toward the developmental stage of motherhood. Leifer (1980) believes that pregnancy and motherhood should be considered from a developmental approach which views the progression of life as a continuous

process of change, characterized by sequential development and continuity from birth to death. The major milestones of adulthood- marriage, parenthood, retirement, and widowhood- bring changes in a wide range of psychological characteristics, such as self-concept.

It was the sociologist Reubin Hill (1949) who first conceptualized the arrival of the first child as a crisis. Crisis was defined by Hill as any sharp or decisive change for which old patterns are inadequate and new ones are called for immediately. Researchers have concluded that the transition to motherhood constitutes a crisis (Cronenwett, 1980; Dyer, 1963; LeMasters, 1957; Meyerowitz & Feldman, 1966; Rossi, 1968; and Russell, 1974).

LeMasters (1957) used Hill's definition of crisis to study the reactions of forty-six couples to parenthood. Thirty-eight couples, or 83%, reported extensive or severe crisis in adjusting to their first child. Dyer (1963), defining crisis in the same manner, attempted to measure the extent of crisis experienced by new parents. He concluded that 25% experienced severe crisis, and 28% experienced extensive crisis. Thirty-eight percent were judged to have undergone moderate crisis, while only 9% encountered slight crisis during their transition to parenthood. Meyerowitz and Feldman (1966) conducted interviews with four hundred couples from several different geographic areas in the United States. Their findings coincided with

the findings of LeMasters and Dyer: the birth of the first child constitutes a crisis.

Research by Hobbs and his associates (Hobbs, 1965; 1968; Hobbs & Cole, 1976) disputes the conclusion that the birth of the first child is a crisis experience for most couples. Hobbs asked mothers and fathers to indicate the extent to which they were bothered by each of twenty-six possible events during the postpartum period. Items included the interruption of routine sleeping habits, increased money problem's, and doubting one's worth as a parent. Based on responses by a randomly selected sample of first-time parents, Hobbs (1966) concluded that 86% experienced only slight crisis. No couples were classified in the severe or extensive crisis categories. Hobbs also reported that women experienced more stress than men, which was indicated by responses on the crisis checklist. Subsequent replications (Hobbs, 1968; Hobbs & Cole, 1976) using Hobbs' checklist yield comparable results. He concluded that it would seem more accurate to view the addition of the first child as a period of transition which is somewhat stressful than to conceptualize beginning parenthood as a crisis experience.

Jacoby (1969) compared Hobbs'(1966) study to LeMasters' (1957) and Dyer's (1963) studies and concluded that the discrepancy in results may be partly explained on the basis of the samples employed. Studies limited to middle-

class respondents (LeMasters and Dyer) have classified more parents in the severe or extensive crisis categories. Hobbs' more representative sample, which was made up in large part of working-class parents, contained no case of severe or extensive crisis. This evidence strongly suggests social class as a significant variable. Since the middle-class samples showed many more adjustment problems than the predominantly working-class samples, it seems reasonable to consider the possibility that the transition to parenthood is more difficult for middle-class parents than for working-class parents.

Rossi (1968) was the first to suggest that the term "crisis" be dropped and "transition" to parenthood be substituted. She identified four unique features which contribute to the stress of the transition. First is the cultural pressure to assume the role. Second, the shift from marriage to first pregnancy represents the major transition point in a woman's life. Third is the irrevocability of the parenting commitment. And finally, there is the lack of preparation most American women bring to parenthood.

Russell (1974) sampled 511 couples in Minnesota. She used Hobbs' (1966) gratification checklist. She concluded that overall a moderate degree of crisis is associated with the entry of the first child into the family, although for the items dealing with one's emotions and physical self, the degree of crisis was significantly higher. Crisis

scores for these items ranged from 44% to 68%.

Millie and Sollie (1980) conducted a longitudinal study of 109 couples designed to evaluate how those couples changed over time and to measure stresses during the transition period. Results showed that both new mothers and fathers reported higher personal stress scores after the birth of the child. New mothers reported higher marital stress scores during the first postpartum period and even higher scores at the six to eight month period.

Older, Educated Career Women Entering the Transition

Even before the trend to delay parenthood was established, researchers noted the particular stress faced by older, educated women. Russell (1974) concluded that education was inversely and significantly related to gratification scores for women on Hobbs' crisis checklist. The more educated they were, the fewer gratifications they derived from their experience. Dyer (1963) came to a similar conclusion. He suggests that education may have some dysfunctional aspects relative to a woman's adjustment to her mother role. Her needs and expectations may be so oriented to extra-family values and other roles that it is harder for her to stay home as a new mother. LeMasters (1957) found that mothers with professional work experience suffered extensive or severe crisis in every case. Cronenwett (1980) found high scores with older, educated women.

Women who have remained childfree until the age of

thirty have had a decade in which to estabish their adult identities. They have established financial independence and social and psychological independence as well (Daniels & Weingarten, 1982). They have often struggled to define a heterosexual relationship that is characterized by intimacy and love, but not dependence. Women over thirty are cognizant of the women's liberation movement. They are aware of the dangers of social and psychological subordination to individual development. They have been warned of the "slavery" of traditional women's roles and the risks of these roles to the self (Colman, 1978; Gray, 1980). These women have established career direction and expectations.

Yogev & Vierra (1983) suggest that many professional women are not confident that they can successfully combine motherhood and a career. Colman (1978) found evidence that women over thirty who did not return to work were the ones in the greatest flux. They were in need of guidance and support. None of the twelve women in her study had an easy or conflict-free time. All of them went back to work sooner than they had expected. They found the struggle with their new identities very difficult. They were clinging to the secure identity established in their careers. They found it easier to return to the area in which they had developed competency than to face the demands of a new role full time. Gladieux (1978) found that women were likely to doubt whether motherhood would be fulfilling. The women in

her study wondered whether motherhood would satisfy the needs fulfilled by employment. Several women in this study found that the transition to motherhood meant exchanging a realm in which competency and adeptness had been demonstrated for one in which aptitude had not yet been proven.

Gordon and Gordon (1961) found that older women had a more difficult time with pregnancy and motherhood. They run a greater risk than tradiitonal women of being dissatisfied with their pregnancy experiences. Jessner (1970) reported that even women in jobs they considered rather boring regretted giving up a life of activity and companionship for the solitude of home. Women for whom a career means a great deal regard motherhood as a real dilemma. Lopata (1971) found that for an educated woman, the birth of a first child was the event causing the greatest discontinuity in her personality and her life. She describes the new mother as moving from a relatively full participation in the life of society to a narrow life space.

Leifer (1980) found that the birth of the first child has been the single most important factor in creating discontinuity in the education and careers of women. Women with a strong commitment to work outside the home are likely to experience considerable crisis as they become full-time mothers. They are isolated from previous work associates. They relinquish the emotional investment in work activities. And they learn to do without an indepen-

dent income (Pickens, 1982). Barber and Skaggs (1975) believe that women who remain at home suffer from the crisis of eventlessness. This phenomena is triggered by the sense that nothing is coming; a mother's day is crowded, but it is filled with events from the child's world.

Handling Stress During the Transition

The literature on stress theory offers some guidance on how mothers may cope with a first pregnancy and birth. Janis (1958) defines psychological stress as the reaction to a physically dangerous event in which pain, bodily injury, or death is anticipated. The way an individual psychologically handles the impending crisis during the pre-impact period is an important determinant for the outcome. Janis used the crisis of major surgery to formulate his theory of normal stress behavior. It involves three phases: the threat phase, the danger phase, and the post-impact phase. The threat phase occurs when the individual becomes aware of the impending crisis; the danger phase occurs when the actual crisis occurs; and the post-impact phase refers to the convalescent period.

Janis interviewed patients before and after surgery and found three clear-cut groups, each of which displayed distinct coping mechanisms. The groups were distinguished by their anticipatory fear behavior during the first of the three phases. One large group, the low anticipatory fear group, claimed not to be disturbed about surgery and sought

no information about what would happen. In essence, they denied the coming crisis. However, when it occurred, they found it extremely difficult. A second large group, the moderate anticipatory fear group, admitted some anxiety about what was going to happen and sought information. They did what Janis calls the necessary "work of worrying". They went through the surgery well. A small third group had high anticipatory fear. They found surgery difficult. They showed symptoms of emotional disturbance.

Janis' theory has considerable relevance for the primiparous woman during the pregnancy, birth, and postpartum periods. Entwisle and Doering (1981) conducted a one-shot study of first time mothers and concluded that a realistic anticipation and some actual training during pregnancy appeared to help these women cope with the birth crisis.

Levy and McGee (1975) designed a study to test Janis' theory with expectant women. They discovered that women who received no information from their mothers about their own childbirth experience evaluated their childbirth experience more unfavorably than women who received information. It was also found that either an extremely positive or negative communication from their mothers effected a poorer outcome than a moderate communication. This reaffirms Janis' conclusion on the beneficial spects of realistic expectations. The results of this study lend further support to Janis' theory of expectation, preparatory communications,

and stress tolerance in crisis resolution. The communication of realistic information concerning childbirth or other anticipated stress situations permits rehearsal of the negative aspects of the expected experience. This allows the individual to indulge in the "work of worrying". Where there is no information or extremely positive information, the negative aspects of the impending experience remain unspoken. When this occurs, individuals anticipate a favorable experience and feel victimized at the time of the event. In cases where extremely negative attitudes are communicated, the person is again psychologically unprepared. In this case, the contemplation of stress is so shattering that realistic rehearsal is impeded.

Breen (1975) found that women who expressed more feelings of anxiety and insecurity during pregnancy experienced fewer difficulties postpartum. This supports the notion that the awareness and expression of conflict and anticipatory anxiety enable a person to work through difficulties. This awareness and expression are also a sign of psychological health. The anxiety a woman feels may reflect the realization that some changes will have to take place in order to meet the demands of the new situation. The woman who is more able to get in touch with her feelings about pregnancy, childbirth, and accomodating the new family member will be more able to cope with those events when they take place.

Postpartum Adjustment

Although the psychological work of adapting to motherhood begins during the pregnancy, the actual physical and environmental adaptation to a new baby begins during the postpartum period as being a time of maximum upheaval and disruption. The demonstrated importance of the early weeks of the mother-child interaction requires that special attention be paid to this period. Sumner and Fritsch (1977) report that one of the most difficult periods in a woman's lifetime occurs immediately following delivery. The woman is faced with establishing her relationship with her infant and altering her life and behavior patterns in order to take care of the newborn's needs. Benedek (1959) notes that the newborn's need for mothering is absolute while the need of the woman to mother is only relative. Adaptation is required when the mother is physically tired and is experiencing mild to severe emotional swings (Barber & Skaggs, 1975).

In an extensive review of the literature, Schwartz (1974) concluded that there is a crucial postpartum period during which a bond between a mother and infant are established. Deutsch (1945) describes the psychological work of the postpartum period as being the key to maternal adaptation. However, it is hard to visualize how a positive emotional bond can be built between mother and child when, as Leifer (1980) discovered in her study of nineteen middle-

class women, the dominant mood of the women during the first two months was moderately to extremely negative. She concluded from her study that the criterion regarding what constitutes successful adaptation to motherhood has often been too simplistic. Typically, if a woman can relate in a nurturing manner to her infant, it is assumed that she is coping successfully with motherhood. However, it is entirely possible for a woman to relate lovingly but feel depressed, inadequate, and anxious about the changes brought about by motherhood. Grossman, Eichler and Winickoff (1980) found a tremendous amount of emotional disequilibrium present in the women they studied at the two month postpartum interview. They noted that the emotional task of adjusting to a first baby is particularly difficult because the woman must enlarge her identity to include the role of mother and integrate the new role into her sense of self.

Rich's (1976) distinction between motherhood as an experience and motherhood as an institution is quite relevant in understanding the reaction of women; most find caring for their infant to be difficult but engrossing. The role requirements of motherhood create major problems. Most women found being at home the most difficult adjustment they had to make (Barber & Skaggs, 1975; Colman, 1978). Motherhood entails an abrupt social discontinuity for women who have spent a large portion of their lives at

jobs and were involved in a wealth of relationships with other people. Although many women shift their relationships during pregnancy, most do not find friends they can spend time with and feel quite isolated during the postpartum period. Carlson (1976) found that the postpartum period is filled with bewilderment. This bewilderment seems to involve three interwoven aspects of one's experience following delivery. The first is difficulty in perceiving the infant as really her own. The second involves surprise at the dramatic changes that have occurred in her body in a very short time span. The third aspect is a confused sense of just how she should behave and function in her new role of mother.

Breen (1975) points out that childbirth involves an abrupt change in one's status. This new role is irrevocable and all-enhancing. Perlman (1968) has called it a "vital role" to distinguish it from transitory roles that can be abandoned. Vital roles are both time- and emotion-extensive. Breen feels that the shift in the woman's perception takes place mainly after the birth when the woman is actually confronted with her new role partner and when other perceptions and expectations become more definite. With the birth of her baby, a woman may have to modify her stereotyped idea of the mother role which is colored by the Christian image of the all-sacrificing perfect mother. The role of the "good ideal mother" is too narrowly defined.

Yalom (1968) discovered that up to 80% of primigradivae have difficulty in their transition to motherhood. Shereshefsky and Yarrow (1973) judged about one-third of the women in their sample to have postpartum difficulties. They discovered that feelings such as excessive anxiety, depressive feelings about their ability to mother, overreaction to realistic problems, and hostile attitudes toward their infant were common. The pervasive findings in the literature on early postpartum adjustment suggest that this is a particularly stressful period marked by physical discomfort, emotional lability, and major personal and social role reformulation.

Empirical Research

Only within the last fifteen years have researchers addressed the "normal" woman's adjustment to motherhood. It is pertinent to this study to examine this empirical research.

There are experimental studies which investigate the effect of prenatal interventions. There are also experimental studies which focus on the postpartum period. Two other types of research that warrant examination are the descriptive as well as the longitudinal studies. Research that pertains specifically to social support groups is also important.

Prenatal Studies

Gordon and Gordon (1961) investigated the effects of

systematic instruction in reducing postpartum emotional difficulties among prospective mothers. This study tried to prepare women in advance. Both the experimental and control groups attended five antenatal classes and received the first questionnaire prior to any experimental intervention. Then, the experimental groups participated in two special classes for psychological and social adjustment to motherhood. Each experimental session consisted of a formal talk with accompanying visual aids covering the subject material systematically. The first talk dealt with changes in one's home life resulting from the baby's birth. The second session discussed reorganization of one's social life and other outside-the-home interests. After the birth of the baby all the subjects received a questionnaire. Six weeks later their obstetricians judged the emotional reactions of all the participants. The obstetricians reported again on the emotional reaction of all the participants at six months. The experimental group was judged by their obstetricians as showing significantly less emotional difficulty six weeks and six months after delivery.

This study was conducted over a two year period of time. The experimental groups in the beginning of the study did not do nearly as well as the experimental groups in the later part of the study. Gordon and Gordon concluded that this was due to contamination. The town where the study was conducted was small and the researchers felt

that "word of mouth" did a lot to improve the emotional adjustment of the women in the later part of the study. The researchers also questioned the methodology of the study. They felt that the verbal reports in the questionnaire might not accurately reflect true behavior in one's life. They also felt the judgements of the obstetricians might have been influenced by the subjects' verbalizations. Even with the problems inherent in their study, Gordon and Gordon recommended psychological intervention during the time of transition as a means to ease the stress.

Carpenter, Aldrich, and Buverman (1968) evaluated the changes in attitudes and behavior that occured in a group of fifty-two patients interviewed throughout their pregnancies by first-year medical students. They compared these women to a control group of fifty pregnant patients who were not interviewed. They wanted to see if the students had a measurable effect on the attitude of the patient toward her pregnancy and her adjustment following delivery. Results indicate that sequential interviews, even with an inexperienced student, can affect the attitude and behavior of a patient significantly. Compared to the control group, patients in the experimental groups reported feeling less nervous during their pregnancies. Only 30% of the experimentals as opposed to 63% of the control group reported feeling more than occasionally nervous. The experimentals also reported feeling less worried during labor, and

required less medication during labor.

Shereshefsky and Yarrow (1973) investigated the effectiveness of prenatal counseling by comparing sixty counseled and non-counseled couples on feminine identification, woman's self-confidence, husband-wife adaptation, and ease of labor and delivery. Findings indicate that counseling served to accentuate changes precipitated by the pregnancy, such as in the woman's confidence and clarity in visualizing herself in the role of mother. The women in the counseled group went through the labor and delivery experience with better adaptation than those in the control group. There were no significant effects of the counseling on maternal adaptation. However, a comparison of the level of marital adjustment at six months postpartum and at the beginning of the pregnancy showed that the marital relationship of the non-counseled group had significantly deteriorated, while the counseled group was found to have held to the initial level.

After the period of formal project participation, group sessions involving the project patients were held. These sessions revealed other differences between the counseled and non-counseled groups. The researchers concluded from these sessions that the counseled women were more content in the role of mother. They were clearly more open in acknowledging and discussing emotional reactions and psychological needs. In the analysis of prenatal counseling, the

researchers identified three counseling approaches: interpretation, clarification, and anticipatory guidance. Using these approaches seemed to yield substantial differences in outcome. Of the three approaches used, anticipatory guidance was the most effective in terms of promoting a higher level of maternal adaptation.

Neumann's (1976) study was an attempt to clarify and extend the usefulness of anticipatory guidance as a counseling technique during pregnancy. She incorporated Gordon and Gordon's (1959) study which suggested informal discussion groups with both husband and wife present. Gordon and Gordon felt these two factors might alleviate postpartum depression. She also incorporated Janis' work (1958), which emphasized realistic preparation and information. She compared two groups. The control group took preparation classes, such as Lamaze, only, while the experimental group participated in the anticipatory guidance classes as well. Neumann used a small group setting. She gave out information to be read at home which was then reinforced with class discussions and rehearsal of stressful situations. This study consisted of both primigradae and multigravida. Neumann hypothesized that the anticipatory guidance technique would affect primigradae more than multigravidae. She also hypothesized that anxiety and depression would be lower for women in the experimental group than in the control group.

No part of these hypotheses was supported. She concluded that there were several problems inherent in the study. First, the women were very traditional in their approach to motherhood, which as the literature states, affects one's adjustment to motherhood. Another problem may have been related to the intervention itself. Most of the women (92%) said they had read the entire booklet; however, only 55% reported practicing the role playing situation at home. Further, the role playing was not received well in the classes. These three facets were vital parts of the anticipatory guidance technique and failure to utilize them raises the question of whether the intervention resulted in the anticipation and rehearsal of the stress situations.

Postpartum Studies

Atkinson and Richel (1984) conducted a study within the framework of the social stress and the behavioral theories of depression. They investigated whether postpartum depression is a function of the disruption of the couples' postpartum functioning. Seventy-eight primiparous middle socioeconomic status, married couples volunteered to complete the questionnaires at eight weeks prepartum and eight weeks postpartum. An Inventory of Caregiving Behavior was designed for this study to assess the amount of time expected and spent by the parents in caregiving activities. The Degree of Bother Inventory (DBI, Beck, 1961) was

administered as well as the Depression Adjective Checklist (Lubin, 1961). The results indicate the strongest predictor of depression was prepartum depression level. It is suggested that if the level of prepartum depression is controlled, the postpartum level of depression would diminish.

Brown (1984) designed a study to identify anticipated and actual postpartum concerns about the marriage relationship during the period of transition to parenthood. Twenty-two couples expecting their first child were randomly assigned to either the prenatal or postpartum interview groups. Husbands and wives individually rank-ordered thirty-five postpartum concerns. They also indicated the three concerns they discussed the most and the least. The assumption behind Brown's research is that appropriate prenatal and postpartum intervention can facilitate the adjustment. However, an understanding of the concerns and relationship dynamics indicate discrepancies in agreement, perceived agreement, and accuracy on issues of concern. Brown stresses the need to facilitate communication within the dyad. Increased communication may promote greater recognition of issues. With increased understanding of the other's view, couples can more efficiently define problems and offer each other needed support.

Descriptive Studies

Colman (1978) conducted a descriptive study of twelve primiparous women over thirty. Not one had an easy or con-

flict-free time, yet most were prepared for the demands of mothering. All were aware of women's liberation issues and were afraid of being "just a housewife". They felt a continuous conflict between the desire to be a good mother and the desire to continue their careers with minimal disruption. Not a single woman in this study stayed out of work longer than expected, in fact 33% returned to work sooner than they expected. The return to work was reported as offering security. The professional identities they had previously established were safer and more familiar than the traditional female role of housewife/mother.

Leifer (1980) conducted a descriptive, hypothesis-generating study involving nineteen primiparous women who participated in a series of five intensive interviews that consisted of both structured and open-ended questions. The interviews occurred at each trimester of pregnancy, on the third day after the birth of the baby, and at six weeks postpartum. Leifer found that abrupt social discontinuities characterize the transition to motherhood. These women had achieved a mature level of personality integration, satisfying marriages, and stable identities. They reported that they enjoyed caring for their infants. However, they experienced considerable stress with motherhood. Data from the study suggests it is important to distinguish between a woman's response to her infant and to the maternal role. It is possible for a woman to relate lovingly to

her infant, yet feel depressed, inadequate, and anxious concerning motherhood. Leifer recommends more programs designed to meet the needs of pregnant women. She cites the Gordons' study (1959) which was designed to increase the social support available to pregnant women in order to reduce postpartum difficulties. However, she believes that the support should continue into the postpartum period.

Entwisle and Doering (1981) investigated what happens to modern couples during the critical period of family formation. This descriptive study used 120 couples experiencing their first pregnancy. The researchers found substantial evidence that emotional preparation for the parenting role is more critical than practice in diapering or other caretaking chores. They found that these couples experienced a real lack of guidance in how to handle a new role. They discovered that the preparation classes prior to the birth did not appear to be helpful in fostering role integration. The authors recommend postpartum guidance to ease the transition to parenthood.

Longitudinal Studies

Grossman, Eichler, and Winickoff (1980) conducted a longitudinal study that focused on the experience of pregnancy and the first year postpartum. The specific goals of the study were: to increase the theoretical understanding of the process of childbearing; and to identify those factors early in pregnancy that are predictive of adaptational

problems in pregnancy, delivery, and the postpartum period. The authors found several aspects of the woman's initial level of psychological adaptation to be strongly related to her adjustment in early and late pregnancy and during the postpartum period. Her early levels of depression and anxiety measured during the first trimester contact strongly predicated how comfortable she would be during the pregnancy and throughout the first year of her baby's life. The authors found no relationship between psychological health measured early in pregnancy and mothering at either two months or one year postpartum. However, mothers who were more depressed early in pregnancy were doing less well with their babies at two months postpartum. The woman's psychological health early in pregnancy predicated her later psychological health, but it had no predictive value about the quality of the relationship with her baby.

Anxiety was an important variable in this study. Anxiety bears a strong relation to the woman's adaptation during pregnancy and childbirth, to her own psychological comfort during the postpartum period, and to the baby's adjustment throughout infancy. Throughout the study, more anxious women felt less comfortable with themselves in general as mothers and as wives.

Josten (1982) conducted a longitudinal investigation of fifty-two women to see what impact their adaptation to pregnancy would have on the quality of the subsequent

mother-infant relationship. These women were assessed by the attending nurses according to the Prenatal Assessment of Parenting Guide (Josten, 1981). The subsequent mother-infant pairs were studied longitudinally and were rated on the quality of care given by the mothers during the infant's first year of life. Trained testers participated in this part of the study. Twenty-seven of the mothers were rated as providing excellent care and twenty-four mothers were rated as providing inadequate care. The excellent care mothers were then compared to the inadequate mothers in relation to the Prenatal Assessment of Parenting Guide. Josten found only one of the inadequate mothers was rated as being emotionally prepared for motherhood. She concluded that the inadequate mothers had not positively dealt with the emotional task of pregnancy. She felt that these women may not have had the resources necessary to cope with the mother role.

Social Support

A growing body of theoretical and empirical literature attests to the importance of social support for psychological adjustment and health (Billings, Cronkite & Moos, 1983; Cobb, 1976). Social support gained via the group process offers a different experience from the support gained from an individual like a neighbor or close friend. According to Yalom (1970) there are several factors that facilitate progress for patients in group treatment. They in-

clude imparting information, instilling hope, recognizing the universality of feelings, developing group cohesiveness, imitative behavior, interpersonal learning, and catharsis. Cobb (1976) makes an excellent case for the importance of social support as a moderator of life stress throughout the life cycle. He cites studies that have examined the effects of social support on hospitalized children, bereaved individuals, pregnant women with complications, and so forth. All of the studies he cites show similar results. It seems there is some protective effect exerted by a high level of social support during times of high stress.

The focus of Kahn's (1978) study was on the influence of the perception of various sources of support during the transition to parenthood. He studied parents during the postpartum period. Four types of support were examined: group, instrumental, marital, and network. No significant relationship was found between the different types of support. However, Kahn concluded that a modest degree of interrelatedness was demonstrated for support soon after childbirth and adjustment six months later. One type of support network was significant for mothers only. Apparently, it is the perception of the mother's informal network of family and friends as supportive that is important for a successful adjustment to motherhood.

Cronenwett (1980) undertook an hypothesis-generating

study that involved sixty-six primiparous women participating in a postpartum support group. Questionnaires were sent to these women to determine: the characteristics of the women who used this form of support, the needs met by the group, the types of discussions found to be the most meaningful, and the factors that influenced the group's effectiveness in providing support. Results show that the women were older, better educated, and more affluent than a random sample of childbearing women. They joined the group primarily to meet other women going through the same experience with whom they could share ideas and feelings. The most meaningful discussions for these women focused on personal issues rather than infant-related issues. Fifty-nine women were glad that their husbands had not participated in their groups. A majority (72%) said they would recommend support groups to others.

Power and Parke (1984) conducted a study to determine the salient factors that account for the decline in marital satisfaction surrounding the birth of the first child. From the results gathered they hoped to propose a social support group model for determining the relative importance of each of these factors. Their basic assumption was that the ease of transition into the parenthood role is largely determined by the nature and availability of social supports. They studied four types of social support: relational, ideological, physical, and informational.

Relational supports are those that characterize close, emotional relationships. The primary agents for relational support are the woman's husband, friends, and relatives. Ideological support refers to the degree to which the woman's social network provides her with support concerning the ideological basis of her role decisions, for example, whether she should continue to work after the birth. Support would only qualify as ideological support if the views expressed in the social network were consistent with or similar to the woman's opinions. The primary agents for ideological support are again one's husband, friends, and relatives. Physical support ranges from routine housekeeping and child care assistance to an occasional financial gift. The primary agents for physical support are one's husband, friends, relatives, neighbors, and the institutions with which the woman is associated. Informational support concerns the degree to which the woman's social network provides her with information or suggestions concerning the transition to parenthood. Primary agents for this type of support include friends, relatives, neighbors, and institutions.

After an extensive review of the literature, Power and Parke came to the conclusion that it is the support from one's husband that is of paramount importance throughout pregnancy and early parenthood. Relational support provided by the husband can facilitate the woman's adaptation

during all phases of this transition. However, there is a tendency for many husbands to provide insufficient support at the time when it is most needed- the early postpartum period. They also concluded that ideological support is extremely important in aiding the psychological acceptance of one's pregnancy and child. Such support is generally offered by the husband, friends, relatives, and work associates. Another conclusion they reached is that the need for physical support arises during the last month of pregnancy and during the early postpartum period. While the birth generally brings increased physical support from relatives, physical support from the husband follows the same course as relational support, a relative decline. The final type of support studied by Power and Parke was informational support. This support can easily be found outside of the social network.

Power and Parke concluded their article by suggesting that intervention programs that utilize the social network would probably be most effective if they concentrated on providing informational and ideological support during pregnancy, and informational and physical support during the postpartum period. However, they never address the issue of where and how a woman can acquire the much needed relational support from others besides one's husband.

Cutrona (1984) investigated specific components of social support and stress as predictors of depressive symp-

toms following the birth of the first child. One of her central goals was to determine what kind of support would prove to be most important for women facing the stress of their first child's birth. She used Robert Weiss' (1976) model of the provisions that may be gained from relationships with others. The relational provisions identified by Weiss are: attachment, social integration, opportunity for nurturance, reassurance of worth, reliable alliance, and guidance. A sample of seventy-one primiparous women was assessed during pregnancy, two weeks postpartum, eight weeks postpartum, and one year postpartum. Assessments included measures of depression and the six relational provisions identified by Weiss.

Results indicate that social support assessed during pregnancy was not a significant predictor of depressive symptoms two weeks after delivery. Social support did play a significant role in women's mental health eight weeks after delivery. Specifically, deficits in reliable alliance, guidance, social integration, and reassurance of worth were predictive of depression at the postpartum assessment. Women with adequate prepartum guidance did, however, report somewhat fewer postpartum stressful events. This highlights the complexity of the relationship between social support and mental health. Cutrona stresses the need for more direct information on social support processes during stressful periods.

The goal of Tietjen and Bradley's (1985) study was to examine the relationship between social support and psychosocial adjustment for women during a four month period surrounding the birth of their first child. They hoped to differentiate between support from husbands and other network members. They also wanted to test whether spousal support during pregnancy is predictive of postpartum adjustment. Their sample consisted of twenty-three women who were recruited from prenatal classes. These women were then given questionnaires to complete at thirty-five weeks gestation and again at three months postpartum. The aspects of psychosocial adjustment measured included depression, anxiety, perceived stress and marital satisfaction. The results of this study confirm that social support has an important role to play in women's psychosocial adjustment during the transition to parenthood. This role is particularly significant in the period immediately before the birth. The findings also confirm that spousal support is closely related to women's psychosocial adjustment.

Levitt, Weber and Clark (1986) undertook a study with the specific goals of describing the structure and functioning of social networks available to mothers of infants and assessing maternal well-being as a function of the mother's interpersonal relationships in conjunction with the temperamental difficulty of the infant. Forty-three mothers of thirteen-month-old infants were asked to posi-

tion individuals who were close to them in a network diagram and indicate which of those individuals provided support.

The network diagram consists of three concentric circles. The inner circle holds those individuals that the woman could not imagine life without. Husbands and children were most often placed in the inner circle. The middle circle contained the mother's family- siblings, parents, in-laws, and female friends. Other relatives and friends were placed in the outer circle. Despite the fact that the average maternal network contains thirteen individuals, mothers reported receiving support from very few people. Half of the women expressed some dissatisfaction with their support networks.

In conclusion, the results of this study clearly support the other previous studies: that the marital relationship is the primary source of support. For mothers of first born infants, it is the amount of support provided by the husband and the mother's satisfaction with the husband that correlates positively with affect and life satisfaction. However, all the authors point out how difficult it is for the husband to provide the support. They recommend research that allows the woman to look for and receive support from others besides her husband. They stress the need for investigators to continue to differentiate the concept of social support, allowing a focus on the parameters

of the individual's support system that contributes to the woman's adjustment to motherhood.

The next chapter describes the methodology of the study. This includes a review of the subjects, procedures, instruments, treatment, hypotheses, and methods of data analysis. The data is analyzed in terms of the study's hypotheses in Chapter IV, and Chapter V examines the results for their implications and offers recommendations for future research.

CHAPTER III

METHODOLOGY

The purpose of this study is to investigate the usefulness of psychological intervention in the form of a support group in easing the adjustment to motherhood for older, career primigravidea. This will be accomplished by comparing a sample of women who participated in a support group to a sample that did not participate. Specifically, this research will measure the possible changes in the women's levels of anxiety, depression, and adaptation after participating in a three month support group. The goal of this section is to describe the methodology used to determine whether significant levels of change occurred.

The design of the study will be presented first. This will be followed by a description of the sample selection and a description of the subjects who participated in the total study. Next, the instruments used and the topics covered in the support groups will be discussed. The group leader, the testing procedures, the data collection and the hypotheses will be set forth in the following section. Finally, the statistical methods used to indicate the

significance of the data will be detailed.

The Design of the Study

The design of this study was the Pretest-Posttest Control Group Design (Campbell & Stanley, 1963). The main strength of the design is that it controls for the effects of history, maturation, testing instrument decay, statistical regression, selection, and mortality; thus, it has good internal validity. This design compares experimental and control groups. Table 1 illustrates this design.

TABLE 1

THE PRETEST-POSTTEST CONTROL GROUP DESIGN

R	01	X	02
R	03		04

Equivalent groups are achieved through randomization, however, randomization can only be assumed "in the long run" with enough samples (Kraemer, 1981). To ensure equivalent groups, the Bartlett Test of Homogeneity for Variance was run. The results showed the variance to be equal among the experimental and control groups on all but two of the twenty variables. The variance scores on these two variables can be attributed only to chance. Both variance scores occurred on the Prenatal Self-Evaluation Questionnaire. Table 2 presents a summary of the information con-

cerning the variance scores on the Prenatal Self-Evaluation Questionnaire.

TABLE 2

BARTLETT TEST OF HOMOGENEITY FOR VARIANCE

Variable	Exp. Group $\bar{x}$	sd	Control Gp. $\bar{x}$	sd	Uni. F	df	p
Fear of pain, helplessness, and loss of control	33.5	5.0	30.7	3.4	4.28	1,38	.05
Quality of relationship with mother	33.1	4.4	25.7	10.3	11.5	1,38	.002

This illustrates the significant difference between the two groups. The researcher believes that this is due to chance alone. If there were truly a significant difference it might have shown up in the corresponding scales on the Postpartum Self-Evaluation Questionnaire. However, those scales indicate no significant differences between the groups. Because a significant difference exists on the pretest measures, there is reason to doubt that random assignment was 100% effective in equating the experimental and control groups. This suggests that covariance be used whenever possible.

Sample Selection

Local obstetricians and Lamaze instructors were contacted to recruit volunteers for the study. (See Appendix A for all correspondence with doctors and Lamaze instruc-

tors.) They were given a description of the study and an announcement to pass out to all women who met the requirements for the study. The criteria for participating in the study included: having intact marriages, being involved in a career but intending to stop working for at least six weeks after the birth of the baby, being approximately thirty years of age or older, and being pregnant full-term for the first time. Forty women volunteered to participate in the study; all forty completed the study. Subjects were randomly selected to serve in the experimental or the control group based upon similar due dates.

Subjects

Forty women volunteered to participate in the study. Table 3 presents a summary of the demographic makeup of the participants. They are described according to the following pertinent characteristics (see Appendix B for a demographic information sheet):

Age: The women's ages ranged from 27 to 40 years. Both the mean and the median age was 31 years.

Race: The total population was Caucasian.

Occupation: This study employed the Four Factor Index of Social Status by August Hollingshead (1975) to determine the subjects' occupational levels. The four factors used in Hollingshead's Index are education, occupation, sex, and marital status. The occupation is graded on a nine step scale. The scale is keyed to the occupational title used

TABLE 3

SUMMARY OF WOMEN'S DEMOGRAPHIC DATA

	Frequency	Percent
Age		
27-30	19	47.5
31-34	15	37.5
35-40	6	15.0
Occupation		
Skilled Manual Workers	1	2.5
Clerical and Sales Workers	1	2.5
Technicians, Semi-Professionals	5	12.5
Managers, Minor Professionals	10	25.0
Administrators, Lesser Professionals	6	40.0
Higher Executives, Major Professionals	7	17.5
Length in Occupation		
2-4 years	16	40.0
5-7 years	14	35.0
8-12 years	10	25.0
Length of Marriage		
1-4 years	23	57.5
5-8 years	12	30.0
10-18 years	5	12.5
Previous Marriage		
No	32	80.0
Yes	8	20.0
Parents Here		
No	17	42.5
Yes	23	57.5
Pregnancy Planned		
No	2	5.0
Yes	23	95.0
Prenatal Classes		
Yes	40	100
Returning to Work		
No plans	6	15.0
1-3 months	18	45.0
4-11 months	13	32.5
1 year and longer	3	7.5

TABLE 3, continued

	Frequency	Percent
Reason for Returning		
Economic	10	25.0
Personal fulfillment	8	20.0
Career aspirations	7	18.0
Combination of reasons	9	22.0
Available Support Network		
None	6	15.0
Family of origin	19	48.0
Friends	32	80.0
Husband	8	20.0
In-laws	2	5.0
Family of Origin- Supportive		
No	7	17.5
Yes	33	81.2
Family of Origin- Stressful		
No	25	62.5
Yes	15	37.5
In-laws Supportive		
No	16	40.0
Yes	24	60.0
In-laws Stressful		
No	19	48.5
Yes	21	52.5

by the United States Census in 1970. The occupational levels for the subjects ranged from 3 to 9, with a mean level of 7 and a median of 8. Examples of occupations included in the various levels are as follows: level 3 (childcare worker, file clerk); level 4 (stewardess, receptionist); level 5 (bank teller, dental assistant); level 6 (dental hygienist, sales manager); level 7 (elementary school teacher, reporter, buyer); level 8 (registered nurse, computer analyst, accountant); level 9 (psychologist, teacher, lawyer, doctor).

Length of Marriage: The length of marriage ranged from one year to eighteen years. The mean length of marriage was four and one-half years; the median length was three years.

Location of Parents: Twenty-three women's parents were living nearby, nineteen had in-laws living close, and fifteen had both parents and in-laws in close proximity.

Returning to Work: Six women, or 15%, had no plans to return to work. Three women, or 8%, planned to delay their return for one year or longer; seven women (18%) expected to resume their careers between six and seven months postpartum; fifteen women (38%) planned on returning between three and four months postpartum; and seven women (18%) expected to resume their work schedules six weeks postpartum. Both the mean and the median for returning to work was three months postpartum.

Reason for Returning to Work: The women were asked to give their reasons for returning to work. Their answers fell into three broad categories: economic, personal fulfillment, and career aspirations. Six women, or 15%, had no plans to return. Ten women (25%) planned to return for economic reasons; eight women (20%) for reasons of personal fulfillment; and seven (18.5%) because of higher aspirations. Nine women, or 22.5%, planned on returning because of a mixture of reasons.

Available Support Network: The women were also asked in an open-ended question if they felt they had a support network available. They then were asked to list the people they felt fell into this category. Six women, or 15%, felt they had no one to support them during their transition to motherhood. Nineteen (48%) listed their family of origin as a source of support; while thirty-two (80%) felt their friends would be available. Eight women, or 20%, thought their husbands would be a source of support. Two women (5%) thought their in-laws would be helpful.

All other demographic information can be found in Table 3. All demographic information pertaining to the subjects' spouses is contained in Appendix C.

Instruments

In this section, the instruments used in the study are presented. In addition, copies of each of them are contained in Appendix B.

Demographic Questionnaire

This questionnaire, developed by the researcher, was used to obtain relevant demographic data from the participants. Questions included the participant's age, occupation, years in occupation, length of marriage, whether she planned to resume her career after the birth of her child, and why. In addition, this questionnaire included pertinent questions concerning the subjects' perceptions of available sources of support.

Depression Adjective Check List

Depression was measured by this list (Lubin, 1965), developed to provide brief, reliable, and valid measures of self-reported depressive moods. These scales are widely used to measure affective rather than the behavioral aspects of depression. Such an instrument is well suited to an investigation of mood changes during pregnancy and the postpartum period (Lubin, 1975). The adjective check list format was chosen because of its ease of administration and its high degree of subject acceptance (Masterson, 1974). Taking approximately 2 1/2 minutes to complete, the list contains twenty-two positive adjectives and ten negative adjectives. The subject checks all the words that describe her feelings now-today. Sample items include optimistic, lifeless, unwanted.

The internal consistency of the Depression Adjective Check List (DACL) ranges from .79 to .90 depending upon

which form is used and the sex of the subject. The split-half reliabilities range from .82 to .93. The test-retest reliability correlations range from .19 to .24. This is as it should be because an instrument that purports to measure state depression should show a high level of fluctuation. The data presented suggest that despite the brevity of each of the forms, adequate reliability has been established. Validity for the DACL is also significant. Correlation between the DACL and other indicators were rated beyond the .01 level of significance, which demonstrates that there is concurrent validity. It can be concluded from the factor analysis that was run that the two DACL factors- depressed and elevated- show a high degree of reliability and validity. Lubin reported valuable data about the discriminant validity. The overall percent correct classification ranged from 74.8 to 92.9 with a mean of 84.8. Thus, for overall correct classification, the DACL performed better than the Generalized Contentment Scale (82%) and the Beck Depression Inventory (81.6%).

State-Trait Anxiety Inventory

The State-Trait Anxiety Inventory (STAI) was used to measure anxiety. This inventory has been used extensively in research. It comprises separate self-report scales for measuring state and trait anxiety. The S-Anxiety scale consists of twenty statements that evaluate how respondents feel "right now, at this moment". The T-Anxiety scale

consists of twenty statements that assess how some one generally feels. The scales are printed on opposite sides of a single-page test form. Subjects respond to each item by rating themselves on a four point scale. Sample items include: I feel calm; I feel anxious; I feel like crying; I am content.

This inventory has been useful in measuring anxiety in pregnant populations (Gorsuch and Kay, 1974). The essential qualities evaluated by the STAI S-Anxiety scale are feelings of apprehension, tension, nervousness, and worry. The STAI T-Anxiety scale has been widely used in assessing clinical anxiety in medical, surgical, and psychiatric patients. The sensitivity of the S-Anxiety scale to environmental stress has been repeatedly demonstrated in research on emotional reactions to surgery. Typically, S-Anxiety scores rise immediately prior to surgery and decline as patients recuperate (Auerbach, 1973).

The validity of the STAI rests upon the assumption that the examinee has a clear understanding of the "state" instructions which require her to report how she feels at this moment and the "trait" instructions which ask her to indicate how she generally feels. There is concurrent validity which is evidenced by the correlations that are reported with other instruments, such as the Taylor Manifest Anxiety Scale (1953) and the Auckerman Affect Adjective Check List (1960). The test-retest reliability data on the

A-Trait scale are reasonably high. They range from .73 to .86. The test-retest reliability data on the A-State scale are relatively low, ranging from .16 to .54. The low r's for the A-State should reflect the influence of unique situational factors existing at the time of testing. Given the transitory nature of anxiety states, measures of internal consistency, such as the alpha coefficient seem to provide a more meaningful index of the reliability of A-State scales than test-retest correlations. Alpha coefficients ranged from .83 to .92 for A-State. Thus, internal consistency for both STAI subscales is reasonably good. The comparison of mean scores between neuropsychiatric patient groups and normal subjects yields evidence of construct validity.

The STAI is a deservedly popular instrument. The reliabilities and validities are high. The STAI is an excellent tool for the researcher looking for an easy test to administer; an easy to score, reliable, and valid index of individual differences in proneness to anxiety or in the transitory experience of anxiety.

Prenatal Self-Evaluation Questionnaire

Prenatal adjustment will be measured by the Prenatal Self-Evaluation Questionnaire (Lederman & Lederman, 1979). It is a questionnaire specifically designed to measure prenatal adaptation. It was developed to further understanding of psychological factors in pregnancy. It identifies

expectant women who may need counseling in resolving conflict related to assuming the motherhood role. It takes approximately twenty minutes to complete and provides measures of seven variables. The woman reads the statements and indicates the extent to which they reflect her feelings by making one of four responses. Predictive validity studies are presently being conducted.

The Prenatal Self-Evaluation Questionnaire consists of the following seven scales:

1. Concern for well-being of self and baby. This scale focuses on concerns the gravida may have about complications arising in labor. Sample items include: I think the worst whenever I get a pain; I am confident of having a normal childbirth.

2. Degree of acceptance of the pregnancy. This scale focuses on the pregnancy itself. Sample items include: I am happy about this pregnancy; I wish I wasn't having this baby now.

3. Extent of identification of a motherhood role. This scale focuses on the extent to which the gravida looked forward to assuming a motherhood role and anticipated caring for a baby. Sample items include: I look forward to caring for the baby; I feel that babies aren't much fun to care for.

4. Preparation for labor. This scale assesses the extent to which the gravida feels informed and prepared to

cope with the events of labor. Sample items include: I have a good idea of what to expect.

5. Fear of pain, helplessness and loss of control. Sample items include: I can cope well with pain; I feel that the stress of labor will be too much for me to handle.

6. The quality of the gravida's relationship with her mother. This scale measures the closeness, support, and empathy between the gravida and her mother. It has been found that the quality of one's relationship with her mother influences one's response to pregnancy and motherhood. Sample items include: It's easy to talk to my mother; When we get together my mother and I tend to argue.

7. The quality of the gravida's relationship with her husband. Sample items include: I can count on my husband to share in the care of the baby; I find it hard to discuss the changes I'm going through during this pregnancy.

Reliability for the Prenatal Self-Evaluation Questionnaire was determined by Cronbach's alpha coefficient, which is a measure of internal consistency of response. The reliability of the scales ranged from .06 to .54. Thus, it can be seen that the scales are relatively independent and that separate measures are justified for each of the constructs.

Postpartum Self-Evaluation Questionnaire

Postpartum adaptation was measured by the Postpartum Self-Evaluation Questionnaire (Lederman, 1981). This instrument was developed in order to provide a quantifiable

and objective measure of factors frequently cited in the literature as relevant to maternal adaptation. It consists of eight scales. The items were developed from mothers' responses to postpartum interview questions. The mother indicates on this questionnaire the extent to which the items reflect her feelings by choosing one of four response options ranging from "very much so" to "not at all". It takes approximately twenty minutes to complete. The eight scales of the postpartum questionnaire are:

1. The quality of the relationship with the husband. Russell (1974) and Shereshefsky (1973) found that the relationship with the husband was a significant factor in maternal postpartum adaptation. Sample items include: My husband cares about how I feel; My husband lets me down when I need him.

2. A mother's perception of the father's participation in child care. This measures the mother's view of the time and interest that the father devotes to caring for the baby. Sample items include: My husband wants to share in the care; My husband feels that caring for the baby is not his responsibility.

3. The mother's gratification with her labor and delivery experience. This reflects the mother's sense of gratification and accomplishment versus disappointment from childbirth. Sample items include: Overall, my labor and delivery was a good experience; I feel disappointed in my

delivery experience.

4. The mother's satisfaction with her life situation and circumstances. This assesses the mother's satisfaction with her family's financial status, material assets, and size of home. Sample items include: I worry about how we will manage on our present income; Our home is too small for us.

5. The mother's confidence in her ability to cope with the tasks of motherhood. This scale measures the mother's doubts about her ability to parent. Sample items include: I have doubts about whether I am a good mother; I feel I know my baby.

6. The mother's satisfaction with motherhood and infant care. This scale assesses the mother's pleasure with mothering activitites versus other roles. Sample items include: I feel overburdened with the many demands made on me as a mother; I enjoy being a mother.

7 and 8. Support for the maternal role from parents and friends and other family members. The measures of support were analyzed in combination. The amount of support and individual receives during a period of critical life change has frequently been cited as a factor influencing adaptation. Sample items include: My parents are interested in the baby; I can talk to some of my friends or relatives about questions I have concerning motherhood.

The scale reliabilities, determined by Cronbach's

alpha coefficient, ranged from .73 to .90 at six weeks postpartum. The reliability coefficient at six weeks was higher than the intercorrelations among the scales. This indicates that the scales are providing unique information and that separate scales are justified.

Postpartum Questionnaire

The researcher developed the postpartum questionnaire to focus on the women's adjustment to motherhood. One set of questions requires the participants to rate on a scale of 1 to 5 their reactions to becoming mothers and their feelings about their babies, husbands, and careers. A second set of questions, which are open-ended, deal with support groups for new mothers. The respondents are asked to express the perceived benefits, both psychological and tangible, to belonging to this type of group.

Administration of Tests

The experimental groups were given the Demographic Questionnaire, the Depression Adjective Check List, the State-Trait Anxiety Inventory and the Prenatal Self-Evaluation Questionnaire during the first support group session. This was at the beginning of their ninth month of pregnancy. The same instruments were mailed to the control group on packets containing self-addressed stamped return envelopes. This also was at the beginning of their ninth month of pregnancy.

Both the experimental and control groups were post-

tested on the same measures at eight weeks postpartum. In addition, they were asked to complete the Self-Evaluation Postpartum Questionnaire. The experimentals were given the postpartum measures at the last support group meeting in packets containing self-addressed stamped return envelopes. The control group was mailed the same packets. All packets were returned within the eight week time limit.

The Group Leader

The group leader was the researcher. She is a psychologist for the Chicago Board of Education and a Ph.D. candidate in Counseling and Educational Psychology at Loyola University of Chicago. She has had experience both as a counselor and a group leader. Her approach to support groups is primarily psychodynamic in nature. She is committed to providing a warm and trusting atmosphere conducive to maximum growth, self-exploration, and awareness. She will also serve as a role model, having recently begun the experience of motherhood herself. Because the support groups were led by one leader, the researcher, it is difficult to separate the group content from the personal effectiveness of the leader; therefore, it is the total effect of the support groups which is to be considered as the independent variable. However, the use of one group leader insured consistency, as much as possible, across the group sessions.

The Treatment

Treatment consisted of thirteen weekly support group

meetings that began in the ninth month of pregnancy and continued through eight weeks postpartum. Each session lasted approximately two hours. Each group consisted of five members and the one group leader. The groups were loosely structured to meet the needs of the participants. The discussions covered a variety of topics which in the literature have proven to be relevant to prospective and new mothers (Breen, 1975; Entwisle & Doering, 1981; Gordon & Gordon, 1960; Gray, 1980; and Power & Parke, 1984). The amount of time and energy spent on each topic varied among the groups. Each session was tape recorded to allow maximum feedback for the group leader.

The following outline was used as a general guide for each session. After each session the tape was reviewed in order to decide what the specific focus would be for the following week. The next session, while attending to the topics on the outline, also addressed specific and immediate concerns of the members.

1. Psychological events of the pregnancy
    a. The motivation for having a baby
        1. Why now, physically
        2. Why now, psychologically
    b. Expectations for self as a mother
        1. Will I be good
        2. Will I meet physical needs of baby

3. Will I meet psychological needs of baby

c. Expected relationship issues with baby, husband, and parents

1. Will I be jealous of husband's relationship with baby

2. Will my husband be jealous of my relationship with baby

3. Will our relationship change drastically

d. Fears about motherhood

1. Will it be satisfying

e. Feelings about careers

1. Will it mean the same

2. Will I be able to do both

2. Issues concerning childbirth

a. Physical concerns

1. Will baby be okay

2. Will I be okay

3. Can I handle the pain- physically and psychologically

b. Psychological needs

1. Will I be able to handle pain

2. Will I lose control

3. The birthing experience

a. Feelings about the delivery experience

1. Psychologically, was it wonderful or anti-climatic

b. Feelings about self during delivery

1. Did I do as well as I wanted

2. Did I need medication

c. Feelings about husband as coach

1. Did he help me physically

2. Did he help me psychologically- was he supportive or critical

d. Feelings about support staff

1. Who was helpful

2. What are feelings about doctor

4. Postpartum Experience

a. Feelings about the baby

1. What are positive feelings

2. What are negative feelings

b. Feelings about self

1. How am I as a woman

2. How am I as a mother

c. The realities of motherhood

1. What are the positive aspects

2. What are the negative aspects

d. Feelings about husband

1. Have my feelings changed toward my husband

2. How is he as a father

3. How is he as a husband

e. Changing relationships

1. How are things with friends

2. How are things with family

3. How are things with in-laws

f. New stressors

1. What's causing stress in my life

2. How am I dealing with it

5. Feelings about careers

6. Available resources

7. Separation issues

a. How do I feel about leaving baby with husband and relatives

b. How do I feel about leaving baby with sitter

8. Reactions to group experience

Hypotheses

The hypotheses in this study are stated in the null form:

1. There will be no significant difference between the experimental and control groups in terms of postpartum anxiety as determined by the scores on the State-Trait Anxiety Inventory.

2. There will be no significant difference between the experimental and control groups in terms of postpartum depression as determined by the scores on the Depression Adjective Check List.

3. There will be no significant difference between the experimental and control groups in terms of postpartum adaptation as determined by the scores on the Postpartum

Self-Evaluation Questionnaire.

Analysis of the Data

The study employed three statistical techniques to analyze the data. Multivariate analysis of covariance was used when there were both pre- and posttests. Multivariate analysis of variance was employed when there was only a posttest. Chi Square was used to make statistical comparisons involving the categorical variables.

Two of the main hypotheses were tested statistically using multivariate analysis of covariance with group assignment as the independent variable, Depression Adjective Check List 2, State-Trait Anxiety Inventory State 2, and State-Trait Anxiety Inventory Trait 2 posttest scores as the dependent variables, and pretest scores on these measures as covariates. This procedure is superior to using regular multivariate analysis of variance because it reduces pretest score error variance from the statistical comparisons. This makes the statistical test more sensitive to differences between experimental and control groups. This was important because of the significant differences that were found on two of the pretest variables.

Multivariate analysis of variance was used to test the third hypothesis that postpartum adaptation scores would be higher in the experimental group when compared to those in the control group. In this analysis, group assignment was

used as the independent variable and the seven postpartum questionnaire scales were used as dependent variables. Multivariate analysis of variance was selected because it allows for consideration of the extent to which the various measures are interrelated. It is also used to demonstrate the discriminant function analysis for multiple groups and variables. It is a powerful tool in that multiple conditions can be studied using multiple measures in a way in which the individual effects and interaction of conditions can be assessed differently (Hardych & Petrinovich, 1975).

In addition to statistical analyses related to the null hypotheses stated above, qualitative analysis will be used to explore patterns related to participation in a support group. This qualitative analysis is designed to examine opinions, feelings, and beliefs not easily measured by standardized instruments.

Summary

To summarize, the participants in this study were forty primiparous career women who were interrupting their careers for at least six weeks following the birth of their first child. To determine the effect of the treatment, a social support group, subjects were randomly assigned into an experimental and a control group. Both groups were pre- and posttested. The Depression Adjective Check List was used to assess changes in levels of depression. The State-Trait Anxiety Inventory was given to determine changes in

levels of anxiety. A posttest, the Self-Evaluation Questionnaire, was given to assess the differences between the experimental and control groups on postpartum adaptation. An open-ended questionnaire was administered to garner pertinent information regarding the women's perceptions of support groups.

Multivariate analysis of covariance was the statistical technique used to test the hypotheses concerning anxiety and depression. Multivariate analysis of variance was employed as the statistical technique for analyzing the Self-Evaluation Questionnaire. The qualitative variables were analyzed using Chi Square and percentages.

Chapter IV will report the findings in terms of the hypotheses. Chapter V will examine the results for their implications and will offer recommendations for future research.

CHAPTER IV

PRESENTATION AND ANALYSIS OF THE DATA

This chapter will present an analysis of the data comparing the adjustment to motherhood of older primiparous career women who participated in a thirteen week support group to a control group who did not participate in a support group. The changes of interest to this study include: level of depression, level of anxiety, and level of postpartum adaptation. The more subtle changes which involve the women's attitudes, beliefs, and opinions are also included. The analysis was based on a comparison of the experimental and control groups' scores on the following posttest measures: the Depression Adjective Check List, the State-Trait Anxiety Inventory, Lederman's Postpartum Self-Evaluation Questionnaire, and the Postpartum Questionnaire. The scores on the Postpartum Questionnaire yield the qualitative data of interest.

Randomization was used initially to achieve equivalent groups; however, randomization can only be assumed "in the long run" with enough samples (Kraemer, 1981). To determine whether equivalence between the groups was

achieved, the Bartlett Test of Homogeneity for Variance was run. The results showed the variance to be equal among the experimental and control groups on all variables except two. (Table 2, p. 51, presents a summary of the results of this test.) The variance scores on these two variables can be attributed only to chance. The variables with the variance scores are: fear of pain, helplessness, and fear of control; and the quality of the gravida's relationship with her mother.

Analysis of the Data

This study employed three statistical techniques to analyze the quantitative data. Two of the hypotheses were tested statistically using multivariate analysis of covariance with group assignment as the independent variable, the posttest scores as the dependent variable, and pretest scores on these measures as the covariates. This procedure is superior to using regular multivariate analysis of variance because it reduces pretest score error variance from the statistical comparisons. This was important because of the significant difference that showed up on two of the pretest variables. (Kraemer, 1981).

Multivariate analysis of variance was used to test the third hypothesis, that postpartum adaptation scores

would be higher in the experimental group when compared to the adaptation scores in the control group. In this analysis, group assignment was used as the independent variable, and the seven postpartum questionnaire scales were used as the dependent variables. Multivariate analysis was selected to demonstrate discriminant function analysis of multiple groups and variables. It allows for consideration of the extent to which the various measures are interrelated, and is a powerful tool in that multiple conditions can be studied using multiple measures in a way in which the individual effects and interactions of conditions can be assessed. (Hardych & Petrinovich, 1975). Analyzing the qualitative data involved Chi Square and percentages.

Hypothesis I

Null hypothesis I stated that there would be no significant difference between the experimental and control groups in terms of postpartum anxiety, both state and trait, as determined by the scores on the State-Trait Anxiety Inventory. Multivariate analysis of covariance was used to analyze these scores. Using the means and standard deviations, Table 4 presents the summaries of the analysis of covariance scores on the State-Trait Anxiety Inventory. The table illustrates that the experimental group means (33.2 for State and 35.2 for Trait) were essentially the same as the control group means (33.5 for State and 35.1

TABLE 4

POSTTEST MEANS AND STANDARD DEVIATIONS FOR EXPERIMENTAL AND CONTROL GROUPS ON ANXIETY MEASURES

	Experimental (N=20)		Control (N=20)		Univ. F	df	p
Variable	$\bar{x}$	sd	$\bar{x}$	sd			
State-Trait Anxiety Inventory:							
State	33.2	10.1	33.5	10.7	.48	1, 35	.9
Trait	35.2	7.8	35.1	8.7	.89	1, 35	.3

TABLE 5

POSTTEST MEANS AND STANDARD DEVIATIONS FOR EXPERIMENTAL AND CONTROL GROUPS ON DEPRESSION MEASURES

	Experimental (N=20)		Control (N=20)		Univ. F	df	p
Variable	$\bar{x}$	sd	$\bar{x}$	sd			
Depression Adjective Check List	7.3	3.4	8.6	3.8	.31	1, 35	.58

for Trait). The results indicate that the null hypothesis cannot be rejected. The experimental group did not demonstrate a lower level of anxiety than the control group, thus indicating that the treatment did not produce a lower level of anxiety for the experimental group.

Hypothesis II

Null hypothesis II stated that there would be no significant difference between the experimental and control groups in terms of postpartum depression as determined by the scores on the Depression Adjective Check List. Multivariate analysis of covariance was used to analyze these scores. Table 5 presents the means and standard deviations for the Check List; it shows that the experimental mean, 7.3, was lower than the control group mean, 8.6. This indicates a lower level of depression for the experimental group, although not significantly so. The results indicate that the null hypothesis cannot be rejected. The findings indicate that the treatment did not effect a significantly lower level of depression for the experimental group. However, the change that did occur was in the predicted direction.

Hypothesis III

Null hypothesis III stated that there would be no significant difference between the experimental and control groups in terms of postpartum adaptation as determined by the scores on the Postpartum Self-Evaluation Questionnaire.

Multivariate analysis of variance was used to analyze the scores on each of the seven scales. Using the means and standard deviations, Table 6 presents the summaries of the analysis of variance scores on each of the seven scales of the questionnaire. The results indicate that the null hypothesis cannot be rejected. The experimental group did not demonstrate a higher level of postpartum adaptation than the control group. However, on three variables- mother's gratification from her labor and delivery experience, mother's confidence in her ability to cope with the tasks of motherhood, and support for the maternal role from friends and other family members- the change was in the predicted direction.

Qualitative Report

In addition to the statistical analyses related to the null hypothesis, qualitative analyses were used to explore patterns related to participation in a support group. The qualitative analysis was employed in order to enable the researcher to garner information involving the participants' opinions, feelings, and beliefs not easily measured by standardized instruments.

Reaction to Support Groups

One variable that proved to be statistically significant was the women's reactions to support groups. Using the means and standard deviations, Table 7 summarizes the analysis of variance scores on this variable. The results

TABLE 6

POSTTEST MEANS AND STANDARD DEVIATIONS FOR EXPERIMENTAL AND CONTROL GROUPS ON POSTPARTUM ADAPTATION MEASURES

	Experimental		Control		t	df	p
Variable	$\bar{x}$	sd	$\bar{x}$	sd			
Quality of relationship w/husband	44.2	5.3	44.2	3.3	.0	1, 38	1.0
Perception of father's participation in childcare	40.5	4.2	42.0	2.7	-1.39	1, 38	.174
Gratification from labor & delivery experience	36.0	6.2	35.1	5.5	.46	1, 38	.648
Satisfaction with life circumstances	31.3	9.8	32.6	6.3	- .50	1, 38	.619
Confidence of ability to cope with tasks of motherhood	45.7	6.1	44.1	6.2	.85	1, 38	.402
Satisfaction with motherhood and infant care	44.7	4.6	45.0	4.6	- .21	1, 38	.838
Support for maternal role from parents, friends, family	44.6	3.7	42.8	5.3	1.25	1, 38	.218

indicate that the women in the experimental group had a positive reaction to support groups. At eight weeks postpartum the experimental group had a more positive attitude toward support groups than the control group. This was significant at the .001 level.

TABLE 7

REACTION TO SUPPORT GROUPS

Experimental Group		Control Group		T	df	p
$\bar{x}$	sd	$\bar{x}$	sd			
4.5	1.0	3.3	1.3	3.33	1, 3	.001

There were no other statistically significant differences between the two groups on any other qualitative variables. However, since this is the first piece of research to look exclusively at older career women's adjustment to motherhood, it is pertinent to analyze the qualitative data using the experimental and control groups as one entity. This qualitative data will be reported using frequencies and percentages. Direct quotations will also be used to describe the women's feelings.

Careers

With regard to resuming their careers, it is noteworthy that only nine women, or 22.5%, planned on staying

home for any length of time after their babies' births. Eighteen women, or 45.0%, planned to resume their careers within three months. Thirteen women, or 32.5%, intended to resume their careers within six months. The results indicate that 77% of the women in this study plan on combining motherhood and careers. Table 8 presents a summary of the information concerning career resumption.

Table 9 presents a summary of the information concerning the level of interest in careers. Only four women, or 10%, said they felt very positively about their careers, while seven women, or 17.5 %, felt negatively. The majority, 50%, were just neutral. Several women reported that they did not want to go back to work, but felt they "just had to," that they "had invested so much time, energy, and emotion" that they couldn't imagine not returning. One woman said that "not returning would be like losing a leg." Another woman said she left her career three months ago, but was now returning to a job. Another woman reported that her career did not have the same appeal it had had before her baby.

Support

Table 10 presents a summary of the responses given when the women were asked the question, "Do you feel you have a support network to whom you can turn? If so, please list" prepartum. Six women, or 15%, felt they had no support network available to them. Nineteen women, or 47.5%,

TABLE 8

RESUMPTION OF CAREERS

Variable	Frequency	Percent
Staying Home	9	22.5
Three months	18	45.0
Six months	13	32.5

TABLE 9

INTEREST IN CAREERS

Variable	Frequency	Percent
Very Positive toward Career	4	10
Neutral toward Career	20	50
Negative toward Career	7	17.5
Not returning	9	22.5

TABLE 10

AVAILABLE SUPPORT NETWORK

	Frequency	Percent
None available	6	15
Family	19	47.5
Friends	32	80.0
Husband	8	20
In-laws	2	5
Neighbors	4	10
Others	2	5

felt they would be able to turn to their families of origin for needed support. Thirty-two women, or 80%, felt their friends would be supportive during the transition, and two women, or 5%, felt their in-laws would be supportive. However, only eight women, or 20%, listed their husbands as possible agents for support. The following section, which focuses on areas of stress and coping with stress, gives some indication of sources of support for these women during the postpartum period.

Areas of Stress

The women were asked to list what they felt were areas of stress for them since the birth of their babies. Table 11 presents a summary of the sources of stress for the women. Several women did mention that they were surprised at what turned out to be areas of stress for them. For example, the two women who prenatally thought their in-laws would be supportive actually found dealing with them stressful. One woman said her in-laws came to help out after the baby's birth, but that just seeing her mother-in-law touch the baby made her feel "nauseous." Another woman said that her mother-in-law got a cold shortly after the birth, and was unable to help out. She said she was grateful for this because she found being with her mother-in-law very difficult. Her mother-in-law was extremely critical of everything she did with the baby.

Half of the eight women who prenatally felt their

TABLE 11

SOURCES OF STRESS

Variable	Frequency	Percent
Parents	10	25
In-laws	15	37.5
Husband	13	32.5
Baby	25	62.5
Lack of Sleep	30	75
Weight	11	27.5
Finances	5	12.5
Lack of Time	30	75
Household Responsibilities	21	52.5
Breastfeeding	16	40
Feeling Out of Control	20	50
Childcare	31	77.5

husbands would be supportive found being with them stressful. In fact, thirteen women, or 32.5%, felt their husbands were sources of stress to them. Several women mentioned that their husbands were not able to listen to them when they wanted to vent their frustrations. A few others said their husbands tried taking on a new role- that of the "boss." They said that they went from having an egalitarian marriage to a traditional marriage. Two other women mentioned that they suddenly became very critical of their husbands. Nothing they did was satisfactory.

Twenty-five women, or 62.5%, found their babies to be sources of stress. An overwhelming number of women commented that they couldn't believe it but they found this "tiny, lovely" infant a source of tremendous stress. One woman said, "Sometimes I want to put her down and never go in that room again." Three women said their ambivalent feelings were a real issue for them. They never in their wildest fantasies thought they would have these negative feelings for their babies.

Thirty women, or 75%, found both lack of sleep and lack of time to be areas of stress. Twenty-one women, or 52.5%, found household responsibilites to be stressful. Twenty women, or 50.0%, also found themselves to be feeling out of control. And an overwhelming number, 31 women, or 77.5%, said that childcare was a source of much anxiety. Two women who were returning to work three months after the

birth of their babies commented that childcare issues made every other issue pale in comparison.

Coping with Stress

To alleviate stress in their lives, twenty women, or 50%, talked with their friends. This, however, was a drop from the 92.5% who talked with friends as a means of alleviating stress in their lives prenatally. This drop was a result of the women feeling distanced from their friends after the birth of their babies. Several women commented that their friends just stopped calling. One woman said, "Now when I really need friends to talk to, I can't find any."

Twenty-five women, or 62.5%, talked with their husbands about the stress they felt in their lives. However, only thirteen women, or 32.5%, found their husbands to be receptive. Essentially, then, only 12 women, or 30%, found talking with their husbands helpful. One woman wrote, "I don't know what has gotten into my husband, but the moment I want to express any negative fellings he picks a fight." Another wrote that her husband had begun staying late at work so as to avoid listening to her "complain." Another said, "I don't know what has happened or why, but our relationship has taken a major change for the worse." Yet another wrote, "I used to be able to talk with my husband about anything and he'd listen. Now he says I'm just complaining." And another wrote, "I always thought my husband

would be my source of support, instead of a source of stress."

Twenty-six women, or 65%, talked with their families. And thirty women, or 75%, chose to talk with other mothers as a means of alleviating the stess in their lives. Two women in the control group wrote that they really wished they had been picked for the support group because they felt they had no one to to talk to- no one who understood what they were going through. Another woman in the control group wrote that she felt so ashamed of her feelings and so alone. "I have no one to talk to. I feel like I'm on a ship that's sinking fast. My friends and husband have deserted me and I'm too ashamed to ask for help." Table 12 presents a summary of all the information regarding how the women were coping with the stress in their lives.

Control Group

Sixteen women, or 80%, of the control group wished they had been chosen to participate in the experimental group so they could have been part of a support group. They felt a lack of support during their transition. One woman wrote that she was certain her adjustment would have been smoother if she had been part of the support group. Three women said they had contacted their doctors to see if they knew of any support group or if they would consider organizing one.

Four women, or 20%, felt their families were sup-

TABLE 12

MEANS OF COPING WITH STRESS

Variable	Frequency	Percent
Sleep	7	17.5
Eat	9	22.5
Exercise	3	7.5
Smoke	1	2.5
Talk with Friends	32	80
Talk with Husband	25	62.5
Husband Receptive	13	32.5
Talk with Other Mothers	30	75
Talk with Family	26	65

portive. Three women, or 15%, felt they could count on their husbands for needed support. However, 80% of the control group felt that being part of a support group would have helped ease the transitional period. Table 13 presents a summary of the information pertaining to the control group's feelings.

Support Group

Table 14 summarizes the expressed experiences of the support group. Every participant felt that being part of a support group eased their transition into motherhood. One woman wrote tht it really helped seeing everyone in the same confused emotional state. "I wouldn't have known it was normal otherwise." Another woman wrote that the support group "put minor irritations which had become major ones into perspective as part of the fabric of life as a parent. Having an outlet for those more trivial things allows the growth and realization of the deeper feelings involved in having a baby. I just wish I had had a support group for other things in my life." Another woman wrote that the "support group has helped in many ways. When I hear other mothers talk I don't feel all alone in my feelings of frustration and inadequacy. The sessions really uplifted my spirits." Another woman commented that she felt her sense of independence return with each session. Another woman wrote, "Although I had high expectations for what I would gain from participating in a support group, my

TABLE 13

CONTROL GROUP'S FEELINGS REGARDING SUPPORT GROUP

Variable	Frequency	Percent
Felt Support Group Would Have Been Helpful	16	80
Felt No Need for Group	2	10
Felt Supported by Family	4	20
Felt Supported by Friends	2	10
Felt Supported by Husband	3	15
Felt It Would Have Eased Their Transition	12	60
Felt They Would Have Gotten Good Practical Advice	13	65

TABLE 14

SUPPORT GROUP'S EXPERIENCES

Variable	Frequency	Percent
Eased Transition	20	100
Increased Sense of Belonging	20	100
New Friends	10	50
Positive Experience	17	85
Leader Good Resource	14	70
Air Feelings	16	80

actual experiences surpassed my expectations. The group is not only a collective support to me, but the women participating have become my friends. Such an intense common experience has succeeded in creating a bond of friendship that usually takes years to accomplish. There is a need for support groups because the benefits are visible and tangible and can't be sustituted from other sources." Another woman wrote, "I really looked forward to the meetings. It was the one place I could go and not worry about him crying or having to nurse him. I felt totally accepted and at home." Another wrote, "For weeks, it was practically the only thing that got me out of the house. It certainly was the only time I went out and felt relaxed."

The entire experimental group also felt that participation in the support group increased their sense of belonging. One woman wrote that "being thrown into a 24-hour job without any real preparation has been very stressful. The first few weeks were so unpredictable and there was the fear that life would never be normal or relaxed again. However, hearing that everyone else was experiencing the exact same thing gave me a new sense of normal." Another woman wrote, "I didn't feel so isolated or alone in my situation. It gave me strength and security." Yet another participant wrote, "For the first time in my life I had a real need and desire to pursue female friendships. And this was absolutely the perfect milieu for that." Another woman wrote, "The

group made me feel less isolated, and it gave me the reassurance about myself when I wasn't getting much from my husband."

The majority of the experimental group (80%) felt that participating in the group allowed them the opportunity to air feelings that they otherwise would not have been able to. One woman wrote, "The support group was valuable as a forum for venting myself. Beth really created an atmosphere of trust so for the first time in my life I really opened up with people." Another woman wrote that "expressing myself doesn't come easily, nor does dealing with my feelings. Yet each week I went home and tried some of the things that were discussed in the group. Now I just hope I can continue expressing myself now that the group has officially terminated."

Summary

Statistical analysis revealed that the experimental and control groups were equivalent at the beginning of the study on all but two variables. The significant differences on these two variables (fear of pain, helplessness, and loss of control; and the quality of the gravida's relationship with her mother) can be attributed to chance alone. However, since randomization did not ensure equivalence, multivariate analysis of covariance was used as the statistical technique whenever possible because of its sensitivity to differences between the experimental and

control groups when they are not equal. When it was not possible to use MANCOVA, multivariate analysis of variance was used. Chi Square was also used to make some statistical comparisons involving the qualitative variables.

The results indicate that the treatment did not have a significant positive effect on the levels of anxiety, depression, or postpartum adaptation. However, the results of the qualitative analysis present evidence of the benefit of a support group for these women. One hundred percent of the experimental group felt that being part of the support group eased their transition into motherhood, while 80% of the control group felt that if they had been able to participate, it would have eased their transition. The entire experimental group felt that being part of the support group increased their sense of belonging. The vast majority (85%) felt that being part of the support group was a positive experience.

Chapter IV has presented an analysis of the data for the study. A further discussion and summary of the findings, conclusions of the investigation, and implications for future research are presented in Chapter V.

CHAPTER V

SUMMARY

The Problem

It is becoming increasingly common for first time mothers to be age thirty and older. This trend has been attributed to such variables as educational level, career orientation, and feminist ideology. These older career women bring new attitudes, expectations, experiences, and needs with them when they become mothers. However, little has been written with respect to understanding and assisting these older career women as they make the transition to motherhood.

Until this current study, the research in the area of support during this transitional period has focused on the husband's role in assisting their wives. The conclusions drawn from the past research have been that it is the husband's support that is of paramount importance in the wife's adjustment to motherhood. However, husbands are unable to be truly supportive to their spouses during this transitional period for it is a crisis period for them as well. In light of these findings, the present study inves-

tigated the effectiveness of a support group consisting of older primiparous career women in altering the adjustment to motherhood.

The Purpose

The purpose of this study was to evaluate the effectiveness of psychological intervention in easing the adjustment to motherhood. It involved primiparous career women who had chosen to delay motherhood until their thirties, and who intended to stop working for at least six weeks after the birth of their children. A sample of women who participated in social support groups was compared to a similar sample of women who did not participate in support groups. Specifically, this research quantitatively measured the changes in the women's levels of anxiety, depression, and adaptation after participating in a three-month support group compared with the levels of change in the women in the control group. It also used qualitative analyses to explore patterns related to participation in a support group. Qualitative analysis is designed to examine opinions, feelings, and beliefs not easily measured by standardized instruments.

The Hypotheses

The hypotheses tested in this study are stated in the

null form. The hypotheses are:

1. There will be no significant difference between the experimental and control groups in terms of postpartum anxiety as determined by the scores on the State-Trait Anxiety Inventory.

2. There will be no significant difference between the experimental and control groups in terms of postpartum depression as determined by the scores on the Depression Adjective Check List.

3. There will be no significant difference between the experimental and control groups in terms of postpartum adaptation as determined by the scores on the Postpartum Self-Evaluation Questionnaire.

The Instruments

Four paper and pencil self-report instruments were used. The Depression Adjective Check List, developed by Lubin (1965), is a self-report instrument which measures depressive moods. The State-Trait Anxiety Inventory, developed by Spielberger (1966), measures state and trait anxiety. The Postpartum Self-Evaluation Questionnaire was developed by Lederman (1981) to provide a quantifiable and objective measure of factors relevant to maternal adaptation. The Postpartum Questionnaire was developed by the researcher in order to gather qualitative information about the women's adjustment to motherhood. This questionnaire consisted of a set of questions requiring the participant

to rate on a scale of one to six her reaction to becoming a mother and her feelings about the baby, her husband, and her career. A second set of questions dealt with her feelings about support groups for mothers. (See Appendix B.)

The Design

The design of this study was the Pretest-Posttest Control Group Design (Campbell and Stanley, 1963). The main strengths of the design are that it controls for the effects of history, maturation, testing instrument decay, statistical regression, selection, and mortality; thus, it has good internal validity.

Findings

This study employed three statistical techniques to quantitively analyze the data. The first two hypotheses were tested using multivariate analysis of covariance; the third using multivariate analysis of variance.

The analysis revealed no significant difference between the experimental and control groups in postpartum anxiety; in fact, on both measures of anxiety, the mean scores were almost identical. Thus, hypothesis I was not rejected. Similarly, although the mean score for the experimental group on measures of depression was slightly lower than that for the control group, the difference was not significant. Thus, hypothesis II was not rejected.

Statistical analysis also revealed no significant

differences between the two groups on the seven variables of the Self-Evaluation Questionnaire. Although hypothesis III was not rejected, three variables- mother's gratification from her labor and delivery experience, mother's confidence with her ability to cope with the tasks of motherhood, and support for the maternal role from parents, friends, and family members- showed change in the predicted direction. On three other variables- mother's perception of father's participation in childcare, mother's satisfaction with life circumstances, and mother's satisfaction with motherhood and infant care- the mean scores for the experimental group were lower than those for the control group.

Statistical analysis did reveal that the experimental and control groups were significantly different in their reactions to support groups. At eight weeks postpartum, the experimental group had a more positive attitude toward support groups than the control group. This was significant at the .001 level.

Qualitative analysis was used to explore patterns related to participation in a support group. The qualitative analysis was employed in order to examine opinions, feelings, and beliefs not easily measured by standardized instruments. The results of the qualitative analysis revealed the benefit of a support group to these women. One hundred percent of the experimental group felt

that participation in the support group had eased their transition into motherhood.

Discussion of Quantitative Data

Statistical analysis revealed no significant differences between the experimental and control groups on the measures of anxiety, depression, or postpartum adaptation. One issue that needs to be addressed is the size of the sample. It is possible that with a larger number of subjects, a statistically significant difference would have been observed. On the measure of depression, the change that was observed was in the predicted direction. This was also true for three variables on the measure of postpartum adaptation. The three variables which showed change on the predicted direction were mother's gratification from her labor and delivery experience, mother's confidence with ther ability to cope with the tasks of motherhood, and support for the maternal role from parents. friends, and family members. All of this gives credence to the notion that an increase in the size of the sample may have yielded statistically significant results.

A second issue which warrants discussion is the instrumentation used in the study. Of the three standardized instruments employed, only one dealt exclusively with women's overall adjustment to motherhood, and it did not primarily deal with primiparous women. Lederman's postpartum adaptation instrument focuses on both the primi-

gradae and the multigavidae.

The Depression Adjective Check List was developed by Lubin (1965) in order to investigate the mood changes during pregnancy and the postpartum period. It does have high consistency, reliability, and validity. It is the best instrument available for pregnant populations (Materson, 1974). However, this study was not interested only or even necessarily in the mood changes, for during pregnancy and the postpartum period mood changes are frequent and often drastic. Rather, the researcher was interested in long-lasting depressive feelings to which the Depression Adjective Check List may not be sensitive.

This inability to tap the overall long-lasting feelings also applies to the State-Trait Anxiety Inventory. The other negative aspect of the State-Trait Anxiety Inventory is that its usefulness is limited to pregnant populations (Gorsuch and Kay, 1974). However, as with the other instruments chosen, the researcher felt it was the best available and she was interested in looking at the changes in anxiety level.

The postpartum questionnaire developed by the researcher also has drawbacks, in hindsight. Many of the questions asked postnatally should have been asked prenatally- for example, the women's reactions to support groups. At eight weeks postpartum, the experimental group expressed a more positive attitude toward support groups

than the control group. However, the validity of this measure must be questioned, because there is no pretest measure available for comparison. The experimental group obviously responded to the question with this particular support group in mind. The control group responded with their generalized feelings toward support groups. One woman in the control group even stated, "I don't know how I would have felt about this support group, but my overall feelings is . . ." A woman in the support group wrote, "My previous experiences with support groups have not been so positive." Consequently, and unfortunately, the results of the measure must be questioned.

Other questions that should have been asked both during the prenatal and postpartum periods include: feelings toward careers, who the women felt they could look to for support, and how long they planned to be away from work. The last two were asked only on the prenatal demographic questionnaire. This made any comparisons impossible. It also made drawing valid conclusions about these questions difficult.

Another issue that needs to be discussed is the possibility that this sample is not representative of the general population of older career women entering motherhood. All participants in this study volunteered. This signifies a willingness to express their feelings to others, to expose themselves- experiences involved in

belonging to a support group, but ones that some women would not seek out. Thus, some of those women in the sample who were not selected for a support group probably worked out their anxieties and conflicts with friends or family members. Others may not have confronted their anxieties or conflicts. Conversely, those women who did not volunteer for this study may be the ones who most need some outside support.

Discussion of Qualitative Data

Another issue that needs to be discussed is that participants in the support gorup did not necessarily end with quantifiably positive results. Some of the results of participation were observed as negative, although they may actually have been realistic. For example, on three variables of the postpartum adaptation measure the mean score of the experimental group was lower than the mean score for the control group. The three variables for which this happened were: mother's perception of father's participation in childcare, mother's satisfaction with life circumstances, and mother's satisfaction with motherhood and infant care. This indicates that for these three variables the control group experienced a more positive postpartum adaptation than the experimental group. It is possible that the discussions in the weekly support groups had a negative effect on these women's attitudes toward these topics. The content of the sessions may have helped the

women to confront and openly express some of their negative feelings surrounding these topics. However, in eight sessions it is hard to accomplish both awareness and problem-solving of the issues discussed. Consequently, the women expressed their negative, or realistic, feelings on the postpartum measures.

The next issue which warrants discussion is that the findings of this study refute conclusions drawn from previous research regarding support systems for women entering motherhood. Previous research (Kahn, 1978; Power & Parke, 1984; Tietjen & Bradley, 1985) has concluded that it is the support from one's husband that is of paramount importance in the woman's adjustment to motherhood. This, however, is not found in this study. This researcher believes that older career women do not necessarily look to their husbands for support. Unlike younger, more traditional women who become mothers in their early twenties, these older women have had a decade to establish autonomous identities. They have established financial independence and social and psychological independence as well. They have defined a heterosexual relationship that is characterized by intimacy and love, but not dependence. Hence, they do not look to their husbands as their primary source of support. Instead they prefer to look to other women. The results of this study support the idea of support groups for older career women entering motherhood.

The findings of this study also indicate that women intend to combine careers and motherhood. Only nine women, or 15%, were not planning to return to work, while 75% of the women planned on resuming their careers within six months of the birth of their babies. Few, though, had any idea who would be taking care of their child when they did return to work. Many women said that this would be the next crisis in their lives. This researcher feels that this highlights the need for improvement in childcare services. Both the government and the private sector must become attuned to the growing trend of working mothers.

In conclusion, although quantitively there was no statistically significant difference between the experimental and control groups on measures of anxiety, depression, or postpartum adaptation, the results of the qualitative aspect of this study supports the idea of support groups for older career women entering motherhood. This researcher urges psychologists and other health care professionals as well as the government and private sector to investigate further the older career woman's transition to motherhood in order to increase our understanding and ability to meet the needs of the mother and child as well as the needs of the newly formed triad.

Recommendations

1. The most obvious recommendation is further qualitative research in the area of older career women's

adjustment to motherhood. This was the first piece of research to look exclusively at older career women's adjustment. It is just a beginning. More qualitative research is needed before valid hypotheses can be drawn.

2. More experimental research would also be beneficial. The findings of this study refute previous research regarding women's support systems during the transition to motherhood. However, it is impossible to draw any valid conclusions from just one study.

3. Also more experimental and qualitative research using a more representative sample would be beneficial. The subjects in the present study were all middle-class and Caucasian. Further, this study employed only volunteers. This signifies a willingness to express their feelings to others- an experience involved in belonging to a support group, but one that some women do not seek out. Thus, those who were not selected for the support group may very well have worked out their anxieties and conflicts with friends and family members. Conversely, if those women who did not volunteer had somehow participated, it may have altered the results.

4. Construction of an instrument to assess primiparous psychological adjustment to motherhood should be given consideration. There is currently no instrument which addresses primiparous psychological adjustment. Such an instrument would yield extremely valuable information

concerning "normal" and "abnormal" adjustments to motherhood.

5. More research is needed which focuses on women combining motherhood and careers. This might help "wake up" employers to the real need of providing good quality childcare and support groups (mothercare) for their employees.

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APPENDIX A

49 Salem Lane
Evanston, IL 60203
676-4404

In response to our phone conversation I am sending this letter as a means of introduction and information.

I am a Ph.D. candidate in Counseling Psychology and Higher Education from Loyola University. For my dissertation I am evaluating the effectiveness of a support group in easing the primiparous career woman's adjustment to motherhood after the age of thirty. I am appealing to you for help in recruiting subjects. I need women who are due to deliver from the end of April through the end of December. They must meet the following criteria; married, currently working, but intending to stop for at least six weeks after the birth of their child, pregnant full-term for the first time and at least twenty-nine years old.

Enclosed is a brief description of my study which has the approval of the Institutional Review Board for the Protection of Human Subjects of Loyola University. Also included is a sample explanation sheet which will be handed out to possible participants.

I will contact you shortly to see if you have any questions, comments, or concerns. At that time I will then send you the additional explanation sheets to be distributed to the possible participants, a sign-up sheet for them, and a self-addressed envelope for you in which to return the sign-up sheet after one month's time.

Your time and assistance is greatly appreciated. Please feel free to contact me at any time.

Sincerely,

Beth Schiff

THE EFFECTS OF PSYCHOLOGICAL INTERVENTION ON PRIMIPAROUS CAREER WOMEN'S ADJUSTMENT TO MOTHERHOOD AFTER THE AGE OF THIRTY

PURPOSE

The purpose of this study is to evaluate the effectiveness of psychological intervention, in the form of an organized social support group, in easing the adjustment to motherhood. It involves primiparous career women who have chosen to delay motherhood until their thirties, and who intend to stop working for at least six weeks after the birth of their children.

RATIONALE OF THE STUDY

Pregnancy and motherhood have come to be regarded as a developmental crisis, equal in importance to adolescence and menopause (Benedek, 1959; Bibring, 1961; Rossi, 1968). Researchers (Gordon and Gordon, 1960; Leifer, 1980; Rossi, 1968; Shereshesky and Yarrow, 1973) have found evidence that even for women who optimally use their pregnancies to prepare for motherhood, the transition is difficult and the role of mother creates severe stress; thus there is a real need for health care professionals to help first time mothers through this stressful period.

Colman (1978), Dyer (1963) and LeMasters (1957) found that older women tend to have the most difficult transition of all entering motherhood because they have spent at least a decade developing their careers and the roles identified with them. Colman (1978) found that more and more women are postponing childbearing until their thirties. Whether or

not they consciously chose this pattern, these women have developed their careers and the roles identified with them first and then have turned to family. They have established career directions and expectations. Colman (1978), Leifer (1980), and Neumann (1982) all found evidence that women over thirty who did not return to work were the ones in the greatest flux and were the most in need of guidance and support. Colman (1978) found these women struggling with their new identities. Gladieux (1978) found the women in her study doubting whether motherhood would be fulfilling. Several women in her study found the transition to motherhood meant exchanging a realm in which competency and adeptness have been demonstrated for one in which aptitude had not yet been proven. Women with a strong commitment to work outside the home are likely to experience considerable crisis as they become full-time mothers and are isolated from previous work activities, relinquish the emotional investment in work activities, and learn to do without an independent income.

Researchers (Broussard, 1976; Carpenter et al, 1968; Gordon and Gordon, 1960; Klaus and Kennell, 1976) have found evidence which supports the notion that the way in which a prospective mother's environment is managed by those who care for her, affect the way she adapts to her new role. Caplan (1960) noted that during significant transitional periods in life, such as pregnancy, individuals often experience a heightened desire for help and may be more open to receiving help.

The proposed research project will evaluate the effectiveness of a support group in easing the adjustment to motherhood.

SPECIFIC AIMS

The primary question to be addressed is whether psychological intervention begun during the later part of pregnancy and continued through the eighth week postpartum alters the adjustment to motherhood.

Specifically, the study proposes to answer the following questions: Will postpartum adaptation be better for women who participated in the group than those who did not? Will anxiety be lower for the women who participated in the group than those who did not? Will depression be lower for the women who participated in the group than those who did not?

I am a Ph.D. candidate in Counseling Psychology and Higher Education from Loyola University. For my dissertation I am studying the adjustment to motherhood in first time mothers twenty-nine years and older who intend to stop working for at least six weeks after the birth of their child. It's also fine not to be returning to work at all. I hope to find out if a support group begun during the later part of pregnancy and continued through the first eight weeks post-partum alters the adjustment to motherhood. In order to do this I need two groups: one that will participate- the experimental group; and one that will not- the control group. I need to randomly select the experimental and control group, so you need to be willing to participate in either one. If you are willing to participate, you must meet the following requirements: married, currently working, but intending to stop for at least six weeks after the birth of your child; approximately twenty-nine years or older, pregnant full-term for the first time; and have a due date anywhere from the end of April through December.

If you are willing to participate and are randomly selected for the support group, it would involve attending weekly group meetings beginning in the ninth month and continuing through the first eight weeks postpartum. Attendance is an important variable, so all meetings will be scheduled at your convenience. After the birth, the babies are welcome at the meetings, in fact, much can be gained from their presence. Each session will last about two hours. The meetings will be tape recorded. Participation would also involve filling out a few questionnaires prior to the sessions and after termination. The tape recordings and questionnaires will be kept strictly confidential. Only the group leader and other members will know your name. Your privacy will be protected. This study is being conducted with the approval of the Institutional Review Board for the Protection of Human Subjects of Loyola University.

The support group will offer you an opportunity to meet and know other women who share a similar experience. It is likely to provide you with a support network during your early stages of motherhood. Unfortunately, I cannot offer to pay the participants, but to show my appreciation, I am offering to babysit while you and your husband have an evening out.

I certainly appreciate your help. If you have any questions please feel free to contact me:
Beth Schiff, 676-4404

APPENDIX B

CONSENT FORM

I hereby give my consent to the use of my written responses to questionnaires for the purpose of the research. I understand that the study is aimed at evaluating the effectiveness of a support group in easing the adjustment to motherhood for first time mothers approximately thirty years and older. I understand that my written responses will be coded to protect my privacy before they are given to research assistants for evaluation.

I am willing to complete a few questionnaires which will be used to evaluate the effectiveness of a support group in easing the adjustment to motherhood.

I am participating in this study of my own free will, without coercion of any sort.

Signature _____ Date _____

Witness _____ Date _____

IDENTIFYING SOCIAL DATA

Name:_____

Address:_____

Telephone:_____

	Wife	Husband
Birthdate	_____	_____
Age at pregnancy	_____	_____
Occupation	_____	_____
Length of time in occupation	_____	_____
Length of marriage	_____	
Have you been married previously	_____	_____

Does husband have children from previous marriage? yes__ no__

Do your parents live in this area _____ _____

Was this pregnancy planned? yes__ no__

Are you taking lamaze or other prenatal classes? yes__ no__

When are you planning to return to work_____

Reason for returning to work_____

Do you feel you have a support network to whom you can turn? yes__ no__
If yes, please describe_____
_____

Do you experience your family of origin as a source of support or stress (please comment)_____
_____

Do you experience your in-laws as a source of support or stress (please comment)_____
_____

CHECK LIST

DACL FORM A

By Bernard Lubin

Name_____ Age_____ Sex_____

Date_____ Highest grade completed in school_____

DIRECTIONS: Below you will find words which describe different kinds of moods and feelings. Check the words which describe How You Feel Now - - Today. Some of the words may sound alike, but we want you to check all the words that describe your feelings. Work rapidly and check all of the words which describe how you feel today.

1. ☐	Wilted	17. ☐	Strong
2. ☐	Safe	18. ☐	Tortured
3. ☐	Miserable	19. ☐	Listless
4. ☐	Gloomy	20. ☐	Sunny
5. ☐	Dull	21. ☐	Destroyed
6. ☐	Gay	22. ☐	Wretched
7. ☐	Low-spirited	23. ☐	Broken
8. ☐	Sad	24. ☐	Light-hearted
9. ☐	Unwanted	25. ☐	Criticized
10. ☐	Fine	26. ☐	Grieved
11. ☐	Broken-hearted	27. ☐	Dreamy
12. ☐	Down-cast	28. ☐	Hopeless
13. ☐	Enthusiastic	29. ☐	Oppressed
14. ☐	Failure	30. ☐	Joyous
15. ☐	Afflicted	31. ☐	Weary
16. ☐	Active	32. ☐	Droopy

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name _____ Date _____ S ___

Age _____ Sex: M ___ F ___ T ___

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	①	②	③	④
2. I feel secure	①	②	③	④
3. I am tense	①	②	③	④
4. I feel strained	①	②	③	④
5. I feel at ease	①	②	③	④
6. I feel upset	①	②	③	④
7. I am presently worrying over possible misfortunes	①	②	③	④
8. I feel satisfied	①	②	③	④
9. I feel frightened	①	②	③	④
10. I feel comfortable	①	②	③	④
11. I feel self-confident	①	②	③	④
12. I feel nervous	①	②	③	④
13. I am jittery	①	②	③	④
14. I feel indecisive	①	②	③	④
15. I am relaxed	①	②	③	④
16. I feel content	①	②	③	④
17. I am worried	①	②	③	④
18. I feel confused	①	②	③	④
19. I feel steady	①	②	③	④
20. I feel pleasant	①	②	③	④

Consulting Psychologists Press
577 College Avenue, Palo Alto, California 94306

SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	①	②	③	④
22. I feel nervous and restless	①	②	③	④
23. I feel satisfied with myself	①	②	③	④
24. I wish I could be as happy as others seem to be	①	②	③	④
25. I feel like a failure	①	②	③	④
26. I feel rested	①	②	③	④
27. I am "calm, cool, and collected"	①	②	③	④
28. I feel that difficulties are piling up so that I cannot overcome them	①	②	③	④
29. I worry too much over something that really doesn't matter	①	②	③	④
30. I am happy	①	②	③	④
31. I have disturbing thoughts	①	②	③	④
32. I lack self-confidence	①	②	③	④
33. I feel secure	①	②	③	④
34. I make decisions easily	①	②	③	④
35. I feel inadequate	①	②	③	④
36. I am content	①	②	③	④
37. Some unimportant thought runs through my mind and bothers me	①	②	③	④
38. I take disappointments so keenly that I can't put them out of my mind	①	②	③	④
39. I am a steady person	①	②	③	④
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	①	②	③	④

PRENATAL SELF-EVALUATION QUESTIONNAIRE II

Directions

The statements below have been made by expectant women to describe themselves. Read each statement and decide which response best describes your feelings. Then circle the appropriate letter next to each statement.

		Very Much So	Moderately So	Somewhat So	Not At All
1.	This is a good time for me to be pregnant	A	B	C	D
2.	I like to watch other parents and children together.	A	B	C	D
3.	I can tolerate the discomforts that I've had during pregnancy.	A	B	C	D
4.	My husband and I talk about the coming baby.	A	B	C	D
5.	My husband has been critical of me during the pregnancy.	A	B	C	D
6.	I feel that rearing children is rewarding.	A	B	C	D
7.	I feel it is necessary to know a lot about labor.	A	B	C	D
8.	I can cope well with pain.	A	B	C	D
9.	It's hard for me to get used to the changes brought about by pregnancy.	A	B	C	D
10.	My husband is understanding (calms me) when I get upset.	A	B	C	D
11.	I can perform well under stress.	A	B	C	D
12.	I think my labor and delivery will progress normally.	A	B	C	D
13.	There is little I can do to prepare for labor.	A	B	C	D
14.	My mother shows interest in the coming baby.	A	B	C	D
15.	I have confidence in my ability to maintain composure in most situations.	A	B	C	D
16.	I am worried that the baby will be abnormal.	A	B	C	D
17.	I think the worst whenever I get a pain.	A	B	C	D
18.	Realizing that labor has to end will help me maintain control in labor.	A	B	C	D
19.	I look forward to caring for the baby.	A	B	C	D
20.	My mother is happy about my pregnancy.	A	B	C	D

		Very Much So	Moderately So	Somewhat So	N A
21.	My mother offers helpful suggestions	A	B	C	
22.	I have enjoyed this pregnancy.	A	B	C	
23.	My husband is interested in discussing the pregnancy with me.	A	B	C	
24.	I have a good idea of what to expect during labor and delivery.	A	B	C	
25.	I understand how to work with the contractions in labor.	A	B	C	
26.	I look forward to childbirth.	A	B	C	
27.	I suspect the doctors and nurses will be indifferent to my concerns in labor.	A	B	C	
28.	It's easy to talk to my mother about my problems.	A	B	C	
29.	I have doubts about being a good mother.	A	B	C	
30.	I dwell on the problems the baby might have.	A	B	C	
31.	My mother looks forward to this grandchild.	A	B	C	D
32.	I am glad I'm pregnant.	A	B	C	D
33.	I like having children around me.	A	B	C	D
34.	It will be hard for me to balance child care with my other commitments and activities.	A	B	C	D
35.	My husband helps me at home when I need it.	A	B	C	D
36.	I find it hard to talk to my husband about any changes in sex drive during this pregnancy.	A	B	C	D
37.	I feel good when I'm with my mother.	A	B	C	D
38.	I am preparing myself to do well in labor.	A	B	C	D
39.	I feel sure that I will lose control in labor.	A	B	C	D
40.	I can count on my husband's support in labor.	A	B	C	D
41.	I am afraid that I will be harmed during delivery.	A	B	C	D
42.	I feel that babies aren't much fun to care for.	A	B	C	D
43.	My husband feels I burden him with my feelings and problems.	A	B	C	D
44.	When we get together my mother and I tend to agrue.	A	B	C	D
45.	It will be difficult for me to give enough attention to a baby.	A	B	C	D
46.	I think the baby will be a burden to me.	A	B	C	D
47.	I feel prepared for what happens in labor.	A	B	C	D
48.	I know some things I can do to help myself in labor.	A	B	C	D

Page three.

		Very Much So	Moder-ately So	Some-what So	Not At All
49.	When the time comes in labor, I'll be able to push even if it's painful.	A	B	C	D
50.	I think about the kind of mother I want to be.	A	B	C	D
51.	I am anxious about complications occurring in labor.	A	B	C	D
52.	I feel that the stress of labor will be too much for me to handle.	A	B	C	D
53.	I think I can bear the discomfort of labor.	A	B	C	D
54.	I am concerned that caring for a baby will leave me little time for myself.	A	B	C	D
55.	My mother reassures me when I have doubts about myself.	A	B	C	D
56.	I feel well informed about labor.	A	B	C	D
57.	I am worried that something will go wrong during labor.	A	B	C	D
58.	It's difficult for me to accept this pregnancy.	A	B	C	D
59.	My mother encourages me to do things in my own way.	A	B	C	D
60.	I think my husband would say we have made a satisfactory sexual adjustment during this pregnancy.	A	B	C	D
61.	This has been an easy pregnancy so far.	A	B	C	D
62.	I wish I wasn't having the baby now.	A	B	C	D
63.	I worry that I will lose the baby in labor.	A	B	C	D
64.	If I lose control in labor it will be hard for me to regain it.	A	B	C	D
65.	My mother criticizes my decisions.	A	B	C	D
66.	I'm having a problem adjusting to this pregnancy.	A	B	C	D
67.	I am worried that my baby may not like me.	A	B	C	D
68.	I focus on all the terrible things that could happen in labor.	A	B	C	D
69.	This pregnancy has been a source of frustration to me.	A	B	C	D
70.	I can count on my husband to share in the care of the baby.	A	B	C	D
71.	I am confident of having a normal childbirth.	A	B	C	D
72.	I feel that childbirth is a natural, exciting event.	A	B	C	D
73.	I feel I already love the baby.	A	B	C	D
74.	I have found this pregnancy gratifying.	A	B	C	D
75.	I believe I can be a good mother.	A	B	C	D
75.	I have regrets about being pregnant at this time.	A	B	C	D

Page four.

	Very Much So	Moder-ately So	Some-what So	Not At All
77. I find many things about pregnancy disagreeable.	A	B	C	D
78. I feel I will enjoy the baby.	A	B	C	D
79. I am happy about this pregnancy.	A	B	C	D

Revised - 1981 - after statistical analyses

POST-PARTUM SELF EVALUATION QUESTIONNAIRE

Directions

The statements below have been made by mothers of young infants. Read each statement and decide which response best describes your feelings. Then circle the appropriate letter next to each statement.

		Very Much So	Moder-ately So	Some-what So	Not At All
1.	I know what my baby likes and dislikes.	A	B	C	D
2.	My husband participates in the care of the baby.	A	B	C	D
3.	It bothers me to get up for the baby at night.	A	B	C	D
4.	My husband is understanding (calms me) when I get upset.	A	B	C	D
5.	This baby is a financial burden for us now.	A	B	C	D
6.	Childbirth gave me a feeling of accomplishment.	A	B	C	D
7.	My husband feels that caring for the baby is not his responsibility.	A	B	C	D
8.	We need more things than we can afford to buy.	A	B	C	D
9.	My recent delivery made me proud of myself.	A	B	C	D
10.	I feel close to my husband.	A	B	C	D
11.	It is boring for me to care for the baby and do the same things over and over.	A	B	C	D
12.	I am uncertain about whether I can make the right decisions for my baby.	A	B	C	D
13.	My husband helps as little as possible with child care.	A	B	C	D
14.	When the baby cries, I can tell what s/he wants.	A	B	C	D
15.	I have friends or relatives who reassure me as a mother.	A	B	C	D
16.	My husband spends time with the baby.	A	B	C	D
17.	My patience with the baby is limited.	A	B	C	D
18.	I am concerned about raising children in the neighborhood we live in.	A	B	C	D

Page two.

		Very Much So	Moderately So	Somewhat So	Not At All
19.	My parents criticize me as a mother.	A	B	C	D
20.	I am unhappy with the amount of time I have for activities other than child care.	A	B	C	D
21.	My husband gets annoyed when I ask him to help with the care of the baby.	A	B	C	D
22.	I enjoy taking care of the baby.	A	B	C	D
23.	I am upset about having too many responsibilities as a mother.	A	B	C	D
24.	It is hard to talk to my husband about problems I have.	A	B	C	D
25.	When bathing and diapering the baby, I would like to be doing something else.	A	B	C	D
26.	I have doubts about whether I am a good mother.	A	B	C	D
27.	I would like to be a better mother than I am.	A	B	C	D
28.	I remember labor as unpleasant and frightening.	A	B	C	D
29.	I can talk to some of my friends or relatives about questions I have concerning motherhood.	A	B	C	D
30.	My budget allows me to get the help I need with housework and other tasks.	A	B	C	D
31.	My husband criticizes me as a wife.	A	B	C	D
32.	My husband wants to share in the care of the baby.	A	B	C	D
33.	I am glad I had this baby now.	A	B	C	D
34.	I get annoyed if the baby frequently interrupts my activities.	A	B	C	D
35.	I am concerned about having a steady income for my family.	A	B	C	D
36.	I feel that I know my baby and what to do for him/her.	A	B	C	D
37.	My husband would rather spend time at work or a hobby than be with me.	A	B	C	D
38.	My husband cares about how I feel.	A	B	C	D
39.	My husband makes me feel I am a burden to him.	A	B	C	D

Page three.

		Very Much So	Moderately So	Somewhat So	Not At All
40.	I have friends or relatives who encourage me to care for the baby in my own way.	A	B	C	D
41.	I am able to hire a babysitter when I need one.	A	B	C	D
42.	I enjoy being a mother.	A	B	C	D
43.	When I am feeling down or depressed, my husband reassures me.	A	B	C	D
44.	Feeding the baby gives me a feeling of satisfaction.	A	B	C	D
45.	My husband and I are having problems with our marriage.	A	B	C	D
46.	My parent(s) are interested in the baby.	A	B	C	D
47.	I feel joyful when I remember the birth of the baby.	A	B	C	D
48.	I feel I reacted badly to the pain of labor.	A	B	C	D
49.	I can share my thoughts and feelings with my husband.	A	B	C	D
50.	I am concerned about being able to meet the baby's needs.	A	B	C	D
51.	There is enough money for all my family's basic needs.	A	B	C	D
52.	I don't know how to care for the baby as well as I should.	A	B	C	D
53.	I play with the baby between feedings when s/he is awake and quiet.	A	B	C	D
54.	My husband shows an interest in the baby.	A	B	C	D
55.	Discussions I have with my husband end in arguments.	A	B	C	D
56.	My husband lets me down when I need him.	A	B	C	D
57.	When the baby cries, my husband ignores it.	A	B	C	D
58.	I have regrets about how I coped in labor.	A	B	C	D
59.	I trust my own judgement in deciding how to care for the baby.	A	B	C	D

Page four.

		Very Much So	Moderately So	Somewhat So	Not At All
60.	Our home is too small for all of us.	A	B	C	D
61.	I know what my baby wants most of the time.	A	B	C	D
62.	I can rely on friends or relatives to help me with the baby when necessary.	A	B	C	D
63.	I am unsure about whether I give enough attention to the baby.	A	B	C	D
64.	I feel burdened with the many demands made on me as a mother.	A	B	C	D
65.	My husband dislikes caring for the baby.	A	B	C	D
66.	My parent(s) make me feel like there is little I can do right.	A	B	C	D
67.	Overall, my labor and delivery was a good experience.	A	B	C	D
68.	I feel disappointed in the delivery experience I had.	A	B	C	D
69.	I have friends or relatives who are interested in the baby.	A	B	C	D
70.	I worry about how we will manage on our present income.	A	B	C	D
71.	My husband enjoys holding the baby.	A	B	C	D
72.	My parent(s) think I should take better care of the baby.	A	B	C	D
73.	Giving birth was gratifying to me.	A	B	C	D
74.	My husband avoids helping with child care.	A	B	C	D
75.	I would prefer to go to work or classes and have someone else care for the baby.	A	B	C	D
76.	I am unsure of what to do for the baby when s/he cries.	A	B	C	D
77.	My parent(s) seem to like the way I care for the baby.	A	B	C	D
78.	I have friends or relatives who think I am a good mother.	A	B	C	D
79.	I feel good about how I handled myself during labor and delivery.	A	B	C	D

Page five.

	Very Much So	Moderately So	Somewhat So	Not At All
80. My parents show little interest in the baby.	A	B	C	D
81. I feel secure about my future financial situation.	A	B	C	D
82. I have confidence in my ability to care for the baby.	A	B	C	D

POSTPARTUM QUESTIONNAIRE

1. Indicate your reaction to support groups.
   very helpful helpful neutral waste of time detrimental
   Comment:

2. Indicate how you have dealt with stress in your life previously.
   Circle all that are applicable.
   sleep eat drink smoke exercise talk with friends fight
   talk with friends talk with family talk with professional cry
   talk with husband
   Other:
   Comment:

3. Since the baby's arrival how have you dealt with stress.
   Circle all that are applicable
   sleep eat exercise drink smoke talk with friends cry
   talk with husband talk with professional talk with other mothers
   talk with family
   Other:
   Comment:

4. Rate your adjustment to motherhood.
   very easy somewhat easy satisfactory difficult very difficult
   Comment:

5. Do you feel a support group would have been helpful to you during your postpartum period? YES NO
   Comment:

6. Do you feel a support group would have been helpful to you during your postpartum period? WHY? WHY NOT?

7. Circle what/who have been your sources of stress since the baby's arrival.
   Circle all that are applicable.
   parents parents-in-law husband baby lack of sleep weight
   finances lack of time household responsibilities breastfeeding
   feeling out of control
   Other:
   Comment:

8. Rate yourself in the following roles, situations, or feelings since the baby's arrival.

1=very positive 2=positive 3=neutral 4=negative 5=very negative

a) Myself as a wife. 1 2 3 4 5
Comment:

b) Myself as a woman. 1 2 3 4 5
Comment:

c) Myself as a mother. 1 2 3 4 5
Comment:

d) My behavior during labor and delivery. 1 2 3 4 5
Comment:

e) My baby. 1 2 3 4 5
Comment:

f) The realities of motherhood. 1 2 3 4 5
Comment:

g) My husband as a father. 1 2 3 4 5
Comment:

h) My career. 1 2 3 4 5
Comment:

i) My husband as a partner. 1 2 3 4 5
Comment:

j) Myself as a homemaker. 1 2 3 4 5
Comment:

Other:

Comment:

9. Describe your up moods and how you express it.

10. Describe your down moods and how you express it.

11. Do you think a support group would have helped you cope with these areas of stress? YES NO

12. Do you think a support group would have helped you cope with these areas of stress? WHY WHY NOT

POSTPARTUM QUESTIONNAIRE

1. Indicate your reaction to support groups.
very helpful helpful neutral waste of time detrimental
Comment:

2. Indicate how you have dealt with stress in your life previously.
Circle all that are applicable.
sleep eat drink smoke exercise talk with friends fight
talk with friends talk with family talk with professional cry
talk with husband
Other:
Comment:

3. Since the baby's arrival how have you dealt with stress.
Circle all that are applicable
sleep eat exercise drink smoke talk with friends cry
talk with husband talk with professional talk with other mothers
talk with family
Other:
Comment:

4. Rate your adjustment to motherhood.
very easy somewhat easy satisfactory difficult very difficult
Comment:

5. Do you feel a support group would have been helpful to you during your postpartum period? YES NO
Comment:

6. Do you feel a support group would have been helpful to you during your postpartum period? WHY? WHY NOT?

7. Circle what/who have been your sources of stress since the baby's arrival.
Circle all that are applicable.
parents parents-in-law husband baby lack of sleep weight
finances lack of time household responsibilities breastfeeding
feeling out of control
Other:
Comment:

8. Rate yourself in the following roles, situations, or feelings since the baby's arrival.

1=very positive 2=positive 3=neutral 4=negative 5=very negative

a) Myself as a wife. 1 2 3 4 5
Comment:

b) Myself as a woman. 1 2 3 4 5
Comment:

c) Myself as a mother. 1 2 3 4 5
Comment:

d) My behavior during labor and delivery. 1 2 3 4 5
Comment:

e) My baby. 1 2 3 4 5
Comment:

f) The realities of motherhood. 1 2 3 4 5
Comment:

g) My husband as a father. 1 2 3 4 5
Comment:

h) My career. 1 2 3 4 5
Comment:

i) My husband as a partner. 1 2 3 4 5
Comment:

j) Myself as a homemaker. 1 2 3 4 5
Comment:

Other:

Comment:

9. Describe your up moods and how you express it.

10. Describe your down moods and how you express it.

11. What impact did the support group have in your coping with these areas of stress? Also, please use back to write any additional feelinc

APPENDIX C

Summary of Demographic Information on Spouses

	Frequency	Percent
Age		
27-30	10	25.0
31-34	19	47.5
35-39	9	22.5
40 and older	2	5.0
Occupation		
Clerical and sales workers	1	2.5
Technicians, semi-professionals	3	7.5
Managers, minor professionals	14	35.0
Administrators, lesser professionals	5	12.5
Higher executives, major professionals	17	42.5
Length in occupation		
1-4 years	11	27.5
5-9 years	17	42.5
10-14 years	8	20.0
15-20 years	4	10.0

	Frequency	Percent
Previous marriage		
No	33	82.5
Yes	7	17.5
Children from previous marriage		
No	36	90.0
Yes	4	10.0
Parents here		
No	19	47.5
Yes	21	52.5

APPROVAL SHEET

The dissertation submitted by Beth Schiff has been read and approved by the following committee:

Dr. Marilyn Susman, Director
Assistant Professor, Counseling & Educational Psychology, Loyola

Dr. Gloria Lewis
Associate Professsor, Counseling & Educational Psychology, Loyola

Dr. Carol Harding
Associate Professor, Counseling & Educational Psychology, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

10-3-87
Date

Director's Signature