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Pregnant Women's Expectations of Newborns

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PREGNANT WOMEN'S EXPECTATIONS OF NEWBORNS

by

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VITA

The author, Margery Salter, is the daughter of Gershon Salter and Edythe (Falk) Salter. She was born June 17, 1952, in Boston, Massachusetts. She was married to Henry Biller, Ph.D. on October 7, 1979, and continues the use of own name professionally.

Her elementary and secondary education was obtained in the public schools of Swampscott, Massachusetts. She was graduated from Swampscott High School in 1970.

In September 1970, she entered Sarah Lawrence College in Bronxville, New York, and in May 1974 received the degree of Bachelor of Arts. While attending Sarah Lawrence College, she worked as a teacher-assistant in the Early Childhood Center from January 1971 through May 1973. While a college senior, Margery worked as a teacher-therapist in the Therapeutic Nursery at the Albert Einstein College of Medicine in Bronx, New York.

In September 1975, she was admitted to the Doctoral program in Clinical Psychology at Loyola University in Chicago. She was granted a United States Public Health Assistantship in September 1973-May 1976, and September-December 1978. She was awarded a United States Public Health scholarship in September 1965-May 1977. During her Clinical Psychology Internship at the Emma Pendleton Bradley Hospital in Riverside,

Rhode Island, she was funded through a National Institute of Mental Health Training Grant.

She worked as a research assistant at the Child Study Center, Brown University from June 1979-December 1980. She is currently a Staff Psychologist at the Northern Rhode Island Community Health Center in Woonsocket, Rhode Island.

She co-authored the chapter "The Unwed Adolescent Father" with Henry Biller, Ph.D., which will appear in Children Bearing Children: Adolescent Pregnancy and Parenthood, Duxbury, Press, Scituate, Massachusetts.

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CHAPTER I

REVIEW OF RELATED LITERATURE

Pregnancy is a major developmental milestone in the lives of most women. It is a rite of passage when a woman must confront a variety of changes in her lifestyle, her body and in the ways that other people react to her. Early psychodynamic research (Bibring, 1959); Brazelton, 1963; Caplan, 1960) described pregnancy as a time of psychological disequilibrium which prepares the woman for identity reorganization and readjustment to her new maternal role. Subsequent research which focused on pregnancy as a maturational crisis defined various developmental tasks to be mastered (Colman, 1968; Leifer, 1977; Rubin, 1967).

Other investigations have linked anxiety or tension during pregnancy to labor times (Davids and DeVault, 1962; Davids, DeVault and Talmadge, 1961a, b; Grimm, 1961; Grimm and Venet, 1967), obstetrical complications (Erickson, 1965; Heinstein, 1967; McDonald, 1968; McDonald, Gynther and Christakos, 1963; Zucerman et al, 1963) and neonatal behavior (Ottinger and Simmons, 1964; Yang, Zweig, Douthitt and Federman, 1976). More recently, researchers have also evaluated how anxiety and stress across trimesters was related to adaptations to previous life changes (Gorsuch and Key, 1974; Jones, 1978; Lebo and Nesselrode, 1978; Lubin, Gardener and Roth, 1975;

Williams, Williams, Griswold and Holmes, 1978; Yamamoto and Kinney, 1976).

There has been a paucity of research, however, concerning ways in which maternal expectations of infants might relate to various aspects of maternal-child attachment and development. Broussard and Hartner (1970) studied the relationship of the mother's perception of her neonate as measured by their Neonatal Perception Inventories to the child's subsequent development. They divided the infants into Low-Risk and High-Risk groups based on the maternal perceptions. The mothers' ratings were predictive of a need for therapeutic intervention for the child at 4-1/2 years. Infants classified as High-Risk on the basis of maternal ratings were more likely to have need of therapeutic intervention at age 4-1/2 than were those who were categorized as Low-Risk neonates. Using a modified version of the Broussard and Hartner Inventories, Nagy and Arney (1976) reported results suggesting that maternal perceptions of premature babies were related to subsequent development and maternal attachment.

The present study is the first step in a longitudinal research project to examine pregnant women's perceptions concerning the type of baby they think they will have, and factors which might influence such expectations. The discrepancy between a woman's expectations of an average baby and her own baby appear to be a particularly meaningful

criterion. A mother was asked to rate an average baby on nine variables, and then to rate her own expected baby on the same variables. For example, if a woman thinks all babies cry a lot, are weak and passive, she would not be deviant if she expected her baby to have these traits. A discrepancy between the mothers' ratings of their own babies and an average baby were predicted to be related to maternal self-perceptions, medical risk, feelings of anxiety, control and hostility, and source of prenatal care (clinic vs. private obstetrician).

CHAPTER II

METHODS

SUBJECTS

The subjects were 48 women in the last trimester of pregnancy who volunteered to participate in the study. Thirty women were recruited from the High-Risk Pregnancy Clinic at Women and Infants Hospital of Rhode Island; the remaining 18 subjects were participants in the Childbirth Education classes at the same hospital.

Among the Clinic mothers, twelve were married; four became married during pregnancy; eleven were never married and lived alone at the time of the interview; two were not married but lived with the father of the child; and one woman was separated from her husband and living with the father of her child. Three women were Black; all the rest were White. The mean age was 23.7 years; the age range was from 17 to 38 years. The modal pattern of the Clinic mothers' education was tenth or eleventh grade: typical occupations were nurses' aides and unskilled factory workers. Among the Clinic women, seventeen were having their first child; nine had had one child already and four had two previous children. The medical conditions which defined a high-risk pregnancy included diabetes, previous stillborns, premature labor, drug addiction,

hypertension and maternal-age-over-35.

All the women in the Childbirth Education classes were married, White and went to private obstetricians for their prenatal care. The mean age was 27.8 years; the age range was from 22 to 34 years. In this group, all women but two had at least a high school education: about one-half had some college experience; five had some graduate training and one was a practicing lawyer. Among the volunteers from the Childbirth Education classes, six had one child previously; twelve were first-time mothers.

GENERAL PROCEDURES

The research proposal for this study was approved by the Committee for Ethics and Research with Human Subjects at Loyola University, and the Research and Human Subjects Committee at Women and Infants Hospital.

The examiner reviewed each High-Risk patient's chart to determine the mother's expected delivery date, the medical reason for placement in the High Risk Clinic and whether the woman had a telephone. The examiner then approached individually each woman who attended the High-Risk Clinic from April through September 1980. They were told that a research project was being conducted in the Clinic to examine pregnant women's attitudes and expectations of child raising and family life, and to compare them to attitudes that the women have after their babies are born. The women were shown the consent form (see Appendix A) and told that participation in the study involved filling out some questionnaires while they waited for their appointment that day, and a telephone interview. The women were then given an opportunity to ask questions about the study. If the subject was willing to participate, she signed the consent form and was given the Neonatal Perception Inventories, the Maternal Self-Perception Scale, the Pregnancy Anxiety Scale and the PARI (Parental Attitude Research Instrument). These were collected by the examiner before the patient left the

Clinic. If any of the scales were not completed, the examiner presented the scales during the telephone interview which also included questions about maternal age, marital status, stress and medical history.

The examiner visited five Childbirth Education classes at Women and Infants Hospital during October 1980. The study was described to each group of prospective mothers and fathers in the same manner as it had been presented to the Clinic mothers. Volunteers were asked to read and sign the consent form, and fill out the Maternal Self-Perception Scale and the Neonatal Perception Inventories. The PARI, Pregnancy Anxiety Scale and questions concerning maternal age, marital status, stress and medical histories were answered in a telephone interview conducted within the following week.

MATERIALS

Neonatal Perception Inventories (see Appendix B) were developed by Broussard and Hartner (1970) to measure the mother's perception of her neonate as compared to the average baby. These Inventories were modified to a seven-point Likert Scale by Nagy and Arney (1976) to measure the mother's perception of her infant in the following areas: crying, sleeping, size, alertness, activity level, deviance, happiness and maternal concern. In this study, the scales were administered during pregnancy to assess the mother's expectations of her baby's characteristics as compared to those of average babies. Lower scores indicate more positive expectations.

A difference score was determined by subtracting the total score for Your Baby Perception Inventory items from the total score of My Baby Perception Inventory items. For instance, if a woman rated her baby as being better than average, her difference score was a positive number. If she rated her baby as likely to be less adequate than the average baby, the difference score was a negative number. For example, it was predicted that Higher-Risk mothers would rate their babies as being less adequate than average. Similarly,

Lower-Risk mothers would probably rate their babies as average or better.

Using a similar format, a Maternal Self-Perception Scale (see Appendix C) was designed for this study to assess the mother's view of herself on traits parallel to those on which she rated her expected infant. These traits included items relating to size, emotional and physical strength, activity level, sociability, maturity and happiness. Lower scores represent more positive self-ratings.

Some evidence for the validity of these scales was presented in the findings of Broussard and Hartner (1970); maternal ratings of neonates at one month of age were significantly associated with the child's need for therapeutic intervention as assessed by a psychiatrist when the children were 4-1/2 years old.

The Pregnancy Anxiety Scale (see Appendix D) was conceptually based on Leifer's (1977) Attachment to Baby Scale, but the final version was considerably different from hers. The Pregnancy Anxiety Scale consisted of eight statements expressing anxiety about mother's own health, diet and figure, pain or harm during labor or delivery; lower scores indicated less anxiety. The women were asked to respond to each statement in terms of the frequency with which they experienced the feeling.

A Risk Factor (see Appendix E) was derived from the

Manual for Obstetrical Complications (Parmlee and Littman, 1974) which uses medical and pregnancy complications to compute a score defining an infant as being medically-at-risk. In addition to medical factors (previous stillbirths, maternal chronic diseases, unwanted sterility, high blood pressure) the following items were considered in determining the Risk Factor used in this study; smoking more than one package of cigarettes a week, alcohol or aspirin more than two times a week, stress (i.e., death of friend or relative, moving, divorce, car accident).

The Parental Attitude Research Instrument (Schaeffer and Bell, 1958) consists of 23 subscales of five items each. The items are opinion-statements describing various aspects of childraising and family life; subjects indicate how much they agree with the statements on four-point scale. Six subscales of the PARI (see Appendix F) were used in this study to assess the women's feelings of Control and Hostility. The Hostility Factor was derived by summing the following subscales: Marital Conflict, Rejection of Homemaking, Irritability. The Control Factor consisted of the sum of the scores for these subscales: Ascendancy, Intrusiveness, Deification.

In addition to the variables listed above, the effects of maternal age, parity and source of prenatal care (Clinic vs. private obstetrician) were assessed.

CHAPTER III

RESULTS

A Multiple Regression Analysis was done (Winer, 1971). This technique was used to determine whether the difference score of Average Baby minus My Baby was related to the following variables: Risk Factor, Parity, Control and Hostility as measured by the PARI, Pregnancy Anxiety, Maternal Self-Perception, Maternal Age and Source of Prenatal Care. In terms of the Multiple Regression Analysis, Risk was the only clearcut individual predictor of mothers' expectations of how their babies would differ from the average baby (Multiple R=.45; R-Square=.20; F=11.50; df=1/46; $p<.005$). The higher the mother's Risk score, the more likely she was to expect her newborn to be less adequate than the average baby.

Table 1

Multiple Regression Analysis:

Step 1 Findings for Risk

Main Analysis/Risk		Variables Not in Equation	Partial Variance
Multiple R =	.45	Self-Perception	.01
R-Square =	.20	Pregnancy Anxiety	.12
Adjusted R-Square =	.18	Mother's Age	.10
Standard Error =	4.97	Parity	-.23
df Regression =	1	Hostility	.18
df Residual =	46	Control	.21
F = 11.50,	$p<.001$	Clinic vs. Private	.17

Even though Parity alone was not a significant predictor when combined with Risk, it did account for slightly more of the variance than did Risk alone (Multiple R=.49; R-Square=.24; F=13.88; df=2/45; $p<.001$). This is particularly interesting since Parity is one of the components of the Risk Factor, but it apparently accounts for some of the variability that Risk alone does not explain.

There were also extremely high correlations of mother's age with Hostility on the PARI (r=.98; df=46; $p<.001$) and Control on the PARI (r=.06; df=46; $p<.001$). This unusually high association indicates that PARI scores are almost completely predictable as a function of mother's age. There was a direct increase of Hostility and Control as measured by the PARI with greater maternal age. As would be expected, the PARI scores for Hostility and Control were also extremely highly correlated (r=.98; df=46; $p<.001$). Similarly, Source of Prenatal Care (Clinic vs. private obstetrician) was correlated with mother's age (r=.96; df=.46; $p<.001$). The high intercorrelations between Your Baby and Average Baby Perception Inventories (r=.55; df=46; $p<.001$) and Your Baby Perception Inventory and Maternal Self-Perception Scale (r=.54; df=46; $p<.001$) would also be expected. Interestingly there was also a relationship (r=.56; df=46; $p<.001$) between Risk Factor and Maternal Self-Perception. Mothers with high Risk scores saw themselves as being less adequate than mothers with low risk scores.

CHAPTER IV

DISCUSSION

The results of the Multiple Regression Analysis indicate that the most variance in the difference score between Your Baby and Average Baby Perception Inventories was accounted for by the Risk Factor. In other words, mothers who seem to be particularly concerned that their babies will be less healthy than average babies did, in fact, have more concrete reasons to expect that that would be true. The mothers seem to have a realistic understanding of what to expect. Mothers who were low on the Risk Factor were likely to have congruent perceptions of their baby being about as healthy as the average baby.

If mothers viewed themselves as competent, they were also likely to expect their babies to be normal and competent. The results of this study are consistent with the notion that the way that the mother sees herself and feels about her physical adequacy are reflected in her expectations of the viability of her offspring.

One has to remember that 63% of the mothers were clearly defined as High-Risk patients. In general most of the subjects in this study seemed to be very influenced by the reality of their medical condition. It is possible that in a sample of expectant mothers who were not medically-at-risk

that other personality and situational factors might play a greater role in the development of expectations about their babies.

The present study was designed to be exploratory in nature and to suggest directions for more methodologically refined data collection. There are many ways that this study could be modified or improved; for example, in the area of subject selection. The study was presented to Clinic mothers individually, but to entire classes of the Childbirth Education women. Also, Clinic mothers were usually alone when deciding to participate in the study, whereas Childbirth Education women all had their husbands present. There may have been a hidden selection factor in that the more concerned women from the Childbirth Education Classes volunteered to participate, whereas the Clinic mothers with highest Risk refused as they already had enough stress in their pregnancies. This could have possibly muted or mitigated the effects of other personality-maternal expectation variables.

It should also be noted that Childbirth Education women tended to get Risk Factor points for maternal-age-over-thirty, parity or smoking; Clinic mothers tended to get additional Risk Factor points for diabetes, previous stillborns, or drug addiction. Obviously, the latter medical problems present a greater risk than parity or maternal age.

A more complete analysis would have been possible with

a comparison group of Low Risk Clinic Mothers and High Risk private patients. A more representative social class sampling may have allowed additional meaningful results to emerge. Similarly, there could have been more careful sampling of subjects for such variables as parity, maternal age and marital status.

The assessment procedure used in the study could have been expanded to include more standardized personality and anxiety measures, for example the Manifest Anxiety Scale (Taylor, 1953), the IPAT Anxiety Scale Questionnaire (Cattel and Scheier, 1963) or the Schedule of Recent Experience (Holmes and Rahe, 1967). Rather than only interviewing the women once during pregnancy, it would have been more methodologically sound to measure certain traits at several times during their pregnancies.

SUMMARY

The purpose of this study was to examine how discrepancies between pregnant women's ratings of their expected babies and an average baby were related to such factors as maternal self-perceptions, parity, medical risk, and self-reported feelings of anxiety, hostility and control. The subjects were 48 women in the last trimester of pregnancy: 30 were recruited from a hospital High Risk Clinic and 18 were participants in Childbirth Education classes at the same hospital. A Multiple Regression Analysis revealed that risk for medical and pregnancy complications was the only clear-cut predictor of the mothers' expectations of how their babies would differ from the average baby. The higher the mother's risk score, the more likely she was to expect her newborn to be less adequate than the average baby. Similarly, the higher the mother's risk score, the more likely she was to perceive herself as inadequate. The data was discussed in terms of the reality factors that influenced maternal perceptions, and several methodological suggestions were made to improve future research in this area.

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APPENDIX A

APPENDIX A: CONSENT FORM

WOMEN AND INFANTS HOSPITAL OF RHODE ISLAND

I, _____ of _____, consent to participation in the Project, "Psychological Variables in Maternal Attachment." I understand that the study involves:

A. Purpose, Nature and Duration of Study: This research project is designed to investigate the feelings, attitudes and expectations of pregnant women, and to document how they develop and change as their babies grow. If you agree to participate in the study, you will be interviewed at a regular clinic appointment during your pregnancy, within two weeks after your baby is born, and again when your baby is two-three months old.

B. The Means By Which It Is To Be Conducted: The procedure requires about an hour of interview questions administered by a psychologist and 30 minutes of self-administered questionnaires at each session. These questions were designed to assess certain attitudes toward pregnancy, motherhood and one's self-concept. Your identity will remain confidential; answer forms will be coded so that only the interviewer will know your name in association with your answers.

C. Possible Benefit or Lack of Benefit to Myself and/or My Child: The main focus of this research is to understand relationships between maternal attitudes during pregnancy and child-rearing. Hopefully, knowledge of how women like yourself feel about pregnancy, their babies and their new maternal roles will assist physicians and other health professionals in understanding and sensitively helping other pregnant women. It is possible that some of the interview questions will help you to reflect on some ideas that you had not considered before, or to think of them in a new way. While the study may not be of personal benefit to every individual who participates, eventually we should obtain results that will prove helpful to others.

D. Risks and Hazards of this Study: No apparent risks.

E. Possible Alternative Procedures: None, as this is exploratory and non-therapeutic.

If you have any questions about this study, please call Margery Salter at (401) 884-0772,

I certify that:

(a) I understand the written/oral explantation of this study, and that an offer was made to answer my questions.
(b) I understand that in no instances will any names be used, but that statistical information from the study may be used for professional education or research purposes. If I desire, my specific conditions and findings may be discussed at a personal conference with my physician and family.
(c) I will be told of any changes in the risks or benefits of this project.
(d) I understand that I am free to withdraw consent and to stop taking part in this study at any time, and that I will continue to receive the best possible care for myself and/or my child.
(e) I acknowledge that I have been given a copy of this consent form.

Patient _____ Date _____

Witness _____ Date _____

APPENDIX B

APPENDIX B

NEONATAL PERCEPTION INVENTORIES

On the left side of the page, please circle the point between the two words on each line which best describes the way that you expect your newborn baby to be. On the right side of the page, please circle the point which best describes your impression of the average newborn infant.

YOUR NEWBORN INFANT		AVERAGE NEWBORN INFANT	
calm	excitable	calm	excitable
sleeps poorly	sleeps well	sleeps poorly	sleeps well
weak	strong	weak	strong
does not cry-quiet	cries a lot	does not cry-quiet	cries a lot
passive	alert and active	passive	alert and active
different	normal	different	normal
small for age	big for age	small for age	big for age
happy	unhappy	happy	unhappy
causes me a lot of worry	causes me no worry	causes me a lot of worry	causes me no worry

1 2 3 4 5 6 7

APPENDIX C

APPENDIX C:

MATERNAL SELF-PERCEPTION SCALE

Circle the point between the two words on each line which you think best describes you compared to other women your age (use the mid-point 4 as the average for women your age).

Calm	1	2	3	4	5	6	7	Excitable
Sleep Poorly	1	2	3	4	5	6	7	Sleep Well
Emotionally Strong	1	2	3	4	5	6	7	Emotionally Weak
Physically Strong	1	2	3	4	5	6	7	Physically Weak
Quiet	1	2	3	4	5	6	7	Talkative
Passive	1	2	3	4	5	6	7	Active
Different	1	2	3	4	5	6	7	Normal
Small	1	2	3	4	5	6	7	Big
Happy	1	2	3	4	5	6	7	Unhappy
Withdrawn	1	2	3	4	5	6	7	Outgoing
Immature	1	2	3	4	5	6	7	Mature

APPENDIX D

APPENDIX D:

PREGNANCY ANXIETY SCALE

Please put a check in the column (Always, Often, Sometimes, Rarely, Never) which best describes your agreement with the following statements.

	Always	Often	Sometimes	Rarely	Never
I am worried about my own health					
I am worried about my developing baby					
I am looking forward to having my baby					
I am anxious about pain during labor					
I am anxious about pain during delivery					
I worry about getting my figure back after the baby is born					
I am worried that my baby will be harmed during delivery					
I am very careful about what I eat					
I feel that childbirth will fulfill my womanly role					

APPENDIX E

APPENDIX E: RISK FACTOR

For every item that was scored in a positive direction, the subject received one point which contributed to the total score on the Risk Factor.

(a) Marital status: 1 point for unmarried; 0.5 for married during pregnancy; 0.5 for unmarried but living with father of baby.

(b) Maternal age: less than 18 years or greater than 30 years.

(c) More than two previous abortions.

(d) A previous premature baby.

(e) A previous stillborn.

(f) A period of prolonged (greater than 1 year) unwanted sterility.

(g) Length of time since last pregnancy less than 12 months.

(h) Parity less than one child or greater than seven children.

(i) RH Blood Group Incompatibility.

(j) Maternal infections or acute medical problems.

(k) Maternal chronic disease(s). (One point assigned for each disease.)

(l) Blood pressure higher than 140/90.

(m) Prescription medication given to mother during pregnancy.

(n) Chronic drug abuse.

(o) Smoking more than one package of cigarettes per week.

(p) Alcohol more than two times per week.

(q) Aspirin more than two times per week.

(r) Twins or multiple births.

(s) Stress (i.e., death of friend or relative; divorce; moving; car accident).

APPENDIX F

APPENDIX F: PARI

Name _____ Date _____

Below are a group of questions about your opinions and ideas about family life and child-rearing. Read each of the statements below and then rate them as follows:

A	a	d	D
Strongly agree	Mildly agree	Mildly disagree	Strongly disagree

Indicate your opinion by drawing a circle around the "A" if you strongly agree,around the "a" if you mildly agree, around the "d" if you mildly disagree, and around the "D" if you strongly disagree.

There are no right or wrong answers, so answer according to your own opinion.

1.	A young mother feels "held down" because there are lots of things she wants to do while she is young.	A	a	d	D
2.	Raising children is a nerve-wracking job.	A	a	d	D
3.	A married woman knows that she will have to take the lead in family matters.	A	a	d	D
4.	A good mother wants to have a share in all her child's experiences.	A	a	d	D
5.	Parents deserve the highest esteem and regard of their children.	A	a	d	D
6.	People who think they can get along in marriage without arguments just don't know the facts.	A	a	d	D
7.	Most young mothers are bothered more by the feeling of being shut up in the home than by anything else.	A	a	d	D
8.	It's a rare mother who can be sweet and even tempered with her children all day.	A	a	d	D
9.	The whole family does fine if the mother puts her shoulder to the wheel and takes charge of things.	A	a	d	D
10.	A child should never keep a secret from his parents.	A	a	d	D

11. Loyalty to parents comes before everything else. A a d D

12. No matter how well a married couple love one another, there are always differences which cause irritation and lead to arguments. A a d D

13. One of the bad things about raising children is that you aren't free enough of the time to do just as you like. A a d D

14. Children will get on any woman's nerves if she has to be with them all day. A a d D

15. Children and husbands do better when the mother is strong enough to settle most of the problems. A a d D

16. It is a mother's duty to make sure she knows her child's innermost thoughts. A a d D

17. A child soon learns that there is no greater wisdom than that of his parents. A a d D

18. Sometimes it's necessary for a wife to tell off her husband in order to get her rights. A a d D

19. One of the worst things about taking care of a home is a woman who feels she can't get out. A a d D

20. Mothers very often feel they can't stand their children a moment longer. A a d D

21. If a mother doesn't go ahead and make rules for the home, the children and husband will get into trouble they don't need to. A a d D

22. An alert parent should try to learn all her child's thoughts. A a d D

23. The child should be taught to revere his parents above all other grown-ups. A a d D

24. It's natural to have quarrels when two people who both have minds of their own get married. A a d D

25. Having to be with the children all the time gives a woman the feeling her wings have been clipped. A a d D

26. It's natural for a mother to "blow her top" when children are selfish and demanding.	A	a	d	D
27. A mother has to do the planning because she is the one who knows what's going on in the home.	A	a	d	D
28. A mother should make it her business to know everything her children are thinking.	A	a	d	D
29. More parents should teach their children to have unquestioning loyalty to them.	A	a	d	D
30. There are some things which just can't be settled by a mild discussion.	A	a	d	D

APPROVAL SHEET

The thesis submitted by Margery Salter has been read and approved by the following Committee:

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

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

Feb 18, 1981
Date

Deborah L. Holmes, PhD
Director's Signature