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To the Graduate Council:

I am submitting herewith a thesis written by Andrea Darlene Marable entitled "The Effects of Depressive Symptomology on Women's Childbearing Considerations." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Child and Family Studies.

Julia A. Malia, Major Professor

We have read this thesis and recommend its acceptance:

Priscilla Blanton, Mary Jane Moran

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Anne Mayhew

Vice Chancellor and
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THE EFFECTS OF DEPRESSIVE SYMPTOMOLOGY ON WOMEN'S CHILDBEARING CONSIDERATIONS

A Thesis
Presented for the
Master of Science
Degree
The University of Tennessee, Knoxville

Andrea Darlene Marable
May 2005

DEDICATION

This thesis project is dedicated to my late grandmother, Della Marable, who believed in the power of education and always supported and encouraged me in my educational pursuits.

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First, I must thank the chair of my thesis committee, Dr. Julia Malia, for her academic expertise and guidance. I must thank her also for her words of encouragement, emotional support, and endless hours of editing. I could not have completed this project without her! Next, I must thank my other committee members, Dr. Priscilla Blanton and Dr. Mary Jane Moran, for their advice, guidance, and wisdom throughout this entire process. Additionally, I must thank my statistical consultant, Cary Springer, for her statistical guidance and supportive attitude. Finally, I must thank my family and friends. My parents, Eddie and Tina Marable, have been instrumental in my success by providing words of wisdom and unending support. My sister, Beth Blevins, has been a wonderful source of encouragement and a great listener when I needed to vent my frustration! The friends I have made during my journey as a graduate student have been instrumental also in my success. Thanks to you all for proofreading papers, giving me advice and ideas about possible projects, and just being there when I needed a friend!

ABSTRACT

Empirical literature dedicated to pursuing knowledge of the relationship between women who suffer from depression and their considerations of childbearing is lacking. Therefore, the primary purpose of this study was to determine the types of relationships that exist between depressive symptomology in women and their childbearing considerations.

Secondary data analysis was the chosen form of research analysis, and the National Survey of Families and Households (Wave 1) was the data set employed. There were a total of four independent variables (depressive symptomology, global life satisfaction, global optimism, and self-esteem) and two dependent variables (10 constraint items and 4 motivational factor items) used to determine the relationships, with hierarchical regression analysis being the chosen analysis procedure.

Results from the analysis revealed that there was a positive relationship between a woman's level of depressive symptomology and several of the constraint and motivational factor items, namely, economic well-being, relationship issues, and the stress associated with caring for a child. Additionally, the self-esteem items were found to be negatively correlated with some items, but positively correlated with others. The items were most often negatively correlated with motivational factors (i.e., *having someone to love*, *needing something to do*, *giving my parents grandchildren*, and *having someone to care for me when I am old*), and most often positively correlated with constraints regarding issues of time (e.g., worry that I will have time for my career). Finally, both the global optimism and global life satisfaction variables were dropped from the analysis because they proved to be poor measures.

The findings of the study provide evidence that women who suffer from depression do appear to consider certain constraints and motivational factors when making decisions about their future status as mothers. The study concluded with recommendations for theory, future research, and family life education practice, as well as a description of limitations of the project.

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Chapter 1: Introduction

To say that the mental health of an individual is an important aspect of healthy functioning is no surprise. Just as a broken bone weakens the body, so too does a mental illness. However, a mental illness has the potential to weaken the body in very different ways than a broken bone: A mental illness can harm not only the physical person, but the emotional and spiritual person as well. According to the United States Department of Health and Human Services (1999), mental illnesses are characterized by "abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities" (p. 39). It was the "planning of future activities" (in this study, a woman's childbearing considerations) in accordance with a specific mental illness (depression) that was the object of my work in this thesis project.

The definition of depression is not clearly set in stone and depends on the source one consults. According to the fourth edition (text revision) of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), depression is a type of mood disorder and is classified under the major heading *depressive disorders*. This category is further broken down into *major depressive disorder*, *dysthymic disorder*, *depressive disorder not otherwise specified*, *bipolar disorders*, and *cyclothymic disorder* (p. 398). Each of these categories represents a type of depressive disorder with varying definitions of symptoms and treatment possibilities, but many have aspects of mania as well as depression and are, therefore, not pertinent to this study. Rapmund and Moore (2000) defined depression as "an emotional attitude, sometimes definitely pathological, involving feelings of inadequacy and hopelessness, sometimes overwhelming, accompanied by a general lowering of psychophysical

activity" (para. 2). However, many authors rely upon the symptoms of depression to define it, and the symptoms are described with a great deal of consistency.

The symptoms of depression include a depressed mood, loss of interest in once-pleasurable activities, and a sense of discouragement and apathy (American Psychiatric Association, 2000). Further, those suffering from depression often experience feelings of sadness and hopelessness, and these feelings can become overwhelming (Rapmund & Moore, 2000). Some individuals may experience irritability, an increase or decrease in appetite, or irregular sleep patterns, while others experience poor motivation, poor self-esteem, or suicidal ideation (United States Department of Health and Human Services, 1999). Finally, many individuals experience anger in their struggle with depression, and this is especially true of women (Lerner, 1997).

In her book *The Dance of Anger*, Harriett Lerner (1997) discussed some of the ineffective ways women manage their anger. She mentioned that many women suppress their anger in order to convince others that they are a "nice lady" (p. 5), someone who sacrifices herself so as to avoid stepping on others' toes. She also explained that many women avoid confrontation with others and remain silent so as to appear more ladylike. Similarly, Cox, Stabb, and Bruckner (1999) noted in their work on women's anger that women often try to contain their anger, and this has the potential to have depressive effects. They stated, "We speculate that an anxious or agitated depression as well as more generalized fearfulness often stems from efforts to keep oneself contained" (p. 114). Further, in conducting The Women's Anger Study, Thomas and Jefferson (1996) found that women who were depressed had greater levels of anger than those women who were not depressed and that the more anger a woman experienced, the more depressed she

became. Finally, Thomas (1993) noted in her work on women and anger that many researchers refer to depression as "anger turned inward" (p. 216) and that women suffering from depression exhibit higher levels of anger than those who do not suffer from this illness. Although women may experience more anger than men, are they genuinely more depressed than men? This is a question worth exploring.

Many authors have stated that women struggle with depression more often than men (e.g., American Psychiatric Association, 2000; Hammen, 2003; Rapmund & Moore, 2000; Young, Campbell, & Harper, 2002). However, it should be noted that, though it may appear as though women struggle with depression more often than men, it is likely also that women report depressive symptoms and seek treatment for depression more often than men. For example, in their study of emotional regulation strategies in men and women, Garnefski, Teerds, Kraaij, Legerstee, and van den Kommer (2004) found that women were more likely to use the emotional regulation strategies of rumination and catastrophizing than men and that these types of strategies led women to acknowledge and discuss their emotions more often than men. Further, Thayer, Rossy, Ruiz-Padial, and Johnsen (2003) found, in their study of gender differences in emotional regulation, that women thought about their emotions more often than men and that they "reported greater attention to their emotions and feelings than men" (p. 359). Finally, in their book *Women's Anger*: *Clinical and Developmental Perspectives*, Cox, Stabb, and Bruckner (1999) noted that a woman's level of anger is positively correlated with her level of depression, that is to say that as one rises, so does the other. They also noted that women are more likely than men to try to contain their anger, thus allowing it to build, and that this may be another reason for the greater likelihood of the incidence of depression in

women. Therefore, it appears likely that there may be certain reasons for the reporting of a greater incidence of depression in women. Regardless of whether women suffer from depression more often than men do, the experience of depression may lead many women to experience difficulties in making certain lifestyle choices.

The decision-making process regarding lifestyle choices often is influenced by the stage of the family life cycle in which a woman finds herself. According to Carter and McGoldrick (1999), the family life cycle is "the natural context within which to frame individual identity and development and to account for the effects of the social system" (p. 1). The authors further defined several stages as integral to the concept of the family life cycle, including the *leaving home stage, joining of families through marriage stage, and families with young children stage.* Each of these stages has, at its core, a primary task for the individual to complete, whether that is leaving home, getting married, or having children. However, not all individuals sail through each stage of the life cycle with relative ease, and there is often a propensity for an individual to experience difficulty with a particular stage. For example, it is known that depression is common in women during their childbearing years. According to Marcus, Flynn, Blow, and Barry (2003), "Almost one woman in four will experience depression at some point in her life, most commonly during the childbearing years" (p. 373). Nicholson and Clayfield (2004) concurred when they stated that "women of childbearing ages, between 18 and 45, represent the largest group of individuals with major depression" (p. 136). In fact, in some cases, difficulties with a particular stage are so overwhelming that an individual seeks the therapeutic advice of a professional (Nichols & Schwartz, 2004). It seems only logical to expect that once these difficulties are combined with the occurrence of

depression, certain choices, such as whether or not to have a child, may become very difficult.

Purpose

The primary purpose of this study was to determine whether relationships exist between depressive symptomology in women and their childbearing considerations. Once these relationships were determined, I sought to understand the possible reasons for such relationships and re-examined the relevant empirical literature. Further, I searched the literature for information on varying family life education programs and other preventive measures that could potentially aid women who suffer from depression in their search for reassurance concerning their particular childbearing choices. Finally, I sought to determine ways in which women who suffer from depressive symptomology might be empowered through family life education programs that promote parenting education. It was my hope that I might shed some light on a topic whose time has come by calling to the attention of others a mental health issue that is both pervasive and invasive in the lives of women.

Objectives

There were three primary objectives in this study. They included (a) determining the type of relationships, either positive or negative, that exist between depressive symptomology in women and their childbearing considerations, (b) considering the possible reasons for these relationships, and (c) examining family life education programs and other preventive measures focused on the childbearing decision that would aid women who suffer from depressive symptomology to discover empowering ways to become nurturing, affirming parents if they decide to have children.

Rationale

Empirical literature dedicated to the study of the effects of depression on women abounds (e.g., Belle, 1982; Schreiber, 2001; Stoppard & McMullen, 2003), as does literature pertaining to women who suffer from postpartum depression (e.g., Clay & Seehusen, 2004; Seyfried & Marcus, 2003; Wenzel, Gorman, O'Hara, & Stuart, 2001). Further, there is ample literature concerning disruptions of secure attachment in children whose mothers suffer from depression (e.g., Coyl, Roggman, & Newland, 2002; Martins & Gaffan, 2000; Teti, Gelfant, Messigner, & Isabella, 1995). However, there is no apparent empirical literature dedicated to pursuing knowledge of the relationship between women who suffer from depression and their considerations of childbearing. Do women suffering from depression see childbearing as a burden or an escape from depressive symptoms? Are they concerned about such notions as having someone to care for them when they are older? Do they wish to remain childless for fear they will not be the ideal mother? These questions all deserve to be answered and an intervention plan enacted to encourage women suffering from depression to consider carefully their childbearing decisions and the ramifications of those decisions. However, it is important also to convey to these women the power they have over their lives and how they can become nurturing, affirming parents to children.

Theoretical Basis for Study

Although there were a number of possible theories that could have been helpful in describing my initial notions about the relationships between depressive symptomology in women and childbearing decisions, I thought there were three that were particularly applicable to my study. The first, and perhaps most applicable in my opinion, was social

exchange theory. The basic tenet of social exchange theory is that individuals seek to maximize their rewards and minimize their costs in all relationships (Nichols & Schwartz, 2004). For example, an individual is more likely to be attracted to another individual whom he or she believes will provide him or her with many rewards (e.g., wealth, power, prestige) and few costs (e.g., emotional hassles, loss of self-esteem, uncomfortable conversations). Further, the individual is influenced by his or her particular appraisal of how successful the relationship is likely to be, and this is often based upon the individual's past experiences in similar situations (Winton, 1995). Additionally, theorists supportive of social exchange theory believe that all relationships will incur some costs. According to Winton, "The cost is at least time and energy, but it can also include money, anger, frustration, depression, physical injury, or negative feelings, such as the sense of being exploited" (p. 129). A final concept of social exchange theory is that of reciprocity, which implies that, when individuals receive rewards from others, they feel an obligation to reciprocate those rewards (Sprecher, 1998). It was my intuitive sense that women suffering from depression are searching for rewards in their relationships, perhaps more so than the average individual, so as to make themselves feel better emotionally. The emotions involved in the illness of depression have the potential to make life experiences less enjoyable, and, therefore, a woman suffering from depression may seek relationships with maximum rewards. According to Lawler and Thye (1999), emotions play an important role in the process of social exchange. For example, the authors mentioned the feelings of joy and affection that are so common to friendships and how these feelings invoke a particular tone in the context of social exchange. The authors further asserted that "the processes of exchange may

cause individuals to feel good, satisfied, relieved, excited, and so forth" and that "the outcome of social exchange may generate pride" (p. 218). It was my intuitive sense that the relationship between a mother and child has the potential to be such a maximally rewarding relationship, and I thought that women suffering from depression might seek out this relationship for those rewards. However, I considered also the costs involved in a mother-child relationship. I believe that women suffering from depression may be more likely to try to avoid costs than would those not suffering from depression and, therefore, might shy away from the mother-child relationship for this reason. It was my hope that the findings of this study would reveal which motivational factors or constraints were more likely to sway women suffering from depression.

The second theory I found particularly applicable to my notions about the relationships between women suffering from depression and their childbearing considerations was the perspective of social constructivism. The forefather of this perspective is Vygotsky, who saw child development occurring on both a social and cultural plane. According to Berk and Winsler (1995), Vygotsky's basic premise was that "all uniquely human, higher forms of mental activity are derived from social and cultural contexts" (p. 12) and that "to understand the development of the individual, it is necessary to understand the social relations of which the individual is a part" (p. 12). Further, this particular theoretical lens originated from a postmodernist perspective that sees truth as relative and asserts that each individual creates his or her own reality (Boss, 2002). Social constructivists elaborate on this principle and maintain that "our experience is a function of the way we think about it" (Boss, 2002, p. 12). One final aspect of social constructivism is the emphasis placed on language and the ways in which

individuals use language to create their own stories and mediate their own learning (Boss, 2002). According to Vygotsky (1978), human beings' ability to employ language allows them "to overcome impulsive action, to plan a solution to a problem prior to its execution, and to master their own behavior" (p. 28). He further emphasized the importance of language in the child's ability to engage with and learn from others. It is my belief that language used to describe depression (e.g., sadness, loneliness, hopelessness) does not evoke positive images or experiences, and, if women use such terms or hear such terms used by others to describe their situation, they may indeed be hindered in their ability to plan treatment and seek help. It also should be noted that a word an individual uses to describe a certain situation might mean something entirely different to another individual using the same term to describe the exact same situation. For example, my definition of the term *lonely* might be a general sense of feeling alone, while someone else might use the term *lonely* to imply the problem at the very core of her depressive state. In examining this one example, one can see the power that human language holds over us all, as well as its ability to create our stories and mediate our learning.

The final theory I found applicable to my study was biosocial theory. The basic definition of the term *biosocial* is "the connection between the biological and the social" (Troost & Filsinger, 1993, p. 677). That is to say, all human beings have both a biological and a social side, and there is a connection between the two. For example, in investigating the concept of temperament, researchers have found that temperament is genetically predetermined, but the environment to which one is exposed impacts how temperament is displayed (Ingoldsby, Smith, & Miller, 2004). Another example of

biosocial theory at work is evidenced in the research generated on the concept of gender and the fact that, although hormones differ depending on whether one is male or female, the effects of these hormones can be either weakened or strengthened depending on the environment and how others in one's particular culture view masculinity and femininity (Ingoldsby et al., 2004). Finally, it should be noted that there are several basic assumptions that comprise the core of the theory, a select few of which include (a) "proximate biology has an influence on the family, and the family has an influence on proximate biology and the health of its members" (Ingoldsby et al., 2004, p. 219); (b) "biosocial influences are both biological and social in character" (p. 219); (c) "human biological and biosocial variables do not determine human conduct but pose limitations and constraints as well as possibilities and opportunities for families" (p. 219); and (d) "adaptations in physiology or conduct vary by environment" (p. 219). Each of these assumptions provides more detail into the breadth and depth of the theory, and from these assumptions, as well as the above examples, I saw how the theory was a good fit for the subject of my study. For example, a woman suffering from depression may be suffering because of a chemical imbalance in her brain (a genetic condition), but if and how she copes with her illness depends upon her environment. Does she have familial or other social support systems in place? How do others in her culture view mental illness? The answers to these questions provide a glimpse into how a woman copes with depression and whether or not she is able to function in society at large.

Nominal Definitions

Depression. The American Psychiatric Association (2000) defines depression as a type of mood disorder and characterizes the illness using a cacophony of symptoms,

depending on the individual's diagnosis. However, because this definition is rather vague, I chose to define depression using the *Merriam-Webster Medical Desk Dictionary* (2002), which defines depression as "an act of depressing or a state of being depressed: as (1): a state of feeling sad (2): a psychoneurotic or psychotic disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal thoughts or an attempt to commit suicide" (retrieved January 19, 2005 from http://dictionary.reference.com/search?q=depression).

Self-Esteem. "A positive or negative attitude toward a particular object, namely, the self" (Rosenberg, 1965, p. 30).

Global Optimism. "An expectation that good things will happen" (Chang, 2001, p. 5) or "hopeful expectations in a given situation" (p. 53).

Global Life Satisfaction. "A cognitive evaluation of one's life as a whole" (McKnight, Huebner, & Suldo, 2002, p. 677).

Summary

In summary, experiencing the mental illness known as depression has many implications for women and, more specifically, women who wish to have children. A woman suffering from depression who wishes to have a child may be faced with the possibility of postpartum depressive episodes and/or problematic mother-child attachment patterns. Therefore, I had the notion that some women, suffering from depression and faced with such issues, might have concerns about childbearing. Consequently, in this thesis project I sought to examine the relationships that existed between depressive symptomology in women and their childbearing considerations.

Chapter 2: Review of Literature

The definitions of the terms depression, self-esteem, global optimism, and global life satisfaction can be vague and obscure. Further, how each of these terms relates to the others is a puzzle, and one could potentially discover many ways to describe these relationships. However, it was my sense that the overall relationship between self-esteem, global optimism, global life satisfaction, and depression was negative, that is, as the first three diminished, depression increased and as the first three increased, depression diminished. Additionally, the childbearing decision is one that requires a great deal of women and is fraught with varying pros and cons. For many women, a sense of psychological well-being and societal acceptance would be reason enough for becoming a parent, while other women feel career motivation and maternal depression are sufficient suppressors to the childbearing decision. Finally, practitioners in the field of family life education are beginning to note the importance of perinatal and postnatal parenting programs geared toward women who suffer from depression, although the number of programs is quite small at the present time.

Incidence of Depression in Women

The mental illness known as depression is difficult to define because the presenting symptoms have the potential to be different for every individual. Further, every individual's experience of depression will be unique, and certain individuals are more likely to experience more severe forms of depression (e.g., Bipolar Disorder) than are others, perhaps because of certain physiological factors. In general, researchers have noted a relationship between certain types of physiological factors and depression. For example, Levitan, Vaccarino, Brown, and Kennedy (2002) found that women diagnosed

with atypical depression had lower plasma cortisol levels and more elevated corticotrophin levels than those not diagnosed with the disorder. Additionally, in their work with rats, Schmitz et al. (2002) found that, when pregnant rats were subjected to 20 minutes of stress daily, they had lower levels of hippocampal granule cells than their male counterparts. The authors concluded that "in humans, prenatal stress may induce cell loss in the granule cells of the hippocampus preferentially in females compared to males, and this may be a sex-specific predisposing factor for the development of depression in adulthood" (p. 810). The relationship between certain physiological factors and depression is expanded when one examines the literature specifically related to women and depression.

The physiological factors of depression in women are not limited to those listed above, but also are evidenced in the biological structure of the female. For example, according to Young, Campbell, and Harper (2002), women often suffer from thyroid disorders and anxiety disorders, and these conditions often lead to the exhibition of depressive symptomology. Further, the authors maintained that certain menstrual disorders such as Premenstrual Dysphoric Disorder can lead women to exhibit depressive symptomology. Another example of a contributing biological factor is that of pregnancy. According to Nazrro, Edwards, and Brown (1998), "women may be at more risk because of certain biological consequences of pregnancy and childbirth" (p. 315). Rapmund and Moore (2000) concurred when they stated, "Biological and physiological changes associated with the female reproductive system predispose women to depression and help to maintain it" (para. 6). It has been well documented (e.g., Marcus, Flynn, Blow, & Barry, 2003; Nazroo, Edwards, & Brown, 1998; Nicholson & Clayfield, 2004) that

women of reproductive age are at a greater risk of developing depressive symptomology than women who have undergone menopause. However, although physiological factors are important to consider in the occurrence of depression in women, one should not forget a second important factor: society.

According to Rapmund and Moore (2000), “A woman’s relationships seem to be central to an understanding of depression in women” (para. 5), and these authors continue, “Despite the satisfaction that women derive from their relationships, the strains involved in these relationships constitute a greater risk factor for depression than strains in other realms of life” (para. 9). Further, women who suffer from depression often perceive their social relationships and activities to be impaired. This type of thinking creates a vicious cycle, with women believing they are socially inept and their relationships suffering because of this belief. Hammen and Brennan (2002) concurred when they stated, “It has been shown that depressed individuals interact maladaptively with others in ways that contribute to the occurrence of interpersonal stressful life events, that in turn may precipitate further depression” (p. 146). This observation is evidenced further in a study conducted by Hammen (2003) in which the author stated that “depressed women select themselves into, become entrapped in, and even contribute to, highly stressful personal environments” (p. 9). Finally, Rapmund and Moore (2000) took note of the fact that women often experience role-strain, trying “to be everything everyone wants [them] to be” (p. 3). For example, a woman often finds herself in a situation that calls for her to be a financial provider, mother, lover, homemaker, and career professional. According to Nazroo, Edwards, and Brown (1998), not only are women more at risk of developing depressive symptomology than men, but “this risk was

more than five times greater for women following crises involving children, housing and reproduction" (p. 324). When the combination of role-strain and relational issues become too much for a woman to handle, she can experience the detrimental effects of depression.

In summary, there appear to be two primary contributing factors to the occurrence of depression in women: (a) physiological factors and (b) social factors. Further, women exhibit varying types of symptoms in their experience with depression, one of which may be a diminished level of self-esteem.

Self-Esteem

The term self-esteem is one that also is difficult to pin down because one sees a variety of definitions employed to describe the term. However, although there may be varying definitions of the term, for purposes of this study I believe there is a need for a more precise definition.

According to Rosenberg (1965), self-esteem is defined as "a positive or negative attitude toward a particular object, namely, the self" (p. 30). He went on to describe the levels of self-esteem (high and low) and how these affect the individual in terms of how she sees herself. For example, a woman with high self-esteem will believe she is a person of worth, but a woman with low self-esteem will feel self-contempt or rejection. It is important to note that Rosenberg defined high self-esteem in terms of an individual believing she was "good enough," not "superior to others" (p. 31).

The relationship between self-esteem and depression appears self-evident. In fact, one of the symptoms of depression is experiencing low self-esteem (United States Department of Human Service, 1999). Further, many of the symptoms of depression are

the same as those of low self-esteem (e.g., hopelessness, self-contempt, rejection). Finally, the findings of a number of studies have demonstrated that the relationship between self-esteem and depression is a negative one. According to Man, Gutierrez, and Sterk (2001), "Many studies have shown a strong negative relationship between self-esteem and depression" (p. 303). The authors further found in their own study of undergraduate students that depression was related to low self-esteem. Further, Hayward, Wong, Bright, and Lam (2002) found evidence that those who suffer from manic depression have lower levels of self-esteem than those who do not suffer from this illness. They stated that they believe one reason for this finding was that those who suffer from manic depression also experience a great deal of stigma from society at large and, thus, experience lower self-esteem. Finally, Cheng and Furnham (2002) studied a group of adolescents to determine causes of happiness and depression in the group and found that adolescents with lower self-esteem were more likely to be depressed, suggesting a bi-directional relationship between the two.

In summary, the relationship between depression and self-esteem is a negative one, that is, as an individual's level of depression increases her level of self-esteem decreases. It should be noted also that one of the symptoms of the illness of depression is that of a diminished level of self-esteem.

Global Optimism

When one thinks of the term *optimism*, it may well be that a vision of someone who always sees the glass as half full is what comes to mind, and in a very general sense this may not be far from the truth. According to Chang (2001), optimism in its most raw form means "an expectation that good things will happen" (p. 5). Further, Seligman

(1990) described optimistic people as those who are “unfazed by defeat” (p. 5) and who perceive bad situations as opportunities to try harder. However, regardless of how one chooses to define optimism, it is undoubtedly the antithesis of pessimism.

According to Seligman (1990), pessimistic individuals tend to believe that the bad things that happen to them in life are their own fault and that these bad events will last for an extended period of time. Further, the author asserted that pessimism leads to a variety of poor life outcomes, including poor physical and emotional health. Chang (2001) concurred with this analysis and noted that pessimistic individuals expect bad things to happen to them and are less likely than optimistic individuals to experience high levels of academic achievement. In light of this information, it is not surprising to discover that the relationship between optimism and depression is a negative one.

In his work *Learned Optimism,* Seligman (1990) dedicated an entire chapter to what he called “Ultimate Pessimism.” In this chapter, he described the relationship between pessimism and depression and stated that “depression is pessimism writ large” (p. 54). He went on to assert that individuals who suffer from depression also use a pessimistic explanatory style and suffer from the same symptoms as those who are pessimistic (e.g., poor physical health). Chang (2001) too noted that he found a link between pessimism and depression and asserted that his finding was in line with the thinking of Beck’s cognitive model of psychological disturbance in which Beck found that “pessimism is presumed to play an important role in the development of depression” (Chang, 2001, p. 271). In light of this information, one can see that the relationship between pessimism and depression is positive and, because optimism is the antithesis of pessimism, that the relationship between optimism and depression must be negative.

In summary, although the definitions of optimism and pessimism are somewhat vague, it is clear that the relationship between pessimism and depression is a positive one. Therefore, it is clear also that the relationship between optimism and depression is a negative one.

Global Life Satisfaction

There are many possible definitions for the term global life satisfaction, just as there are for self-esteem and depression, and the term often is confused by some with the related term global positive affect. However, there is a difference between the two terms, and there seems to be some consensus among various researchers as to a basic definition of global life satisfaction.

According to Diener, Emmons, Larsen, and Griffin (1985) life satisfaction is a "cognitive, judgmental process" (p. 71) and is based upon a standard that each individual sets for herself, not a standard imposed by a group of researchers. Further, the authors asserted that the term denotes an individual's overall evaluation of her life, and is not constrained by specific domains of satisfaction. McKnight, Huebner, and Suldo (2002) agreed with the above definition of the term and stated that global life satisfaction "is a cognitive evaluation of one's life as a whole" (p. 677) and, although related, is markedly different from global positive affect.

In examining the relationship between global life satisfaction and depression, it becomes evident that the relationship is a negative one. According to McKnight, Huebner, and Suldo (2002) individuals that exhibit a low level of subjective well-being, of which global life satisfaction is a component, are at an increased risk of developing depression and anxiety. They went on to suggest that a low level of life satisfaction is a

risk factor for developing future depressive symptoms. Further, Oishi and Diener (2001) stated that a high level of global life satisfaction was associated with positive self-esteem, and I have already noted that there is a negative relationship between self-esteem and depression. Finally, McCullough, Huebner, and Laughlin (2000), in their study of adolescents' subjective well-being, stated that "persons who demonstrate positive subjective well-being experience a preponderance of positive emotions, relatively few negative emotions, and evaluate their overall lives as positive" (p. 281).

In summary, the term global life satisfaction denotes an individual's cognitive appraisal of her life, an appraisal for which she sets the standard. Further, although related, global life satisfaction is not synonymous with global positive affect. Finally, the relationship between global life satisfaction and depression is a negative one.

The Childbearing Decision: Choosing to Remain Childless

There are a number of reasons women choose to remain childless, ranging from financial concerns to personal or relational concerns. For example, many women wish to enjoy their career and financial successes without the concern of supporting a child. Conversely, many women fear the financial strain a child would place on their lives and worry that they would not be able to make major purchases such as buying a home while simultaneously providing for a child. Further, the strain, stress, and worry on women raising children in today's complicated society are more than some wish to undertake. Many women may fear also the impact a child will have on their marital relationship or other personal relationships. Finally, many women fear they may be too old or too young to have children.

One of the possible strains of becoming a parent is the possibility of an episode of postpartum depression after the birth of the child. It is estimated that as many as 20% of women in the United States suffer from postpartum depression after the birth of a child, and over half of these women still exhibit symptoms as late as a year after the birth (Clay & Seehusen, 2004). This statistic should be of grave concern to physicians, psychiatrists, and family life educators because of the possible consequences to both mother and child. According to Seyfried and Marcus (2003), "Recognition and treatment of depressive disorders in pregnancy and postpartum is critical to good health outcomes for both mother and infant" (p. 231). Further, many skills necessary to promote healthy child development (e.g., cognitive skills, emotional skills, and social skills) are often deficient among children of depressed mothers (e.g., Lyons-Ruth, Wolfe, & Lyubchik, 2000; Sanford et al., 2003). Finally, the mothers of these children often exhibit feelings of guilt and anxiety concerning their parenting style and have little confidence in their parenting abilities (Clay & Seehusen, 2004).

Although the prevalence of postpartum depression in women is of grave concern, so too should be the prevalence of mothers who suffer from chronic depression that cannot be classified as postpartum depression because it is an ongoing illness. These women who are chronically depressed are faced not with the challenges of parenting and an acute episode of depression, but rather with the challenges of parenting in association with the chronic illness of depression. Often, these mothers exhibit aggression toward their children, as well as making negative appraisals of their children's behavior (Burke, 2003). For example, results of a study conducted by Hart, Field, and Roitfarb (1999) demonstrated that mothers suffering from depression rated their infant's behavior on the

Brazelton Neonatal Behavioral Assessment Scale lower than those mothers not suffering from depression. Further, Sheppard and Watkins (2000) recognized in their article that families with mothers who suffer from depression represent "the most severely problematic of families" (p. 194) and require greater levels of intervention from social work services. Finally, there are a number of authors (e.g., Carter, Garrity-Rokous, Chazan-Cohen, Little, & Bpiggs-Gowen, 2001; Martins & Gaffan, 2000) who found difficulties with attachment processes in infants of mothers who suffer from depression. For example, Coyl, Roggman, and Newland (2002) found that "infant security was lower when maternal depression was higher" (p. 157), and Teti, Gelfand, Messinger, and Isabella (1995) found that women who suffered from depression were more likely to be less responsive and more critical of their infants than women who were not depressed.

Although the effects of maternal depression on children are probably reason enough for some women to consider remaining childless, there are other possible reasons as well. For example, in their study of the effects of children on adults' psychological well-being from 1957-1976, McLanahan and Adams (1989) found that adults with children who were still living at home reported lower satisfaction in areas of their lives such as leisure activities, marital relationships, and relationships with friends. The authors also found that for some women, their increased participation in the labor force led to a lower sense of satisfaction with the parenting decision. Further, Holahan (1983), in describing her study on the relationship between information searching in childbearing decision making and life satisfaction, found that many women believe their career pursuits to be an important life goal and, therefore, choose to remain childless. Finally, McLanahan and Adams (1989) provided another possible reason for voluntary

childlessness when they noted that the increase in marital instability has altered the experience of parenthood for some women.

In summary, “Parenthood undoubtedly adds a unique dimension to human experience, but it is not an essential dimension” (Campbell, Converse, & Rodgers, 1976, p. 439). The reasons I described are just a few of the many possible for choosing to remain childless, but the motivational factors one might consider when choosing to parent are just as varied and meaningful.

The Childbearing Decision: Motivational Factors to Consider

Although there are a number of potential reasons to remain childless, there are also a number of potential motivational factors one might consider when choosing to parent, ranging from needing someone to love to giving one’s parents grandchildren. A woman may feel also that choosing to parent will give her something to do with her time and energy or insure someone’s presence when she is older and needs assistance with certain activities of daily living.

An interesting study conducted by Englund (1983), in which the author studied the importance of children in the lives of six retired couples, found that the women in the study felt that children were important in their lives in the sense that they contributed to “a purpose to life,” gave them “something useful to do,” and created in them a feeling of having “experienced life fully” (p. 26). These motivational factors seem to suggest some type of psychological benefit to having children, and several other authors corroborated this line of thinking. For example, Holohan (1983) noted that parents’ psychological well-being is enhanced by children in that children present challenges at each stage of the family life cycle that parents have to resolve, and these resolutions add to an increased

sense of well-being. Further, in her work on role changes and psychological well-being, Menaghan (1989) found that combining the roles of marriage, employment, and parenting led to better physical health in some populations and that multiple roles in general helped to provide individuals with a sense of security, ego-gratification, and social prestige.

Although parenting can be beneficial to an individual's psychological well-being, choosing not to become a parent can lead to psychological distress that may lead some women to consider parenting out of some type of societal obligation. According to Menaghan (1989), if an individual's life situation is seen as deviant or unusual, the person is considered somehow responsible for this deviance. She stated that "psychological distress is more likely when one's role repertoire departs from the normal, expectable situation for one's age and gender" (p. 711). For example, if a woman does not have a child, she may be seen as greedy, selfish, or unloving--or at least she may perceive others as portraying her in this light. Further, as a result of this perception, she may begin to blame or denigrate herself because of her childbearing choice. Meyers (2001) noted in her study on the rush to motherhood that "women who prefer not to have any children under any circumstances are commonly reproached for selfishness or pitied for immaturity" (p. 735). She further stated that a woman's childbearing decision is of the utmost importance to her personal well-being and defines her social persona.

In summary, there are a number of motivational factors for women to consider when deciding whether or not to become parents, ranging from needing someone to love to a sense of societal obligation. However, no matter the motivational factor, becoming a parent is a very salient reality for many women.

Family Life Education Programs

Although the literature does not abound on family life education programs geared toward women suffering from depression and their childbearing choices and considerations, there is some literature dedicated to examining perinatal education programs to help prevent some parenting strains.

In her study on the effects of a perinatal program designed to improve the level of emotional well-being in parents, Black-Olien (1993) found the program to be beneficial to the participants. She randomly divided couples into one of two groups: an experimental group or a control group. The participants in the control group took part in a standard perinatal education program that included information on mother-infant health care and medical intervention at birth. The experimental group was provided with the same information, but it was provided also with additional information on communication skills and relaxation techniques. The researcher found that the experimental group "fared better, in terms of perinatal emotional well-being, than the traditional prenatal education program" (p. 172). Additionally, in an editorial on the necessity of early intervention for perinatal distress, Austin (2003) noted the effects of maternal depression on children and the need for interventive services and programs to aid women in the perinatal period to better cope with the role of mother. The author asserted that the first step should consist of trying to find a screening tool to identify women at risk for depression during the perinatal period, followed by enacting needed interventions (e.g., stress management skills classes, medication, counseling). Finally, the author stated that the aforementioned interventions should be both accessible to consumers and cost-effective.

Although the research on family life education programs geared toward women who suffer from depression and their childbearing considerations is lacking, there are a couple of studies that give hope that this topic will become one that is discussed more often among researchers. For example, in their work emphasizing the need for early preventive mental health services for mothers who suffer from depression, Lyons-Ruth, Wolfe, and Lyubchik (2000) noted the problems children of depressed mothers face and the fact that these problems can be long term and difficult for the child to overcome. They further reported that mothers who suffer from depression demonstrate less positive behaviors toward their children than non-depressed mothers. Finally, they noted that child-rearing leads some women to experience depressive symptoms. In light of this research, the authors asserted the need for more preventive programs for mothers who suffer from depression and suggest, among other things, that possible programs consist of home visits to depressed mothers and the development of family-supported teams that serve these mothers by collaborating between psychopharmacology and obstetric services. The authors summed their thoughts by stating, "Treatment models for depressed parents of young children should provide both sophisticated psychopharmacological management for parental depression and help in righting the troubled parenting behaviors that often accompany depression" (p. 152). A second group of authors demonstrated the potential for future research and discussion on this topic in their study of a parent education group for families who are affected by depression. Sanford et al. (2003) attempted to enact a parent education group by recruiting 44 participants from psychiatric clinics and family doctors in Ontario. Their basic premise was that children whose parents suffer from depression often have the propensity for

various negative outcomes and that a parent education group might enable parents to help their children. The educational part of the program entailed information on depression, communication, and enhancing parenting strategies concerning problems found in children. Unfortunately, the authors had a rather large group of participants drop out of the parent education group, and so their results were incomplete. However, at the very least, this study should serve as a starting point for future research in the area.

In sum, there is little information available in the way of how family life education programs might be geared toward the particular population examined in this study. However, there are several studies that demonstrate programs that come very close to targeting the present population, and there is hope that additional programs will be developed.

Chapter 3: Method

I chose to use a quantitative method of research known as secondary data analysis for my thesis project. The data set I chose to use was that of the National Survey of Families and Households. The NSFH is a national, longitudinal survey that gathers data on "a wide variety of aspects of American family life and experience as both determinants and consequences of the family and life course events" (Bumpass & Sweet, 1988). The survey was designed at the University of Wisconsin-Madison under the direction of Larry Bumpass and James Sweet and had as its primary objective "providing improved understanding of both the structure and functioning of American families in order to overcome limitations of previously available data on family structure, family process, and family relationships" (Bumpass & Sweet, 1988). More specifically, I chose to use only the first wave of the survey, which was conducted in 1987-1988 and included a total of 13,017 primary respondents. The data in the survey were obtained via personal interviews and self-enumerated questionnaires, and the individual was used as the unit of observation.

Description of the Sample

The sample for the present study included women who were between the ages of 18 and 34 who had no children. The sample size for the present study was 869, with 565 respondents who were not married and 304 respondents who were married. Further, 743 of the respondents were White and 126 were African-American. In regard to religious affiliation, 769 of the respondents stated that they were affiliated with a religion, while only 100 of the respondents stated that they were not affiliated with a religion. Finally,

297 of the respondents had some type of college degree and 572 of the respondents did not have a degree.

Variables

The independent variables used in the study included (a) depressive symptomology, (b) self-esteem, (c) global optimism, and (d) global life satisfaction. The dependent variables used in the study included (a) constraints in deciding to have children and (b) motivational factors in deciding to have children. Further, the influence of selected demographic variables also were examined and included (a) race, (b) religious affiliation, (c) current marital status, (d) level of education, and (e) age. Several criterion variables were used also to narrow the focus of the study and included (a) age (18-34 year olds), (b) gender (women), and (c) an absence of children.

Hypotheses

1. There will be a positive relationship between a respondent's level of depressive symptomology and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.
2. There will be a negative relationship between a respondent's level of self-esteem and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.
3. There will be a negative relationship between a respondent's level of global optimism and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.

4. There will be a negative relationship between a respondent's level of global life satisfaction and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.

Null Hypotheses

1. There will be no relationship between a respondent's level of depressive symptomology and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.
2. There will be no relationship between a respondent's level of self-esteem and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.
3. There will be no relationship between a respondent's level of global optimism and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.
4. There will be no relationship between a respondent's level of global life satisfaction and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children.

Operational Definitions

Depressive Symptomology. Although I was originally interested in examining thoroughly the effects of depression on a woman's childbearing considerations, I chose to use secondary data analysis as my method of research and, therefore, had to use the data available to me. The data available measured the respondents' level of depressive symptomology, not depression. The respondent's level of depressive symptomology was defined by her responses to a set of 12 items taken from the Center for Epidemiologic

Studies Depression Scale (CES-D) (Radloff, 1977). The author of the scale asks respondents to rank the number of times in the last week certain events have occurred. The events are (a) feel bothered by things that usually don't bother you?, (b) not feel like eating; your appetite was poor?, (c) feel that you could not shake off the blues even with help from your family or friends?, (d) have trouble keeping your mind on what you were doing?, (e) feel depressed?, (f) feel that everything you did was an effort?, (g) feel fearful?, (h) sleep restlessly?, (i) talk less than usual?, (j) feel lonely?, (k) feel sad?, and (l) feel you could not get going? Additionally, for purposes of this project, all of the depression items were combined so as to provide one score for a participant's level of depressive symptomology. The Cronbach's alpha was .9 for the 12 items so there was no need to separate them into 12 measures.

Self-Esteem. The respondent's level of self-esteem was defined by her responses to a set of three items taken from Rosenberg's (1965) Self-Esteem Scale.
The items were (a) I feel that I'm a person of worth, at least on an equal plane with others, (b) On the whole, I am satisfied with myself, and (c) I am able to do things as well as other people. Additionally, each of the three items was entered separately into the analysis because the Cronbach's alpha was .6, and I used as the criterion for Cronbach's alpha .7 or greater in order for a scale to be deemed reliable (Cronbach, 1951). Therefore, it was inappropriate to combine the three items into one measure (Nunnaly, 1978).

Global Optimism. The respondent's level of global optimism was defined by her response to one item taken from the Quality of Life Survey-Institute for Social Research at Michigan, which asked "I have always felt pretty sure my life would work out the way I wanted it to".

Global Life Satisfaction. The respondent's level of global life satisfaction was defined by her response to one item taken from the Quality of Life Survey-Institute for Social Research at Michigan, which asked "First taking things all together, how would you say things are these days?"

Constraints in Deciding to Have Children. The respondent's level of importance for constraints in the childbearing decision (i.e., reasons to not have children) was defined by her responses to 10 items developed by a University of Wisconsin team for use in the National Survey of Families and Households (Bumpass & Sweet, 1988). The items were (a) my age, (b) uncertainty about my ability to support a child, (c) the stress and worry of raising children, (d) being able to make major purchases, (e) being able to buy a home or a better home, (f) having time for leisure or social activities, (g) having time and energy for my career, (h) my spouse or partner having time and energy for a career, (i) uncertainty about whether my marriage or relationship will last, and (j) disagreement with my spouse or partner about having a child.

Motivational Factors in Deciding to Have Children. The respondent's level of importance for motivational factors in the childbearing decision was defined by her responses to four items developed by a University of Wisconsin team for use in the National Survey of Families and Households (Bumpass & Sweet, 1988). The items were (a) giving my parents grandchildren, (b) having someone to care for me when I am old, (c) having someone to love, and (d) needing something to do.

Scale Reliability and Validity

For each of the measures involving more than one item, I tested the scale's reliability with the sample I selected for this project. However, background information about the three scales' reliability and validity from prior studies follows.

The Center for Epidemiologic Studies Depression Scale (CES-D). The Center for Epidemiologic Studies Depression Scale (CES-D) was developed to study "the epidemiology of depressive symptomatology in the general population" (Radloff, 1977, p. 385). The CES-D is a self-report instrument that contains 20 items used to measure an individual's current level of depressive symptomology. The questions are structured so that the respondent has to indicate how many times in the past week a particular symptom has occurred.

Radloff (1977) tested the scale in various household interview surveys and psychiatric settings. The household interview surveys consisted of 300 questions, 20 of which consisted of the CES-D items, and were administered to the general population in Washington County in Maryland and also Kansas City, Missouri. As for the surveys in the psychiatric settings, 70 patients in a private psychiatric facility were selected to participate in testing the scale in New Haven, Connecticut, and 35 participants who had been admitted to treatment for severe depression on an outpatient basis were selected to test the scale in Washington County, Maryland. Radloff found, in regard to reliability, that "both inter-item and inter-scale correlations were higher in the patient sample than in the general population samples" (p. 391). In regard to validity, Radloff found that the CES-D discriminated well between the general population and psychiatric patient sample.

Further, he found that "the pattern of correlations of the CES-D with other scales gives reasonable evidence of discriminant validity" (p. 393).

Other authors have found reliability and validity for the CES-D as well. For example, in their study of primary medical care patients, Fechner-Bates, Coyne, and Schwenk (1994) found that the score of 16 or above on the CES-D was significantly related to the diagnosis of a range of depressive disorders in the DSM-III-R and that "the CES-D was shown to have good sensitivity" (p. 556). In another example, Marcus, Flynn, Blow, and Barry (2003), in reporting the results found in their study of pregnant women, stated that "the CES-D has been found to have adequate sensitivity in identifying a diagnosis of major depression" (p. 375).

Rosenberg's Self-Esteem Scale. Rosenberg's (1965) measurement of self-esteem is a Guttman scale consisting of 10 items. The respondent is asked to rate his or her response to an item on a Likert-type scale from *strongly agree* to *strongly disagree*. In regard to reliability and validity, Rosenberg stated that "this scale is internally reliable and unidimensional and appears to have face validity" (p. 30). He went on to assert that those who scored lower on this scale also reported feeling more depressed, more anxious, and felt that others had little respect for them, which is the outcome one would expect if the scale measures what it is intended to measure. In my study, I created a subscale of three of the items in the full scale because all 10 items were not present in the data set I chose to examine.

Quality of Life Survey-Institute for Social Research at Michigan. After repeated attempts at obtaining information concerning the Quality of Life Survey I did not obtain the necessary information needed to assess the survey's reliability or validity. I e-mailed

and telephoned the Institute for Social Research at Michigan only to be told that there was no information they could obtain about this particular survey. However, the Satisfaction with Life Scale closely resembles the Quality of Life Survey in the questions it poses, and there are researchers who have stated this particular scale's reliability and validity.

According to Diener, Emmons, Larsen, and Griffin (1985) the five items in the Satisfaction with Life Scale showed "a good level of internal consistency" (p. 74) in their study of the life satisfaction of a group of 53 elderly persons. Further, Oishi, Diener, Suh, and Lucas (1999) used the scale with two groups of college students from the University of Illinois in their study of value as a moderator in subjective well-being and stated that the scale's psychometric properties were adequate for use in the United States. Finally, Oishi and Deiner (2001) used the scale with a group of 76 college students from the University of Illinois in their study of the General Positivity Model and found the internal consistency of the scale to be .87 for their particular sample.

Analysis Procedure: Hierarchical Regression

According to Huck (2004), hierarchical regression is a type of multiple regression. Multiple regression procedures involve the use of one dependent variable and two or more independent variables and are used for one of two purposes: to (a) predict or (b) explain. In other words, the researcher seeks to find out the extent to which each independent variable explains or predicts the dependent variable. In hierarchical regression, the independent variables are entered into the data analysis in stages, and the researcher often enters first the independent variables for which he or she wishes to control. After these variables have explained or predicted as much as is possible, the

other independent variables are entered into the analysis. These variables then are used "to see if they can contribute above and beyond the independent variables that went in first" (p. 433). For purposes of this project, the control variables were entered into the regression in the first block and then the independent variables were entered in two additional blocks. The first block consisted of the depressive symptomology items and the global life satisfaction item, and the second block consisted of the self-esteem items and the global optimism item. Finally, because there were 14 dependent variable items, there were a total of 14 various hierarchical regression outcomes.

Chapter 4: Results

Descriptive Statistics

As stated previously, the total sample size for this project was 869, and the criteria for inclusion were that the respondents had to be women, ages 18-34, who had no children. In regard to the age variable (which also was used as a control variable), 73.6% of the respondents were 28 years of age or younger while 26.4% of the respondents were over the age of 28 (M = 25.22) (see Table 1). Further, in regard to the remaining control variables, the majority of respondents were White (n = 743), were not married (n = 565), did not have a college degree (n = 572), and were affiliated with some type of religion (n = 769).

Independent Variables' Frequencies

The depressive symptomology variable was measured using 12 items from the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977), which asks respondents to state how many days out of the past week they have felt certain depressive symptoms. Again, all 12 of the items were combined to create one measure of depressive symptomology (Cronbach's alpha = .9). According to the analysis, the depressive symptomology variable yielded a mean score of 1.46, with the majority (75.0%) of respondents reporting that they experienced the symptoms of depression 2 days or less per week. The global life satisfaction variable was measured using one item from the Quality of Life Survey--Institute for Social Research at Michigan, which asks respondents to rate their feelings on the question, "First taking all things together, how would you say things are these days?" on a 7-point Likert-type scale ranging from *very unhappy* to *very happy*. According to the analysis, the global life

Table 1

Descriptive Statistics for Age of Respondent

Age	Frequency	Percent	Cumulative Percent
18	4	.5	.5
19	76	8.7	9.2
20	71	8.2	17.4
21	63	7.2	24.6
22	75	8.6	33.3
23	73	8.4	41.7
24	72	8.3	49.9
25	61	7.0	57.0
26	52	6.0	62.9
27	57	6.6	69.5
28	36	4.1	73.6
29	44	5.1	78.7
30	43	4.9	83.7
31	37	4.3	87.9
32	35	4.0	91.9
33	40	4.6	96.5
34	30	3.5	100.0
Total	869	100.0	

satisfaction variable yielded a mean score of 5.48, with the majority (69.9%) of respondents reporting a score of 5 or higher. The global optimism variable was measured using one item from the Quality of Life Survey--Institute for Social Research at Michigan, which asks respondents to rate how strongly they agree or disagree with the statement, "I have always felt pretty sure my life would work out the way I wanted it to" on a 5-point Likert-type scale ranging from *strongly agree* to *strongly disagree*. However, for purposes of this study, the variable was reverse coded so that the scale ranged from (1) *strongly disagree* to (5) *strongly agree*. According to the analysis, the global optimism variable yielded a mean score of 3.60, with the majority (58.3%) of respondents reporting a score of 4 or higher. The self-esteem variable was measured using three items from Rosenberg's (1965) self-esteem scale, which asks respondents to answer questions concerning self-esteem on a 5-point Likert-type scale ranging from *strongly agree* to *strongly disagree*. However, for purposes of this study, the variable was reverse coded so that the scale ranged from (1) *strongly disagree* to (5) *strongly agree*. Again, each of the items was entered into the regression analysis separately because it was inappropriate to combine the items into one measure (Cronbach's alpha = .6). In regard to the question, "I feel that I'm a person of worth, at least on an equal plane with others," the mean score was 4.32, with the majority (87.7%) of respondents reporting a score of 4 or higher. In regard to the question, "I am able to do things as well as other people," the mean score was 4.15, with the majority (83.9%) of respondents reporting a score of 4 or higher. In regard to the question, "On the whole I am satisfied with myself," the mean score was 3.98, with the majority (78.8%) of respondents reporting a score of 4 or higher (see Table 2).

Table 2

Descriptive Statistics for Independent Variables

Independent Variable	*N*	Minimum	Maximum	Mean	Std. Deviation
Depressive Symptomology	864	.00	6.92	1.46	1.42
Global Life Satisfaction (How would you say things are these days)	741	1	7	5.48	1.27
Global Optimism (I'm pretty sure my life would work out the way I wanted)	842	1	5	3.60	.99
Self-Esteem (I feel I'm a person of worth)	844	1	5	4.32	.71
Self-Esteem (On the whole I am satisfied with myself)	841	1	5	3.98	.83
Self-Esteem (I am able to do things as well as other people)	844	1	5	4.15	.79
Valid N (listwise)	709				

Dependent Variables' Frequencies

The constraints variable was measured using 10 items selected from a self-enumerated questionnaire section of the first wave of the National Survey of Families and Households (Bumpass & Sweet, 1988). The items were scored on a 7-point Likert-type scale ranging from *not at all important* to *very important*. The items were (a) *my age* (*M* = 4.84), (b) *uncertainty about my ability to support a child* (*M* = 5.06), (c) *the stress and worry of raising children* (*M* = 4.80), (d) *being able to make major purchases* (*M* = 4.27), (e) *being able to buy a home or a better home* (*M* = 4.64), (f) *having time for leisure or social activities* (*M* = 4.30), (g) *having time and energy for my career* (*M* = 4.29), (h) *my spouse or partner having time and energy for a career* (*M* = 4.65), (i) *uncertainty about whether my marriage or relationship will last* (*M* = 3.55), and (j) *disagreement with my spouse or partner about having a child* (*M* = 3.40) (see Table 3). The motivational factors variable was measured using four items from a self-enumerated questionnaire section of the first wave of the National Survey of Families and Households. The items were rated on a 7-point Likert-type scale ranging from *not at all important* to *very important*. The items were (a) *giving my parents grandchildren* (*M* = 3.49), (b) *having someone to care for me when I am old* (*M* = 2.79), (c) *having someone to love* (*M* = 4.97), and (d) *needing something to do* (*M* = 2.38) (see Table 4).

Beginning Analysis

The independent variables chosen for use in the present study seemed to be very similar in nature, and, consequently, there was a concern about the possibility of the problem of multicollinearity. Therefore, a correlation table was constructed comparing each of the independent variables to one another (see Table 5). The results showed that

Table 3

Descriptive Statistics for Constraints

Constraint	*N*	Minimum	Maximum	Mean	Std. Deviation
My Age	840	1	7	4.84	2.12
Uncertain About My Ability to Support a Child	840	1	7	5.06	2.10
The Stress and Worry of Raising Children	838	1	7	4.80	1.93
Being Able to Make Major Purchases	840	1	7	4.27	2.06
Being Able to Buy a Home	839	1	7	4.64	2.11
Having Time for Leisure Activities	840	1	7	4.30	1.91
Having Time and Energy for My Career	838	1	7	4.29	2.02
My Spouse/Partner Having Time and Energy for Career	441	1	7	4.65	1.94
Uncertain That My Relationship/Marriage Will Last	439	1	7	3.55	2.45
Disagreeing With My Spouse/Partner About Having a Child	440	1	7	3.40	2.40

Table 4

Descriptive Statistics for Motivational Factors

Motivational Factor	*N*	Minimum	Maximum	Mean	Std. Deviation
Giving My Parents Grandchildren	833	1	7	3.49	2.12
Having Someone to Care for Me When I Am Old	838	1	7	2.79	2.02
Having Someone to Love	837	1	7	4.97	2.11
Needing Something to Do	837	1	7	2.38	1.87

Table 5

Correlation Table of Independent Variables

Independent Variable	Statistics	Global Life Satisfaction (How would you Say things are these days)	Global Optimism (I'm pretty sure my life would work out the way I wanted)	Depressive Symptomology	Self-Esteem (I feel I'm a person of worth)	Self-Esteem (On the whole I am satisfied with myself)	Self-Esteem (I am able to do things as well as other people)
Global Life Satisfaction (How would you say things are these days)	Pearson Correlation	1	.242**	-.524**	.142**	.450**	.121**
Global Optimism (I'm pretty sure my life would work out the way I wanted)	Pearson Correlation	.242**	1	-.177**	.306**	.461**	.314**
Depressive Symptomology	Pearson Correlation	-.524**	-.177**	1	-.093**	-.325**	-.136**
Self-Esteem (I feel I'm a person of worth)	Pearson Correlation	.142**	.306**	-.093**	1	.393**	.459**
Self-Esteem (On the whole I am satisfied with myself)	Pearson Correlation	.450**	.461**	-.325**	.393**	1	.409**
Self-Esteem (I am able to do things as well as other people)	Pearson Correlation	.121**	.314**	-.136**	.459**	.409**	1

** Correlation is significant at the 0.01 level (2-tailed).

the majority of the independent variables in general were only slightly correlated with one another, although there were several significant correlations. Two of the highest noted correlations were between (a) depressive symptomology and global life satisfaction (r = -.524) and (b) the self-esteem items, *I feel that I'm a person of worth* and *I feel I am able to do things as well as other people* (r = .459). Because these two self-esteem items were highly correlated, I chose to find the Cronbach's alpha of the three self-esteem items to determine if they needed to be condensed into a one-item score. However, the Cronbach's alpha was only .6 and was, therefore, not high enough to cause concern. Finally, in regard to the possible problem with the high correlation between depressive symptomology and global life satisfaction, I found later in the hierarchical regression analysis that the global life satisfaction variable was a poor measure and, therefore, it was dropped from the regression analysis.

There was concern not only about multicollinearity, but also about how to subdivide the marital status variable. Originally, the variable consisted of two groups: (a) married and (b) not married. However, I found that there were three prominent marital status groups in my sample: (a) married (n = 304), (b) divorced (n = 62), and (c) never married (n = 502). Therefore, I decided that all three groups would be used in the hierarchical regression procedure that would later follow. I accomplished this task by creating two dummy variables: (a) a *married* variable that compared married women to both never married and divorced women and (b) a *never married* variable that compared never married women to both married and divorced women.

The next step in the analysis process was to construct a correlation table to examine initial relationships between the control variables and the independent variables.

The results were that the majority of the independent variables were found to be only slightly correlated with the control variables, although there were a few significant correlations. The age variable was negatively correlated with the global optimism variable (r = -.093) and with the self-esteem variable, *I am able to do things as well as other people* (r = -.068). Further, the religious affiliation variable was negatively correlated with the self-esteem item, *On the whole I am satisfied with myself* (r = -.090). I found also that the depressive symptomology variable was negatively correlated with the marital status variable (r = -.152) and with the education variable (r = -.145) (see Table 6).

The next step in the analysis process was to construct two correlation tables, one that would compare the independent variables to the dependent variable *constraints* and one that would compare the independent variables to the dependent variable *motivational factors*. These correlation tables were constructed to examine the initial relationships between the variables. It was found that the majority of variables were only slightly correlated, although there were several significant correlations. The following were the most highly correlated items in terms of *constraints*: (a) the constraint *Uncertain that my relationship/marriage will last* and the independent variables depressive symptomology (r = .228) and global life satisfaction (r = -.261) and (b) the constraint *the stress and worry of raising children* and the independent variable depressive symptomology (r = .132) (see Table 7). The following were the most highly correlated items in terms of *motivational factors*: (a) the motivational factor *needing something to do* and the independent variable self-esteem item, *I feel I'm a person of worth* (r = -.202) and (b) the

Table 6

Correlation Table of Independent and Control Variables

Independent Variable	Statistics	Age	Religious Affiliation	Race	Current Marital Status	Education
Depressive Symptomology	Pearson Correlation	-.014	-.033	.131**	-.152**	-.145**
Global Life Satisfaction (How would you say things are these days)	Pearson Correlation	-.034	.082*	-.060	.200**	.043
Global Optimism (I'm pretty sure my life would work out the way I wanted)	Pearson Correlation	-.093**	.063	.000	.061	.067
Self-Esteem (I feel I'm a person of worth)	Pearson Correlation	.012	-.015	-.046	-.028	.180**
Self-Esteem (On the whole I am satisfied with myself)	Pearson Correlation	-.061	.090**	-.049	.095**	.092**
Self-Esteem (I am able to do things as well as other people)	Pearson Correlation	-.068*	-.016	-.059	-.001	.075*

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Table 7

Correlations of Independent Variables with Dependent Variable Constraints

Dependent Variable Items	Statistics	Depressive Symptomology	Global Life Satisfaction (How would you say things are these days)	Global Optimism (I'm pretty sure my life would work out the way I wanted)	Self-Esteem (I feel I'm a person of worth)	Self-Esteem (On the whole I am satisfied with myself)	Self-Esteem (I am able to do things as well as other people)
My Age	Pearson Correlation	.084*	-.025	.041	.032	.003	-.017
Uncertain About My Ability to Support a Child	Pearson Correlation	.093**	-.108**	-.028	.023	-.046	.021
The Stress and Worry of Raising Children	Pearson Correlation	.132**	-.079*	-.059	.038	-.039	-.027
Being Able to Make Major Purchases	Pearson Correlation	.109**	-.081*	-.045	.043	-.049	-.012
Being Able to Buy a Home	Pearson Correlation	.105**	-.062	-.021	.033	-.027	.038
Having Time for Leisure Activities	Pearson Correlation	.061	-.027	.031	.093**	.015	.016
Having Time and Energy for My Career	Pearson Correlation	.057	-.063	.057	.099**	.037	.038
My Spouse/Partner Having Time and Energy for Career	Pearson Correlation	.071	-.125*	-.029	.084	-.048	-.002
Uncertain That My Relationship/Marriage Will Last	Pearson Correlation	.228**	-.261**	-.111*	-.122*	-.228**	-.086
Disagreeing With My Spouse/Partner About Having a Child	Pearson Correlation	.122*	-.183**	-.042	-.110*	-.169**	-.085

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

motivational factor *having someone to love* and the independent variable self-esteem item, *I feel I'm a person of worth* (r = -.128) (see Table 8).

Hierarchical Regression Analysis

The final analysis procedure for the present study was hierarchical regression. This particular procedure was chosen because I wanted first to determine how much variance in the dependent variables would be accounted for first by the control variables (Block 1) and then by the independent variables *global life satisfaction* and *depressive symptomology* (Block 2). Finally, I wanted to determine the amount of additional variance accounted for by the independent variables *global optimism* and *self-esteem* (Block 3). However, there was initial concern that the variables *global life satisfaction* and *global optimism* would be especially poor measures because they consisted of only one item and were highly correlated with both the *depressive symptomology* and *self-esteem* variables, indicating a possible problem with multicollinearity. However, these variables were entered into the regression as planned to examine the findings, but were found to add no additional variance to the model, and so were dropped from the analysis.

The resulting hierarchical regression consisted of two blocks: (a) a block of control variables (Block 1) and (b) a block of independent variables (using only depressive symptomology and self-esteem) (Block 2). Finally, there were a total of 14 various hierarchical regression outcomes because there were a total of 14 dependent variable items.

Results for the Constraints *Variable*

In regard to the item *my age,* I found in Block 1 that both race (B = .633, p = .004) and marital status (never married as opposed to married or divorced) (B = .683, p = .030)

Table 8

Correlations of Independent Variables with Dependent Variable Motivational Factors

Dependent Variable Items	Statistics	Depression	Global Life Satisfaction (How would you say things are these days)	Global Optimism (I'm pretty sure my life would work out the way I wanted)	Self-Esteem (On the whole I am satisfied with myself)	Self-Esteem (I feel I'm a person of worth)	Self-Esteem (I am able to do things as well as other people)
Giving My Parents Grandchildren	Pearson Correlation	.076*	.050	-.008	.012	-.070*	-.100**
Having Someone to Care for Me When I Am Old	Pearson Correlation	.150**	-.021	-.045	-.108**	-.126**	-.116**
Having Someone to Love	Pearson Correlation	.128**	.031	-.086*	-.103**	-.128**	-.096**
Needing Something to Do	Pearson Correlation	.152**	-.041	-.115**	-.176**	-.202**	-.138**

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

were positively correlated with this item. Therefore, age was more of a constraint for African-Americans and those individuals who had never been married. In Block 2, the only variable found to be correlated with the item was the depressive symptomology variable, and it was a positive correlation (B = .130, p = .022). Therefore, age was more of a constraint the higher the individual's level of depressive symptomology. Finally, the overall R square value was .045 for block one and .052 for block two, with .7% additional variance accounted for by the addition of the independent variables into the model (see Table 9).

In regard to the item *uncertain about my ability to support a child*, I found in Block 1 that both age (B = -.129, p < .01) and marital status (married as opposed to never married or divorced) (B = -1.177, p <.01) were negatively correlated with this item. Therefore, this item was less of a constraint for those women who were married and older. In Block 2, none of the independent variables were found to be significantly correlated with this item. Finally, the overall R-square value was .183 for Block 1 and .188 for Block 2, with .5% additional variance accounted for by the addition of the independent variables into the model (see Table 10).

In regard to the item *the stress and worry of raising children*, I found in Block 1 that both age (B = -.040, p = .019) and martial status (married as opposed to never married or divorced) (B = -.675, p = .018) were negatively correlated with this item. Therefore, this item was less of a constraint for those women who were married and older. In Block 2, depressive symptomology was the only variable correlated with

Table 9

Hierarchical Regression Outcome for the Constraint My Age

Model	Variable	Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	*t*	Sig.
1	(Constant)	4.124	.622		6.627	.000
	Age of Respondent	-.001	.019	-.001	-.038	.970
	Religious Affiliation	.164	.235	.024	.701	.483
	Race of Respondent	.633	.218	.105	2.907	.004
	Do You Have A College Degree	.288	.168	.065	1.721	.086
	Married	.029	.315	.007	.093	.926
	Never Married	.683	.313	.159	2.180	.030
2	(Constant)	3.542	.868		4.081	.000
	Age of Respondent	-.002	.019	-.004	-.092	.926
	Religious Affiliation	.162	.236	.024	.686	.493
	Race of Respondent	.595	.218	.098	2.724	.007
	Do You Have A College Degree	.318	.172	.071	1.856	.064
	Married	.081	.316	.018	.255	.799
	Never Married	.703	.313	.164	2.245	.025
	Depressive Symptomology	.130	.056	.086	2.297	.022
	Self-Esteem (I Feel I'm a Person of Worth)	.056	.123	.019	.458	.647
	Self-Esteem (On the Whole I am Satisfied With Myself)	.116	.108	.045	1.073	.284
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.076	.109	-.028	-.697	.486

Dependent Variable: My Age

Table 10

Hierarchical Regression Outcome for the Constraint Uncertain About My Ability to Support a Child

Model	Variable	Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	*t*	Sig.
1	(Constant)	8.854	.569		15.562	.000
	Age of Respondent	-.129	.017	-.272	-7.552	.000
	Religious Affiliation	-.261	.214	-.039	-1.218	.224
	Race of Respondent	.085	.199	.014	.428	.669
	Do You Have A College Degree	.026	.153	.006	.172	.863
	Married	-1.177	.288	-.269	-4.091	.000
	Never Married	.118	.286	.028	.412	.681
2	(Constant)	8.628	.794		10.869	.000
	Age of Respondent	-.131	.017	-.277	-7.625	.000
	Religious Affiliation	-.217	.216	-.033	-1.004	.315
	Race of Respondent	.061	.200	.010	.302	.763
	Do You Have A College Degree	.053	.157	.012	.336	.737
	Married	-1.121	.289	-.257	-3.880	.000
	Never Married	.126	.287	.030	.439	.661
	Depressive Symptomology	.079	.052	.053	1.523	.128
	Self-Esteem (I Feel I'm a Person of Worth)	.074	.113	.025	.653	.514
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.096	.099	-.037	-.969	.333
	Self-Esteem (I Am Able to Do Things As Well As Other People)	.039	.100	.015	.396	.693

Dependent Variable: Uncertain about My Ability to Support a Child

this item, and it was a positive correlation (B = .187, p <.01). Therefore, this item was more of a constraint the higher a woman's level of depressive symptomology. Finally, the overall R-square value was .036 for Block 1 and .057 for Block 2, with 2.0% additional variance accounted for by the addition of the independent variables into the model (see Table 11).

In regard to the item *being able to make major purchases*, I found in Block 1 that both age (B = -.090, p < .01) and marital status (being married as opposed to never married or divorced) (B = -.867, p = .003) were negatively correlated with this item. Therefore, this item was less of a constraint for those women who were married and older. It was further found that both race (B = 1.046, p <.01) and education (B = .340, p = .030) were positively correlated with this item. Therefore, this item was more of a constraint for African-Americans and those who had college degrees. In Block 2, depressive symptomology was the only variable correlated with this item, and it was a positive correlation (B = .031, p = .013). Therefore, this item was more of a constraint the higher a woman's level of depressive symptomology. Finally, the overall R-square value was .115 for Block 1 and .127 for Block 2, with 1.1% additional variance accounted for by the addition of the independent variables into the model (see Table 12).

In regard to the item *being able to buy a home*, I found in block one that both age (B = -.111, p < .01) and marital status (being married as opposed to being never married or divorced) (B = -1.355, p < .01) were negatively correlated with this item. Therefore, this item was less of a constraint as the participant got older and if she was married. Further, I found that race was positively correlated with this item (B = .803, p <.01). Therefore, this item was more of a constraint if the respondent was African-American.

Table 11

Hierarchical Regression Outcome for the Constraint The Stress and Worry of Raising a Child

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	6.177	.565		10.925	.000
	Age of Respondent	-.040	.017	-.092	-2.348	.019
	Religious Affiliation	-.183	.214	-.030	-.853	.394
	Race of Respondent	.300	.200	.054	1.501	.134
	Do You Have A College Degree	.157	.153	.039	1.031	.303
	Married	-.675	.286	-.169	-2.362	.018
	Never Married	-.124	.285	-.032	-.434	.664
2	(Constant)	5.703	.783		7.285	.000
	Age of Respondent	-.044	.017	-.102	-2.595	.010
	Religious Affiliation	-.147	.214	-.024	-.687	.492
	Race of Respondent	.231	.199	.042	1.161	.246
	Do You Have A College Degree	.212	.155	.052	1.365	.173
	Married	-.585	.285	-.146	-2.051	.041
	Never Married	-.103	.283	-.027	-.365	.715
	Depressive Symptomology	.187	.051	.137	3.671	.000
	Self-Esteem (I Feel I'm a Person of Worth)	.140	.111	.051	1.257	.209
	Self-Esteem (On the Whole I am Satisfied With Myself)	.029	.097	.013	.302	.763
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.119	.098	-.049	-1.212	.226

Dependent Variable: The Stress and Worry of Raising Children

Table 12

Hierarchical Regression Outcome for the Constraint Being Able to Make Major Purchases

Model	Variable	Unstandardized Coefficients		Standardized Coefficients		Sig.
		B	Std. Error	Beta	*t*	
1	(Constant)	6.784	.580		11.694	.000
	Age of Respondent	-.090	.017	-.195	-5.197	.000
	Religious Affiliation	-.161	.219	-.025	-.737	.462
	Race of Respondent	1.046	.204	.178	5.141	.000
	Do You Have A College Degree	.340	.156	.079	2.176	.030
	Married	-.867	.293	-.202	-2.954	.003
	Never Married	-.122	.292	-.029	-.419	.675
2	(Constant)	6.370	.807		7.895	.000
	Age of Respondent	-.094	.017	-.202	-5.373	.000
	Religious Affiliation	-.113	.219	-.017	-.513	.608
	Race of Respondent	.999	.204	.170	4.904	.000
	Do You Have A College Degree	.372	.160	.086	2.332	.020
	Married	-.783	.294	-.183	-2.665	.008
	Never Married	-.106	.291	-.025	-.363	.717
	Depressive Symptomology	.131	.052	.090	2.498	.013
	Self-Esteem (I Feel I'm a Person of Worth)	.167	.115	.057	1.456	.146
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.067	.100	-.027	-.673	.501
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.054	.101	-.021	-.537	.592

Dependent Variable: Being Able to Make Major Purchases

In Block 2, depressive symptomology was the only variable correlated with this item, and it was a positive correlation (B = .113, p = .032). Therefore, this item was more of a constraint the higher a woman's level of depressive symptomology. Finally, the overall R-square value was .151 for Block 1 and .159 for Block 2, with .8% additional variance accounted for by the addition of the independent variables into the model (see Table 13).

In regard to the item *having time for leisure activities,* I found in Block 1 that there were no variables that showed a significant correlation, either positive or negative, with this item. However, in Block 2, the self-esteem item, *I feel I'm a person of worth* (B = .292, p = .009), showed a positive correlation with this item. Therefore, this item was more of a constraint the more a woman felt she was a person of worth. Finally, the overall R-square value was .017 for Block 1 and .029 for Block 2, with 1.2% additional variance accounted for by the addition of the independent variables into the model (see Table 14).

In regard to the item *having time and energy for my career,* I found in Block 1 that age (B = -.072, p < .01) and marital status (being married as opposed to being never married or divorced) (B = -.896, p = .002) were both negatively correlated with this item. Therefore, this item was less of a constraint if a woman was married and older. Further, both race (B = .761, p < .01) and education (B = .515, p = .001) were positively correlated with this item. Therefore, this item was more of a constraint if a woman was African-American and had a college degree. In Block 2, the only variable found to be significantly correlated with this item was the self-esteem item, *I feel I'm a person of worth*, and it was a positive correlation (B = .242, p = .036). Therefore, this item was more of a constraint the more a woman felt she was a person of worth. Finally, the

Table 13

Hierarchical Regression Outcome for the Constraint Being Able to Buy a Home

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	8.004	.584		13.694	.000
	Age of Respondent	-.111	.018	-.233	-6.340	.000
	Religious Affiliation	-.032	.220	-.005	-.148	.883
	Race of Respondent	.803	.205	.133	3.911	.000
	Do You Have A College Degree	.073	.157	.016	.463	.643
	Married	-1.355	.295	-.308	-4.591	.000
	Never Married	-.343	.294	-.081	-1.169	.243
2	(Constant)	7.163	.814		8.795	.000
	Age of Respondent	-.111	.018	-.234	-6.316	.000
	Religious Affiliation	.008	.221	.001	.035	.972
	Race of Respondent	.780	.206	.129	3.787	.000
	Do You Have A College Degree	.093	.161	.021	.576	.565
	Married	-1.279	.296	-.291	-4.322	.000
	Never Married	-.319	.294	-.075	-1.087	.277
	Depressive Symptomology	.113	.053	.076	2.146	.032
	Self-Esteem (I Feel I'm a Person of Worth)	.072	.116	.024	.620	.536
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.045	.101	-.017	-.444	.657
	Self-Esteem (I Am Able to Do Things As Well As Other People)	.114	.102	.043	1.118	.264

Dependent Variable: Being Able to Buy a Home

Table 14

Hierarchical Regression Outcome for the Constraint Having Time for Leisure Activities

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	5.307	.562		9.451	.000
	Age of Respondent	-.024	.017	-.057	-1.443	.149
	Religious Affiliation	-.189	.212	-.032	-.893	.372
	Race of Respondent	.339	.197	.063	1.719	.086
	Do You Have A College Degree	.110	.151	.028	.728	.467
	Married	-.517	.284	-.132	-1.820	.069
	Never Married	-.230	.283	-.060	-.812	.417
2	(Constant)	4.094	.781		5.242	.000
	Age of Respondent	-.023	.017	-.054	-1.370	.171
	Religious Affiliation	-.176	.212	-.029	-.827	.408
	Race of Respondent	.325	.197	.060	1.646	.100
	Do You Have A College Degree	.065	.155	.016	.419	.675
	Married	-.444	.284	-.113	-1.560	.119
	Never Married	-.193	.282	-.051	-.683	.495
	Depressive Symptomology	.073	.051	.054	1.432	.153
	Self-Esteem (I Feel I'm a Person of Worth)	.292	.111	.109	2.631	.009
	Self-Esteem (On the Whole I am Satisfied With Myself)	.034	.097	.015	.348	.728
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.086	.098	-.036	-.875	.382

Dependent Variable: Having Time for Leisure Activities

overall R-square value was .073 for Block 1 and .082 for Block 2, with .9% additional variance accounted for by the addition of the independent variables into the model (see Table 15).

In regard to the item *my spouse/partner having time and energy for a career*, I found in Block 1 that marital status (being married as opposed to being never married or divorced) (B = -.828, p = .035) was the only variable correlated with this item, and it was a negative correlation. Therefore, this was less of a constraint if a woman was married. In Block 2, the self-esteem item *I feel I'm a person of worth* (B = .304, p = .045) was the only variable correlated with this item, and it was a positive correlation. Therefore, this item was more of a concern the more a woman felt she was a person of worth. Finally the overall R-square value was .050 for Block 1 and .062 for Block 2, with 1.1% additional variance accounted for by the addition of the independent variables into the model (see Table 16).

In regard to the item *uncertain that my marriage/relationship will last,* I found in Block 1 that both age (B = -.062, p = .040) and marital status (being married as opposed to being never married or divorced) (B = -2.071, p < .01) were negatively correlated with this item. Therefore, this item was less of a constraint if a woman was older and married. In Block 2, I found that depressive symptomology (B = .240, p = .009) was positively correlated with this item, but the self-esteem item *On the whole, I am satisfied with myself* (B = -.420, p = .013) was negatively correlated with this item. Therefore, this item was more of a constraint the higher a woman's level of depressive symptomology, but less of a constraint the more she was satisfied with herself. Finally, the overall R-square value was .118 for Block 1 and .170 for Block 2, with 5.2%

Table 15

Hierarchical Regression Outcome for the Constraint Having Time and Energy for My Career

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	6.493	.582		11.158	.000
	Age of Respondent	-.072	.017	-.158	-4.115	.000
	Religious Affiliation	-.225	.219	-.035	-1.027	.305
	Race of Respondent	.761	.205	.131	3.707	.000
	Do You Have A College Degree	.515	.157	.122	3.282	.001
	Married	-.896	.294	-.214	-3.048	.002
	Never Married	-.325	.293	-.080	-1.110	.267
2	(Constant)	5.141	.811		6.339	.000
	Age of Respondent	-.070	.018	-.153	-3.966	.000
	Religious Affiliation	-.223	.220	-.035	-1.011	.313
	Race of Respondent	.748	.206	.129	3.640	.000
	Do You Have A College Degree	.468	.160	.111	2.920	.004
	Married	-.831	.295	-.198	-2.819	.005
	Never Married	-.287	.292	-.071	-.980	.327
	Depressive Symptomology	.069	.053	.048	1.305	.192
	Self-Esteem (I Feel I'm a Person of Worth)	.242	.115	.085	2.104	.036
	Self-Esteem (On the Whole I am Satisfied With Myself)	.070	.101	.028	.694	.488
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.038	.102	-.015	-.369	.712

Dependent Variable: Having Time and Energy for My Career

Table 16

Hierarchical Regression Outcome for the Constraint My Spouse/Partner Having Time and Energy for a Career

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	5.670	.817		6.943	.000
	Age of Respondent	-.023	.025	-.049	-.922	.357
	Religious Affiliation	-.039	.301	-.006	-.131	.896
	Race of Respondent	.186	.353	.026	.528	.598
	Do You Have A College Degree	.261	.207	.065	1.260	.208
	Married	-.828	.391	-.203	-2.116	.035
	Never Married	.039	.426	.009	.093	.926
2	(Constant)	4.978	1.135		4.384	.000
	Age of Respondent	-.024	.025	-.052	-.961	.337
	Religious Affiliation	-.011	.304	-.002	-.036	.971
	Race of Respondent	.162	.361	.022	.448	.654
	Do You Have A College Degree	.208	.214	.052	.973	.331
	Married	-.687	.396	-.168	-1.733	.084
	Never Married	.117	.429	.027	.273	.785
	Depressive Symptomology	.052	.077	.036	.672	.502
	Self-Esteem (I Feel I'm a Person of Worth)	.304	.151	.113	2.013	.045
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.106	.142	-.042	-.749	.454
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.084	.142	-.032	-.596	.552

Dependent Variable: My Spouse/Partner Having Time and Energy for Career

additional variance accounted for by the addition of the independent variables into the model (see Table 17).

In regard to the item *disagreeing with my spouse/partner about having a child*, I found in Block 1 that marital status (being married as opposed to being never married or divorced) (B = -1.822, $p < .01$) was the only variable correlated with this item, and it was a negative correlation. Therefore, this item was less of a constraint if a woman was married. In Block 2, I found that there were no variables that were significantly correlated, either positively or negatively, with this item. Finally, the overall R-square value was .106 for Block 1 and .135 for Block 2, with 2.8% additional variance accounted for by the addition of the independent variables into the model (see Table 18).

Results for the Motivational Factors *Variable*

In regard to the item *giving my parents grandchildren*, I found in Block 1 that both age (B = -.044, p = .019) and education (B = -.415, p = .013) were negatively correlated with this item. Therefore, this item was less of a motivational factor for those women who were older and had a college degree. Further, religious affiliation (B = .780, p = .001), marital status (being married as opposed to being never married or divorced) (B = .844, p = .007), and race (B = .588, p = .007) were positively correlated with this item. Therefore, this item was more of a motivational factor for those women who were married, African-American, and affiliated with some type of religion. In Block 2, I found that depressive symptomology (B = .126, p = .024) was positively correlated with this item, but the self-esteem item *I am able to do things as well as other people* (B = -.254, p = .018) was negatively correlated with this item. Therefore, this item was more of a motivational factor for those women who had higher levels of depressive

Table 17

Hierarchical Regression Outcome for the Constraint Uncertain That My Marriage/Relationship Will Last

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	6.637	.993		6.681	.000
	Age of Respondent	-.062	.030	-.106	-2.056	.040
	Religious Affiliation	.105	.366	.013	.288	.773
	Race of Respondent	.661	.429	.072	1.542	.124
	Do You Have A College Degree	-.284	.252	-.056	-1.128	.260
	Married	-2.071	.475	-.402	-4.356	.000
	Never Married	-.796	.517	-.145	-1.539	.124
2	(Constant)	8.871	1.347		6.587	.000
	Age of Respondent	-.077	.030	-.131	-2.581	.010
	Religious Affiliation	.272	.360	.035	.755	.451
	Race of Respondent	.317	.428	.035	.740	.460
	Do You Have A College Degree	-.053	.254	-.011	-.210	.834
	Married	-1.923	.470	-.374	-4.090	.000
	Never Married	-.850	.508	-.155	-1.672	.095
	Depressive Symptomology	.240	.091	.134	2.634	.009
	Self-Esteem (I Feel I'm a Person of Worth)	-.185	.180	-.054	-1.032	.303
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.420	.169	-.133	-2.488	.013
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.003	.168	-.001	-.021	.983

Dependent Variable: Uncertain That My Relationship/Marriage Will Last

Table 18

Hierarchical Regression Outcome for the Constraint Disagreeing With My Spouse/Partner About Having a Child

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	5.411	.977		5.540	.000
	Age of Respondent	-.043	.030	-.075	-1.452	.147
	Religious Affiliation	.276	.360	.036	.767	.443
	Race of Respondent	.562	.422	.063	1.331	.184
	Do You Have A College Degree	.157	.247	.032	.634	.526
	Married	-1.822	.468	-.362	-3.893	.000
	Never Married	-.384	.509	-.072	-.754	.451
2	(Constant)	8.147	1.344		6.059	.000
	Age of Respondent	-.054	.030	-.094	-1.821	.069
	Religious Affiliation	.373	.360	.049	1.038	.300
	Race of Respondent	.384	.428	.043	.897	.370
	Do You Have A College Degree	.332	.254	.067	1.310	.191
	Married	-1.830	.469	-.363	-3.898	.000
	Never Married	-.480	.508	-.090	-.946	.345
	Depressive Symptomology	.064	.091	.036	.705	.481
	Self-Esteem (I Feel I'm a Person of Worth)	-.316	.179	-.095	-1.770	.077
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.303	.168	-.098	-1.802	.072
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.021	.168	-.007	-.125	.901

Dependent Variable: Disagreeing With My Spouse/Partner About Having a Child

symptomology, but less of a motivational factor for those women who reported higher levels of feeling they were able to do things as well as others. Finally, the overall R-square value was .062 for Block 1 and .077 for Block 2, with 1.5% additional variance accounted for by the addition of the independent variables into the model (see Table 19).

In regard to the item *having someone to care for me when I am old,* I found in Block that both age (B = -.036, p = .039) and education (B = -.295, p = .059) were negatively correlated with this item. Therefore, this item was less of a motivational factor for those women who were older and who had a college degree. Further, it was found that religious affiliation (B = .528, p = .015) and race (B = 1.105, p < .01) were positively correlated with this item. Therefore, this item was more of a motivational factor for those women who were affiliated with a religion and who were African-American. In Block 2, I found that depressive symptomology (B = .165, p = .002) was positively correlated with this item, but the self-esteem item *I feel I'm a person of worth* (B = -.222, p = .050) was negatively correlated with this item. Therefore, this item was more of a motivational factor the higher a woman's level of depressive symptomology, but less of a motivational factor the higher her score on feeling she was a person of worth. Finally, the overall R-square value was .071 for Block 1 and .100 for Block 2, with 2.9% additional variance accounted for by the addition of the independent variables into the model (see Table 20).

In regard to the item *having someone to love,* I found in Block 1 that both age (B = -.079, p < .01) and education (B = -.494, p = .003) were negatively correlated with this item. Therefore, this item was less of a motivation factor is a woman was older and had a college degree. Further, I found that race (B = .439, p = .041) was positively

Table 19

Hierarchical Regression Outcome for the Motivational Factor Giving My Parents Grandchildren

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	3.311	.618		5.357	.000
	Age of Respondent	-.044	.019	-.091	-2.350	.019
	Religious Affiliation	.780	.234	.116	3.338	.001
	Race of Respondent	.588	.216	.097	2.724	.007
	Do You Have A College Degree	-.415	.166	-.094	-2.497	.013
	Married	.844	.311	.192	2.715	.007
	Never Married	.558	.309	.131	1.805	.071
2	(Constant)	3.809	.853		4.463	.000
	Age of Respondent	-.048	.019	-.101	-2.580	.010
	Religious Affiliation	.751	.234	.112	3.210	.001
	Race of Respondent	.524	.216	.087	2.428	.015
	Do You Have A College Degree	-.338	.169	-.076	-1.998	.046
	Married	.849	.311	.193	2.733	.006
	Never Married	.552	.308	.129	1.792	.074
	Depressive Symptomology	.126	.056	.084	2.269	.024
	Self-Esteem (I Feel I'm a Person of Worth)	-.062	.121	-.021	-.507	.612
	Self-Esteem (On the Whole I am Satisfied With Myself)	.192	.106	.074	1.803	.072
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.254	.107	-.096	-2.370	.018

Dependent Variable: Giving My Parents Grandchildren

Table 20

Hierarchical Regression Outcome for the Motivational Factor Having Someone to Care for Me When I Am Old

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	3.215	.577		5.570	.000
	Age of Respondent	-.036	.017	-.079	-2.065	.039
	Religious Affiliation	.528	.218	.084	2.430	.015
	Race of Respondent	1.105	.203	.194	5.458	.000
	Do You Have A College Degree	-.295	.156	-.070	-1.895	.059
	Married	-.155	.292	-.037	-.530	.596
	Never Married	-.015	.290	-.004	-.052	.958
2	(Constant)	4.744	.795		5.969	.000
	Age of Respondent	-.045	.017	-.101	-2.636	.009
	Religious Affiliation	.567	.216	.090	2.622	.009
	Race of Respondent	1.018	.201	.178	5.071	.000
	Do You Have A College Degree	-.131	.157	-.031	-.830	.407
	Married	-.132	.289	-.032	-.457	.647
	Never Married	-.050	.287	-.012	-.174	.862
	Depressive Symptomology	.165	.052	.116	3.184	.002
	Self-Esteem (I Feel I'm a Person of Worth)	-.222	.113	-.078	-1.962	.050
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.052	.099	-.021	-.524	.600
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.103	.100	-.041	-1.033	.302

Dependent Variable: Having Someone to Care for Me When I Am Old

correlated with this item. Therefore, this was more of a motivational factor if a woman was African-American. In Block 2, I found that depressive symptomology was the only variable correlated with this item, and it was a positive correlation (B = .161, p = .003). Therefore, this item was more of a motivational factor the higher a woman's level of depressive symptomology. Finally, the overall R-square value was .068 for Block 1 and .094 for Block 2, with 2.6% additional variance accounted for by the addition of the independent variables into the model (see Table 21).

In regard to the item *needing something to do,* I found in Block 1 that both race (B = .738, p < .01) and religious affiliation (B = .464, p = .022) were positively correlated with this item, but that education (B = -.635, p < .01) was negatively correlated with this item. Therefore, this item was more of a motivational factor if a woman was African-American and associated with some type of religion, but less of a motivational factor if a woman had a college degree. In Block 2, I found that depressive symptomology (B = .137, p = .004) was positively correlated with this item, but that the self-esteem items *On the whole I am satisfied with myself,* (B = -.197, p = .031) and *I feel I'm a person of worth* (B = -.342, p = .001) were negatively correlated with this item. Therefore, this item was more of a motivation factor the higher a woman's level of depressive symptomology, but less of a motivational factor the more she was satisfied with herself and felt she was a person of worth. Finally, the overall R-square value was .068 for Block 1 and .119 for Block 2, with 5.1% additional variance accounted for by the addition of the independent variables into the model (see Table 22).

Table 21

Hierarchical Regression Outcome for the Motivational Factor Having Someone to Love

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	6.573	.610		10.773	.000
	Age of Respondent	-.079	.018	-.167	-4.328	.000
	Religious Affiliation	.403	.229	.061	1.759	.079
	Race of Respondent	.439	.214	.073	2.050	.041
	Do You Have A College Degree	-.494	.164	-.112	-3.006	.003
	Married	.152	.310	.035	.491	.623
	Never Married	.152	.309	.036	.491	.624
2	(Constant)	8.098	.841		9.624	.000
	Age of Respondent	-.089	.018	-.189	-4.910	.000
	Religious Affiliation	.454	.228	.068	1.988	.047
	Race of Respondent	.354	.213	.059	1.663	.097
	Do You Have A College Degree	-.327	.167	-.074	-1.966	.050
	Married	.178	.308	.041	.580	.562
	Never Married	.114	.306	.027	.372	.710
	Depressive Symptomology	.161	.055	.108	2.941	.003
	Self-Esteem (I Feel I'm a Person of Worth)	-.198	.119	-.067	-1.665	.096
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.096	.105	-.037	-.918	.359
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.081	.105	-.030	-.766	.444

Dependent Variable: Having Someone to Love

Table 22

Hierarchical Regression Outcome for the Motivational Factor Needing Something to Do

		Unstandardized Coefficients		Standardized Coefficients		
Model	Variable	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	1.918	.537		3.570	.000
	Age of Respondent	-.009	.016	-.022	-.570	.569
	Religious Affiliation	.464	.202	.079	2.299	.022
	Race of Respondent	.738	.188	.140	3.926	.000
	Do You Have A College Degree	-.635	.145	-.164	-4.394	.000
	Married	.374	.271	.097	1.382	.167
	Never Married	.429	.270	.115	1.592	.112
2	(Constant)	4.274	.731		5.846	.000
	Age of Respondent	-.021	.016	-.051	-1.350	.177
	Religious Affiliation	.531	.198	.091	2.682	.007
	Race of Respondent	.650	.184	.123	3.532	.000
	Do You Have A College Degree	-.433	.144	-.112	-3.002	.003
	Married	.378	.265	.098	1.426	.154
	Never Married	.370	.263	.099	1.406	.160
	Depressive Symptomology	.137	.047	.104	2.878	.004
	Self-Esteem (I Feel I'm a Person of Worth)	-.342	.104	-.131	-3.301	.001
	Self-Esteem (On the Whole I am Satisfied With Myself)	-.197	.091	-.087	-2.163	.031
	Self-Esteem (I Am Able to Do Things As Well As Other People)	-.017	.091	-.007	-.190	.849

Dependent Variable: Needing Something to Do

Test of Hypothesis #1

The first null hypothesis stated that there would be no relationship found between a respondent's level of depressive symptomology and the level of importance she gave to constraints in deciding to have children or motivational factors in deciding to have children. The results indicated that there was a positive relationship between a respondent's level of depressive symptomology and 5 of the 10 constraint items. They were (a) *my age*, (b) *being able to make major purchases*, (c) *being able to buy a home*, (d) *uncertain that my marriage/relationship will last*, and (e) *the stress and worry of raising a child*. Further, there was a positive relationship between a respondent's level of depressive symptomology and all four of the motivational factors: (a) *giving my parents grandchildren*, (b) *having someone to care for me when I am old*, (c) *having someone to love*, and (d) *needing something to do*. Therefore, the null hypothesis can be rejected and the conclusion reached that there were relationships found.

Test of Hypothesis #2

The second null hypothesis stated that there would be no relationship found between a respondent's level of self-esteem and the level of importance she gave to constraints in deciding to have children or motivational factors in deciding to have children. I found that the self-esteem item *I feel I'm a person of worth* was positively correlated with three of the constraint items. They were (a) *having time for leisure activities*, (b) *having time and energy for my career*, and (c) *my spouse/partner having time and energy for a career*. Further, this item was negatively correlated with two of the motivational factor items: (a) *having someone to care for me when I am old* and (b) *needing something to do*. I found that the self-esteem item *On the whole I am satisfied*

with myself was negatively correlated with one of the constraint items: *uncertain that my marriage/relationship will last*. Further, this item was negatively correlated with one of the motivational factor items: *needing something to do*. Finally, I found that the third self-esteem item *I am able to do things as well as other people* was correlated with only one item, and it was a negative correlation. The item was the motivation factor *giving my parents grandchildren*. Therefore, the null hypothesis can be rejected and the conclusion reached that there were relationships found.

Test of Hypothesis #3

The third null hypothesis stated that there would be no relationship found between a respondent's level of global optimism and the level of importance she gave to constraints in deciding to have children or motivational factors in deciding to have children. I found that the global optimism variable was a particularly poor measure, and therefore I decided to drop it from the final hierarchical regression analysis. Thus, the null hypothesis cannot be rejected.

Test of Hypothesis #4

The fourth null hypothesis stated that there would be no relationship found between a respondent's level of global life satisfaction and the level of importance she gives to constraints in deciding to have children or motivational factors in deciding to have children. I found that the global life satisfaction variable was a poor measure, and therefore I dropped it from the final hierarchical regression analysis. Thus, the null hypothesis cannot be rejected.

Chapter 5: Conclusions and Discussion

The majority of the sample for the present study were white, not married, did not have a degree, and were affiliated with some type of religion. Further, the majority of the respondents were depressed 2 or fewer days of the week and had high levels of global life satisfaction, global optimism, and self-esteem. The respondents also scored from low to mid-range on the items contained in the dependent variables (constraints and motivational factors).

There were several correlation tables constructed to demonstrate initial relationships between variables, and these included the following: (a) a correlation table comparing the independent variables to one another, (b) a correlation table comparing the independent variables to the control variables, (c) a correlation table comparing the independent variables to the dependent variable *constraints*, and (d) a correlation table comparing the independent variables to the dependent variable *motivational factors*. There were several correlations observed that were significant, although weak.

The final analysis procedure conducted was that of hierarchical regression. There were two blocks in the regression, with the first block containing control variables and the second block containing independent variables (depressive symptomology and self-esteem). The independent variables *global life satisfaction* and *global optimism* were dropped from the hierarchical regression analysis because they proved to be poor measures. There were several results obtained from this procedure.

Conclusions from the Study

First, it was found that the depressive symptomology variable was positively correlated with several of the constraint items and all of the motivational factor items.

Thus, I concluded that certain constraints and motivational factors become more of an issue for women who are depressed. The alternative hypothesis stated that there would be a positive relationship between an individual's level of depressive symptomology and the dependent variables (constraints and motivational factors), and this was the finding. Next, it was found that the self-esteem items were both positively and negatively correlated with various constraints and motivational factors. More specifically, there was a positive relationship between the self-esteem items and the majority of constraints and a negative relationship between the self-esteem items and the motivational factors. Further, two of the self-esteem items, *I feel I am a person of worth* and *On the whole, I am satisfied with myself,* were found to be correlated with the dependent variables more often than was the item *I am able to do things as well as other people*, with the item *I feel I am a person of worth* being the most often correlated with the dependent variables. The alternative hypothesis stated that there would be a negative relationship between level of self-esteem and the dependent variables (constraints and motivational factors). This was the case for several items but not all, and there was a positive relationship between certain items.

The overall hierarchical regression analysis procedure demonstrated that very little variance was accounted for by the addition of the second block of variables into the analysis. In fact, the highest additional variance found was only slightly above 5%. I found this disappointing, but I interpret it to mean one of two things. First, the lack of additional variance might demonstrate the importance of the influence of the control variables (i.e., age, race, religious affiliation, education, marital status) on the dependent variables. However, it might be the case also that the control variables were measured

more precisely than the independent variables. In either case, the fact remains that very little additional variance was found.

Discussion

The experiences of women who suffer from depression vary from one woman to another, and this makes the illness difficult to define and explain in specific detail. Further, it is clear that women who suffer from depression and wish to become mothers must face certain decisions when considering this momentous event in their lives. The implications for children of mothers who suffer from depression include decreased social, cognitive, and affective abilities (Austin, 2003; Lyons-Ruth, Wolfe, & Lyubchik, 2000), and women must take these implications into consideration when thinking about motherhood. Further, women who suffer from depression must consider both certain restraints and motivational factors that might affect their decision of whether or not to pursue motherhood.

The results of the study indicated that women who suffer from depression do indeed consider certain constraints and motivational factors when thinking about becoming a mother. The results indicated that there was a positive correlation between a woman's level of depressive symptomology and her level of the constraints concerning economic well-being, relational status, and the stress associated with caring for a child. Further, the results indicated that there was a positive correlation between a woman's level of depressive symptomology and her level of all four motivational factors (i.e., having someone to love, needing something to do, having someone to care for her when she is old, and giving her parents grandchildren) indicated in the study. The results further indicated that there was a negative relationship between one of the self-esteem

items and a woman's level of the constraint concerning her relational status, although there was a positive relationship between two of the self-esteem items and the constraints regarding issues of time. Further, all three of the self-esteem items were negatively correlated with at least one of the motivational factor items.

It does appear from the results obtained in this study that women who suffer from depressive symptomology do consider certain issues more often than others when thinking about having a child. Further, it appears that both the motivational factor items and the constraint items were considered when thinking about having a child. Finally, it appears that the self-esteem items demonstrate both negative and positive correlations with constraints, although only negative correlations with motivational factors.

It was not surprising that there were significant positive relationships found between the level of a woman's depressive symptomology and the consideration she gives to both constraints and motivational factors in deciding to have a child. Although it might seem at first glance that there would be a positive relationship between depressive symptomology and constraints and a negative relationship between depressive symptomology and motivational factors, one must consider the types of motivational factors included in the study. The motivational factors focus on what the woman receives from the mother-child relationship, not what one might consider typical motivating factors (e.g., bringing another living being into the world, sharing your love with a child). Therefore, after consulting the empirical literature dedicated to examining the varying symptoms of depression, one can see that it makes intuitive sense, as motivational factors are defined here, that there would be a positive relationship between the level of

depressive symptomology a woman experiences and the motivational factors included for use in the study.

Implications for Theory

In regard to social exchange theory, I found my initial notions confirmed. I had the notion that women would attempt to both maximize their rewards and minimize their costs in their relationships with future children, and the results indicated that this was so. Further, these relationships might exist, at least on some level, because women who suffer from depression are seeking a maximally rewarding relationship that will enhance their emotional life. Therefore, the results point to the need for more exploration on the topic of emotion in social exchange theory and how this concept influences the ideas of cost and reward.

In regard to implications concerning social constructivism, I found the need for an increased awareness of the role of language in the theory. The language used to describe depression denotes negative ideas and concepts, and women may internalize these. Further, if a woman constructs her own reality with such negative terms and concepts, she may indeed consider more constraints and motivational factors in her childbearing decision than someone who is not depressed. Therefore, it would be of great interest and importance to investigate ways to aid women in constructing positive life stories.

Finally, in regard to biosocial theory, I found the theory to fit well with the topic at hand and believe that depression is an illness that is both a biological and a societal issue. There is much research concerning the physical aspects of depression, but there is evidence also to support the impact of society on this illness. Further, I see the need for even greater research on the theory so as to better determine if there is a more exact fit

between depression and the physical realm or between depression and the societal realm. However, it is my notion that both realms are involved considerably in the illness.

Implications for Future Research

The current amount of empirical literature dedicated to the issues of women who suffer from depression and their childbearing considerations is notably lacking. There is much research to help explain the problems women experience with postpartum depression, and there is research also devoted to the effects of maternal depression on child outcomes. However, when examining the literature concerning what women who have no children and suffer from depression think about their childbearing considerations, one encounters a problem. This gap in the literature does not mean that the topic is not important and does not warrant further empirical research. In fact, the opposite is true: We need more research conducted on this topic.

One way to better study the topic at hand would be to pursue some type of qualitative research, perhaps interviewing depressed women and examining their responses. I learned in this thesis project that secondary data analysis is probably not the best form of research to use when studying this topic and a more hands-on approach might yield more information. However, it must be noted that depression is an issue that many women do not feel comfortable discussing with others, particularly strangers. Therefore, it might be of help, and more honest information might be obtained, if the researcher had personal experience with the illness so as to better relate to others suffering from the condition. Another interesting possibility to consider for future research would be to examine on-going support group or family life education efforts geared toward these women. The preventive and interventive efforts designed to aid

these women is lacking, and it would be profitable to examine any that are in progress and how effective they are in helping women. It would further be interesting to note ways for the programs to improve their outreach and education efforts.

In sum, the need for future research regarding the topic at hand is warranted, and there are various techniques one might use to gather this research. Also, the preventive and interventive programs aimed at helping these women must not be overlooked, but rather they must be examined, and the cause furthered, so as to enable women to more effectively cope with their illness.

Implications for Practice

As stated previously, one of the objectives of the study was to examine various family life education programs that might aid women who suffer from depression and affirm their worth as mothers, if motherhood is a choice they wish to make. It was found that there are very few programs enacted at this time that target the particular population discussed here. However, there is hope! There are several programs just beginning to flourish that target parenting from the perspective of a woman suffering from depression. However, the need is still great, and more programs would benefit all involved.

If I were to design a program targeting this specific population of women, I would begin with very general information on both parenting and depression. It is vital that women understand the basics of physiological, psychological, emotional, and mental changes they will undergo when becoming mothers, and it is just as vital that they adequately understand their illness. Perhaps a program would involve an obstetrician discussing pregnancy and a psychologist discussing depression. If this wasn't possible, it

would be beneficial to at least provide the audience with advice from these types of professionals via handouts or videos.

Second, after discussing the basics of both parenting and depression, I would try to engage the women in a discussion noting the relationship between anger and depression. As stated in the literature review, many women struggle with the issue of anger when dealing with their depression. Therefore, it might be useful for the program coordinator to discuss varying anger management techniques for those who experience outward bursts of anger and varying coping mechanisms for those who experience a feeling of sadness and loneliness as a mask for their anger.

Third, I think it would be important for women to understand the connection between biology and society when trying to cope with their illness. It would be helpful to explain what is occurring on the physical level in a woman's body that makes her prone to the illness, as well as varying types of physical management techniques (e.g., relaxation techniques, meditation techniques). Further, the social arena of a woman's life is flooded daily with varying relationships that must be understood and enhanced. One way to address this aspect of the illness of depression would be to have a discussion of possible role strains and relationship issues and ways to cope with these.

Finally, if I were designing a family life education program geared toward this population of women, I would have to mention the importance of language as it relates to the illness of depression. I would tell women that the negative language they use to describe both themselves and their illness is harming their creation of a positive life story, and I would initiate group activities designed to enhance positive language acquisition. This might involve some type of role playing activity, simple group discussion, or one-

on-one positive affirmation sessions. However, no matter the type of arrangement, women need to be advised of the importance of language in constructing positive life stories.

In conclusion, it is vital that women who suffer from depression and are considering parenthood be provided several services in a family life education program. They should be taught the following objectives: (a) general information about parenting and depression, (b) the connection between anger and depression, (c) the connection of the biological and societal realms in regard to depression, and (d) the importance of language in constructing positive life stories. However, I do realize that family life education programs are not as easily assembled as I have outlined here. I realize also that these objectives are just the tip of a very large iceberg of potential objectives possible to use with this population. Nevertheless, it is important that there be effort devoted to this type of programming so as to aid women who suffer from depression and their potential children.

Limitations of the Study

There were several limitations of the study, and these should be taken into consideration when noting the results found. First, the chosen analysis procedure for the study was that of secondary data analysis, and although secondary data analysis can be a wonderful way of investigating research questions, it also is limiting in the information it provides. The particular data set chosen (the NSFH-Wave 1) came closest to answering the questions investigated, but it did not answer the questions in a precise manner. Therefore, my research questions had to be changed somewhat so that adequate information could be obtained from the data set. Second, only the first wave of the data

set employed was chosen because it came closest to answering the questions being investigated. However, this meant that the data chosen were rather dated, and there is a strong possibility that ideas about mental illness have changed since the time of the first wave of the survey (whether that means less stigmatization concerning mental illness or simply a greater degree of understanding), as have medical interventions, and thus individuals might answer differently today given the same survey. Next, I must consider the fact that addressing all of the constraint items was a poor decision. The final analysis procedure yielded a total of 14 various hierarchical regression outcomes, and this analysis became both tedious and time consuming. Further, I found myself less interested in certain items (e.g., economic constraint items and spouse/partner relationship items). Therefore, it might have been a better idea to focus on only those constraint items that dealt directly with the topic at hand. A final limitation of the study was the use of one-item measures for global optimism and global life satisfaction. It is very difficult to measure any concept with only one item, and any results found must be considered in light of this fact. Because secondary data analysis was chosen as the analysis procedure, the data provided were all that were available for use.

In regard to limitations found in the actual analysis procedure, there were several. First, all the relationships found between the variables were weak. Although there were significant relationships found, one must consider the fact that they were not strong relationships and take this into account when interpreting results. Second, although the sample size for the project was rather large, there were not many respondents who scored very low on any given independent variable, and this fact should be taken into consideration when interpreting results. Next, although the global life satisfaction and

global optimism variables were dropped from the analysis, there is a further limitation with these variables in that, although I tried diligently, I never could find appropriate sources stating the validity or reliability for the scale from which the items were taken (Quality of Life Scale-Institute for Social Research at Michigan). Additionally, there was a significant correlation found between two of the self-esteem items (although the correlation was weak), and this is problematic. Therefore, it must be considered that the self-esteem items should have been grouped together into one self-esteem score. Finally, there were significant correlations between certain of the independent variables and the control variables (although the correlation was weak), and this also must be considered when interpreting results.

Summary

In sum, women who suffer from depression do appear to consider certain constraints and motivational factors when making decisions about their future status as mothers. Further, this population of women often is neglected in family life education efforts, both preventive and interventive. In light of this information, I conclude that there is a definite need for both future research on the topic and the development of family life education programs geared toward this population of women. It is my hope that the time of this research and outreach work has come.

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