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An examination of the relationship between perceived spousal social support and mood state of primiparous postpartum women, and the subsequent effect on maternal role identity.

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AN EXAMINATION OF THE RELATIONSHIP BETWEEN PERCEIVED SPOUSAL SOCIAL SUPPORT AND MOOD STATE OF PRIMIPAROUS POSTPARTUM WOMEN, AND THE SUBSEQUENT EFFECT ON MATERNAL ROLE IDENTITY

By

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ABSTRACT

It is estimated that up to 85% of all women experience a form of mood disturbance in the postpartum period, most often in the form of postpartum "blues". Up to 20% of women experience a more serious postpartum depression although accurate determination of incidence and prevalence has been challenging. Postpartum depression has considerable ramifications on cognitive and behavioural development of the infant, and integrity of the family unit. It has been generally accepted that the perception of spousal support reduces the occurrence of postpartum mood disturbance (Mercer, 1995) and contributes to effective maternal role identity and attainment (Meighen, 2002).

The Perceived Social Support – Family scale (PSS-Fa) (Procidano & Heller, 1983) and Postpartum Depression Screening Scale (PDSS) (Beck & Gable, 2002) were used to collect data about postpartum mood and perceived spousal social support from 21 new mothers who were married/cohabiting with the fathers of their babies. Results showed that more than 60% of participants were showing signs of postpartum depression despite the fact that all women reported levels of perceived spousal support ranging from moderate to extremely high. Previous studies of postpartum mood have used the Edinburgh Postnatal Depression Scale (EPDS). Use of the Postpartum Depression Screening Scale (Beck & Gable, 2002) allowed closer examination between perceived support and each of the identified dimensions of depression, again with results not consistent with previous literature. Based on the characteristics identified by Mercer (1985) as comprising maternal role identity – attachment, competence and gratification – analysis of a group of 3 dimensions of postpartum mood was done to look at the relationship of inferred role identity and perceived social support.

Findings of the study provided a suggested framework for further research with a larger and more heterogeneous sample. Implications for changes in nursing were identified for delivery of both prenatal education and postpartum mental health.

DEDICATION

To my children Michael, Blythe and Claire for always showing an interest in what I was doing at school … and for not being embarrassed that I was attending university at the same time as them!

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CHAPTER 1

Introduction

The birth of a child changes the focus of the marital relationship from an "adult-focused dyad to a child-centred triad" (Koniak-Griffin, 1993, p. 259). The actualization of maternal role identity, identified by Mercer (1995) as the last of four stages in achieving maternal role attainment, does not occur in isolation, but evolves within the emotional milieu of the nuclear family, or mother-father-child triad (Donley, 1993). Mercer (1995) described the components of role identity as the demonstration of competence in mothering behaviours, expressed gratification in mother/child interactions, and attachment to the infant. The quality of a woman's relationship with her husband or partner, social support, and stress have both indirect and direct effects on the mother/child relationship and formation of maternal role identity (Mercer, 1995). Studies by Fowles (1998) and Westbrook (1978) have shown that both mood state of a woman and social support from her spouse/partner are two key factors in her adjustment to, and attainment of the maternal role. Role identity is also realized in the absence of depression, good self-concept, and ego strength (Fowles, 1996).

Purpose of the Study

The purpose of this study was to examine the relationship between perceived spousal social support and the mood state of primiparous postpartum women, factors believed to be the foundation of an environment harmonious with the realization of maternal role identity. Previous work has shown that there is a relationship between postpartum depression (PPD) and perceived social support of a spouse (Mauthner, 1998;

O'Hara, 1986). No studies have looked at the relationship between the *continuum* of mood and *degree* of perceived social support in relation to maternal role identity.

Mood has been described as a "prolonged emotional state that influences a person's whole personality and life functioning" (Stuart & Laraia, 1998, p. 349). Mood variations are a natural pattern in the course of one's life and are indicative of emotional responsiveness to a perceived event. Mood state can be either adaptive or maladaptive. For example, in Western society experiencing grief after the death of a significant other is part of an adaptive process, whereas denying grief would be considered to be a maladaptive response. Becoming a mother is assumed to be a happy occasion (Nicolson, 1990). Much has been presented in both popular literature and the media romanticizing the role of motherhood (McIntosh, 1993). Unfortunately, the postpartum experience for many women does not match what is seen on television and in magazines, and some mothers remain unprepared for the extent of fatigue and the emotional demands following childbirth (Rubin, 1984).

It has been estimated that after childbirth, the majority of women experience some form of mood disturbance: up to 85% experience postpartum blues, approximately 10 to 20% experience postpartum depression (PPD) and a very small number, 1 to 2 in every 1000 births, suffer from postpartum psychosis (Bright, 1994). While statistics indicate that up to 20% of women experience an actual depression in the postnatal period, it is reasonable to suggest that there are a significant number whose mood falls short of the diagnostic criteria for clinical depression. In a study of depression and maternal role attainment, Fowles (1998) found that more than 60% of women indicated some degree of dysphoria, or mood disturbance postpartum.

These identified mood states can be viewed as being points on a continuum of mood response in the postpartum period when a woman is adjusting to her changing role. Postpartum blues have been described as a transitory condition that occur 3 to 5 days after childbirth, characterized by crying, anxiety, mood lability, sadness and irritability (O'Hara, Schlecte, Lewis, & Wright, 1991). Pitt (1968) stated that the 'blues' are so common that they should be considered part of normal maternal behaviour rather than a psychiatric condition. This would suggest that the 'blues' could be placed at the 'adaptive' end of the mood continuum.

Of more clinical severity is the phenomenon known as postpartum psychosis. It has been estimated this form of psychosis affects 1 to 2 of every 1000 women. A psychosis, during which the individual loses touch with reality, is generally manifested 2 to 3 days after delivery and is considered to be an emergency requiring immediate medical intervention (Bright, 1994). Postpartum psychosis could be placed at the other end of the mood continuum and would be considered to be an extremely maladaptive response.

Significance of the Topic

Work in the prevention of postpartum mood disturbances is significant for several reasons. It has been found there is a relationship between satisfactory maternal role attainment and mood of the mother (Mercer, 1995). Distressed maternal mood and subsequent poor maternal role performance could have a significant impact on the child that could, in turn, have lasting effects (Field, 1995). Murray and Cooper (1996) found a significant relationship between severity and chronicity of maternal mood disorder and outcome for the child. The incidence of behavioural problems in pre-schoolers has been

linked to maternal depression in the postnatal period (Coghill, Caplan, Alexandra, Robson, & Kumar, 1986; Field, 1995). Infants of depressed mothers develop a depressed style of interaction that extends to their interactions with other non-depressed people (Field, 1995). When maternal depression is resolved before 6 months, the negative mood state of the infant is also likely to change. However, infants of mothers who remain depressed for longer than 6 months maintain a *depressed* mode of interaction and show developmental delays at 1-year of age (Field, 1995). The spouse or partner of a depressed woman could also be at risk for developing depression (Lovestone & Kumar, 1993). This in turn could have an impact on the child through poor parental role performance and a depressive milieu in the home.

Living with a mood disturbance, whether it is a full-blown depression or merely a state exhibiting some of the characteristics of depression, is an unpleasant experience. Women who suffer from a mood disturbance, such as depression following childbirth,describe their lives as empty and devoid of pleasure, feeling they are robotic and stripped of emotion (Beck, 1992). In the clinical setting, it has been the experience of the author that women who have recovered from depression during this period have expressed relief and happiness that their mood lifted. However, that feeling was sometimes overshadowed by the sense of sadness they have over the loss of anticipated joy of childbirth and the knowledge that they would never be able to recapture that time.

Perceived social support is defined as the generalized sense that the individual is cared for and valued. Social support is informal and provided by others within ones social group (Cohen & Hoberman, 1983; Stewart, 1993; Thoits, 1986). It is manifested in the

provision of information, assistance with tasks, emotional support and the availability of others to talk about one's problems (House & Kahn, 1985).

The tendency of the dysphoric individual to withdraw and become socially isolated has been shown to lead to a disturbance in satisfactory interpersonal relationships and cause disruptions in family functioning (Coghill et al., 1986). Studies have shown that most women with postpartum mood disturbances experience difficulties within the marital relationship (Mauthner, 1998). A poor marital relationship could influence a woman's mood, or vice versa. Serious mood disturbance could contribute to the development of negative perceptions and faulty cognitions (Whiffen & Gotlib, 1989) and such thoughts could affect how the woman perceives the support she gets from her husband as well as influence how she views the entire relationship. Mercer (1995) found that the perception of spousal support reduces the chance of developing a postpartum mood disturbance and also contributes to effective maternal role attainment (Meighan, 2002). In fact, the mother's relationship with her partner contributes to the process of maternal role attainment in a manner that is unparalled by others (Meighan, 2002).

Maternal role attainment (MRA) has been defined as the process by which the new mother "achieves competence in the role and integrates the mothering behaviours into her established role set, so that she is comfortable with her identity as a mother" (Mercer, 1985, p. 198). Positive interactions between the mother and her partner assist in the diffusion of any tension involved in role adaptation and help facilitate the process (Meighan, 2002). Of course, the reverse also applies. Negative interactions or role conflict between mother and her partner could hinder the process of maternal role attainment (Koniak-Griffin, 1993). Mercer (1985) expanded on Rubin's (1984) earlier

work that focused on the transition of women into the mothering role, and the significance of nursing in facilitating maternal role adaptation.

Theoretical Framework

Mercer's (1985) theory has been applied in clinical obstetrical nursing practice. Meighan (2002) depicted the model in a diagrammatic way using a systems approach (Figure 1). The model shows the microsystem of mother-father-infant interaction which is most influential, and within which maternal role identity is achieved. Personality traits and behaviours of both mother and child that influence the formation of role identity and subsequent MRA, are included in the model, and are considered within the context of the mother-father relationship. Maternal variables affecting MRA are age, self-esteem, confidence in the role, perceptions of the birth, mental health and personality traits, and role conflict or strain. Infant-related factors that may have an impact on MRA are temperament, the ability to give cues, physical appearance, responsiveness, and health status.

There are four stages identified in the process of MRA, the last being formation of maternal role identity: anticipatory, formal or role-taking, informal or role-making, and the personal stage or role identity. The anticipatory stage begins during pregnancy and involves psychological and social adjustments to the state of pregnancy. The woman generally seeks information about pregnancy and mothering, and engages in visualization and fantasy about what the maternal role entails. During the role-taking stage, which begins with the actual birth, the woman learns about mothering from health care professionals and others who are already in the role. She replicates the behaviour of

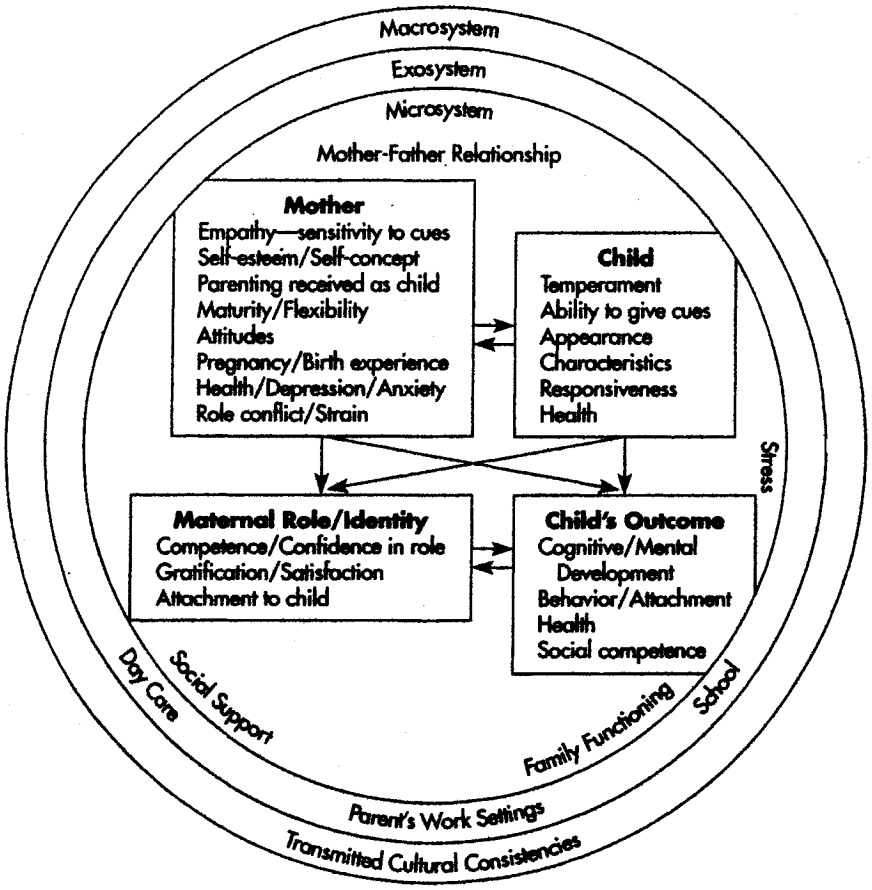

Figure 1. Model of Mercer's Theory of Maternal Role Attainment. This diagram depicts the microsystem of mother-father-infant interaction within which role identity is achieved.

other mothers whom she knows at this time. Role-making occurs when the mother gains comfort in the new role and learns to recognize cues from the infant. She now adapts the maternal role to suit herself.

The final stage (role identity) begins with the integration of the maternal role into the woman's sense of self. The role becomes internalized and the woman develops a feeling of mastery and competence (Koniak-Griffin, 1993). She learns to read her infant's cues and develops her own individual style of mothering. Her competence, or maternal behavioural repertoire, is the result of scrutinization of others in the same role, trial, error and resulting success. Over the course of the first year, a mother must continue to adjust her mothering style to suit the developmental needs of her child, therefore the stages of MRA are not necessarily linear. Mercer's 1985 study of women of varying ages showed a woman's sense of maternal competence ebbs and flows during the first year, being particularly low when the child reaches eight months. This downward turn in not only competence, but also attachment and gratification (the other dimensions of role identity) is felt to be the result of changes in infant behaviour, such as stranger anxiety, increased autonomy, and fretfulness related to teething.

Gratification, or satisfaction in the maternal role is the sense of pleasure and reward that a mother experiences in both carrying out mothering tasks and in interacting with her child. Gratification is important as it provides the motivation for mothering. Attachment to the infant increases over the first few months after birth and is often accompanied by a wide range of emotions – guilt being a predominant one. Mercer (1995) states that role identity may be achieved after a month or so, or may require several months.

During pregnancy the woman begins to form images of herself in the new role and she will frequently engage in fantasy. These fantasies are predominantly of the child and tend to lean toward the idyllic (Rubin, 1984). The ideal self, the vision of how she would like to be, is continually reshaping with each new experience of the woman. However, a discrepancy between the ideal self and the self-image, how she sees herself in reality, can lead to despair and depression (Rubin, 1984).

Disappointment in a woman's perception of her performance in the maternal role can lead to frustration. The frustration arises from a perceived discrepancy between her self-image and her ideal self. The self-image is driven to understand the realities of the world and also identifies the attributes of the ideal self. If able, the mother will seek equilibrium between the ideal self and self-image by seeking out information thereby minimizing the discrepancy (Mercer, 1995).

CHAPTER 2

Review of the Literature

Although the purpose of the study was to examine mood state of postpartum women, much of the literature presented here focuses on postpartum depression (PPD) – one pole of the mood continuum - due to the fact that there is a wealth of literature on the subject. Postpartum depression is a widely recognized mental disorder of the puerperium, or early postnatal period. The actual prevalence rate is unclear partly due to the fact that there is no consensus on a clear definition of PPD (Affonso & Domino, 1984). What is evident is that at least 10% of postnatal women are affected (Affonso et al., 1992; Beck, 1993; McIntosh, 1993) however, it has been felt that this number is a conservative estimate (Pitt, 1968) due to several factors.

Challenges Determining Incidence of Postpartum Depression

The first factor has been the underreporting of symptoms of depression. Many women feel threatened by being identified as having a mental illness, so avoid seeking professional help (Beck, 2001; Ugarriza, 2000). It has been reported that less than half of depressed mothers seek help from anyone (McIntosh, 1993). There are two reasons for their reluctance to get help – first, the belief that PPD is *normal* and more of a social problem than a medical one, and secondly, that telling others of their emotional condition might lead to being labeled as mentally ill and, hence, a *bad* mother. The label of mental illness carries with it social stigmatization. Many people fear that even brief contact with a mental health professional will brand them as a psychiatric patients for life. Women commonly express embarrassment and shame at feeling depressed. They feel inadequate in the mothering role and think that by admitting to depression they are admitting failure

as mothers. Seeking professional help may be the last course of action taken by depressed women and only when symptomatology becomes unbearable.

There has been a tendency to group together various dysphoric affects following childbirth into a single label of depression (Affonso et al., 1992; Beck, 1998; Metz, Sichel, & Goff, 1988). Other dysphoric conditions, such as obsessive-compulsive, anxiety and panic disorders, may also be precipitated by the birth experience. Obsessive-compulsive disorder has been characterized by obsessional thinking, when the individual becomes preoccupied with an idea, and compulsive behaviour, which is the overwhelming urge to carry out certain behaviours as a means to alleviate anxiety. For example, a woman may fear that serious harm may come to her baby. She may have visions in her mind of an accident occurring in the kitchen with knives. It may have begun with her thinking how awful it would be if she accidentally dropped a knife on the baby. This thought may begin to preoccupy her, thereby significantly increasing her anxiety. In order to control her level of anxiety, she may check repeatedly that no knives are left out, she may insist that all knives be locked up, or even dispose of all knives in the house. However, she may not identify that something is wrong, as she does not experience a depressed mood.

It has been recognized that life events that impact on one negatively can precipitate panic attacks. It has been observed that some women present with a history of panic attacks subsequent to delivery without reported feelings of depression (Metz et al., 1988). The development of panic disorders in the postpartum period is not felt to be coincidental, but rather is seen as a sequela of childbirth (Sholomaskas et al., 1993).

In conclusion, *postpartum depression* has historically been used as a term to describe many postpartum mood disorders. However, in order for appropriate treatment it is important that the correct diagnosis be made. Because of this tendency to categorize several mood disorders together, inaccuracies in determining the incidence of PPD has continued.

Characteristics of Postpartum Depression

The characteristics of PPD have been well documented (Beck, 1992, 2001; Mauthner, 1999; Pitt, 1968; Ugarizza, 2002). Postpartum depression is considered to be not unlike a regular clinical depression unrelated to childbirth. Symptoms must be present for longer than 2 weeks and include feelings of sadness, anxiety, feelings of inadequacy, guilt, worthlessness, changes in eating and sleeping patterns, loss of interest in things previously identified as pleasurable, tearfulness, and irritability or lability of mood. There may also be intrusive, compulsive thoughts and suicidal ideation (Beck, 1992; Pitt, 1968). What differentiates PPD from other depressions are the feelings of guilt and inadequacy emanating specifically from the sense of being an incompetent and inadequate mother (Fowles, 1998).

Predictors or Risk Factors of Postpartum Depression

Early work looking at predictors of PPD described them as basically falling into three categories: psychoanalytic theories, personality theories and biophysical theories. More recently, Beck (1996) grouped the factors into four categories: history of psychiatric disorders in the mother and/or her family, psychosocial, obstetrical and physiological factors. Psychosocial factors concern the individual's place in society such as socioeconomic status, relationships with others and adaptation techniques employed in

times of stress and hardship. Obstetrical factors involve the course of the pregnancy, including any complications, the process of childbirth and the immediate period afterwards. Physiological factors include hormonal changes experienced during the pre- and postnatal period. However, Beck (1996) did indicate that physiological variables and obstetrical factors have not been consistently associated with the propensity for developing PPD.

Biophysical theories include the theory of fluctuation of hormone levels, as well as genetic predisposition and history of depression, mania or psychotic episodes. It was originally thought that the occurrence of PPD was primarily resultant of the physiological events following childbirth, namely the radical shifts in levels of estrogen, progesterone and prolactin. However physiological theories do not explain why the majority of women do not suffer from PPD even though all women experience hormonal fluctuations, and, also, not all women with a history of depressive illness experience depression after childbirth (Affonso & Domino, 1984). Additionally they do not explain why some postpartum depressions develop several weeks postnatally when hormone levels have settled.

There has been a resurgence of interest in the role of thyroid gland changes as related to postpartum depression. The majority of women show significant enlargement of the gland during the first trimester of pregnancy (Harris, 1996) and postpartum thyroiditis, or inflammation of the thyroid, has been demonstrated to be the most common of all endocrinologic diseases (Stagnaro-Green, 2000). Hypothryoidism (an underactive thyroid) and depression share many common symptoms such as dysphoria, weight gain, loss of interest, anhedonia, lack of energy, etc., while hyperthyroidism (an

overactive thyroid) and anxiety with agitation have similar presentations (Harris, 1996; Harris et al., 2002; Stagnaro-Green, 2000). Researchers felt that some cases of PPD could actually have been incidences of thyroid dysfunction and a study was conducted whereby thyroid-antibody-positive women who were identified in pregnancy were treated with thyroxine for a 6-month period postnatally. However, the hormonal treatment did not decrease the incidence of PPD and the researchers felt that PPD is more likely associated with the commonly identified risk factors, such as history of psychiatric disorder, poor self-esteem, and lack of social support, rather than abnormal thyroid function (Harris et al., 2002).

Early on it was believed that childbirth factors for PPD included a complicated pregnancy leading to "increased obstetrical manipulation" (Affonso & Domino, 1984, p. 233) such as expensive prenatal monitoring and surgical interventions like caesarean section. Other obstetrical factors are unplanned and possible unwanted use of anaesthetics and analgesia, a long labour, and difficult and stressful delivery. However, as mentioned above, obstetrical factors have not been consistently linked with the potential for developing PPD (Beck, 1996). Unresolved issues related to unmet expectations in such a labour and delivery may preoccupy the new mother afterwards, although this could fall into the psychosocial category (Affonso & Domino, 1984).

More recently, risk factors have been classified into three other categories: pregnancy, childbirth and postpartum factors. Pregnancy factors include an unplanned or unwanted pregnancy, physical changes during pregnancy causing fatigue, decreased self-confidence and mood, body image disturbances causing anxiety, physical complications,

and financial, housing and employment concerns due to the pregnancy (Affonso & Domino, 1984). Childbirth factors have been previously described.

Beck (2001) conducted a meta-analysis of the literature regarding risk factors and her findings corroborated that marital status, socioeconomic status, unplanned or unwanted pregnancy and self-esteem were predictors not previously broadly considered. Marital status and socioeconomic variables may lead to feelings of social isolation, and financial difficulties could impact on the woman's transition into motherhood. An unplanned pregnancy presents the challenge of coming to terms with an event that will have life-long ramifications regardless of whether or not the pregnancy is wanted.

Postpartum risk factors include anxiety or stress related to adjustment to the mothering role, preoccupation with unresolved issues related to unmet expectations of the delivery, lack of social support including poor relationship with the baby's father, having a sickly or premature baby, being an older mother, experiencing disruptions in 'normal' day-to-day functioning and buying into unrealistic portrayals of motherhood in the media (Affonso & Domino, 1984). However a study by Hall, Kotch, Browne, & Rayens (1996) found a weak association between degree of mood disturbance and infants at biomedical risk. They noted that mothers were grateful that their babies had survived the birth experience and were no more depressed than mothers of healthy infants. It should be mentioned that the mothers studied were largely from a low socio-economic background and challenged by a high number of life stressors.

Studies have shown self-esteem to play an important role in the presence of depressive symptoms as a mediator between stressors and mood. Specifically, the better the self-esteem, the lower the level of depression (Hall et al., 1996). It has been found

that during a life crisis, women with low self-esteem have twice the risk for the development of depression (Brown, Andrew, Harris, Adler, & Bridge, 1986). Beck (2001) indicated that low self-esteem is one of the strongest predictors of the development of PPD. Feelings of self-worth are important buffering agents against the negative impact of life stressors. However, Sichel and Driscoll (1999) warned against the health professional being too complacent in feeling that a woman with good self-esteem is resistant against PPD, as they stated that the postnatal period presents many challenges for women with the highest self-esteem, and that self-esteem can deteriorate with the occurrence of a depressive episode.

Many of the above theories of PPD, such as the biophysical model, fall into the predominant medical model. In the medical model, PPD is viewed as an illness or disease. Research has been primarily devoted to describing the condition, looking for predictive factors, looking for preventive measures and exploring effective treatments from a medical perspective (Mauthner, 1999). Alternate perspectives to the medical model are those of the social model and feminist theory. These perspectives are largely the result of criticism that the medical model fails to consider the woman's point of view about the childbirth experience and subsequent emotions. McIntosh (1993) and Nicolson (1990), whose work is described below, both conducted qualitative research capturing the women's perceptions of contributing factors for PPD, the help they received for recovery and the recovery process.

Social theory explains depression as a reaction to occurrences in an individual's environment rather than psychological maladjustment (McIntosh, 1993). Unfulfilled expectations are seen to be associated with the development of PPD. McIntosh's (1993)

study of 60 first-time mothers found a relationship between depression and poor adaptation to the social changes that come with motherhood. The mothers voiced that they were not prepared for the sense of isolation, loneliness, and overwhelming responsibility that they experienced. They felt that this was due to erroneous expectations that were partly the result of popular literature on motherhood being misleading, and from faulty impressions of motherhood and infant demands that they had gained through observation of others. For example, the new trend in "reality" television has included programmes unrealistically portraying easy and uncomplicated deliveries with follow-up stories that included relaxed, happy mothers with relaxed, contented infants.

Nicolson's (1990) qualitative study of 24 new mothers led to the author's explanation of PPD using a bereavement and loss model. In this model, childbirth is viewed as a critical life change producing emotional lability and grief that needs to be expressed and "explored therapeutically" (p. 694) in order for the woman to regain a state of emotional equilibrium. The losses suggested in this model are those of physical, social and professional identities. The woman experiences a change in the balance of power in relationships both inside and outside the home, and even upon her return to work her focus shifts from her career to her new role.

Feminist theory criticizes the medical model that "individualizes and pathologizes women's distress and marginalizes women's perspectives" (Mauthner, 1999, p. 145). Feminist social scientists feel that this way of thinking, "obscures the socio-political nature and context of women's distress" (Mauthner, 1999, p. 145). It is felt that PPD is related to the inferior status of women in society and to structural conditions and constraints that are upon them. Childbirth means the loss of social standing and identity

due to giving up work outside the home, isolation, and the division of household duties into traditional gendered roles. They see depression as the logical consequence of these conflicts. Therefore, PPD is seen not as a medical condition, but as a "social construction" (Mauthner, 1999, p. 145). Furthermore, feminist theorists believe that the label 'postpartum depression' should be abandoned as it implies a form of medical and social control because of the suggestion of abnormality and pathology.

Results of many studies of predictors of PPD, examined together, have been shown to be inconclusive. What has been found to be predictive in one study has not necessarily been supported in another. Only the relationship between PPD and marital relationship, as predictor, has been shown to be the most consistent finding to date (Graff, Dyck, & Schallow, 1991; Misri, Kostaras, Fox, & Kostaras, 2000; Mauthner, 1998, 1999; O'Hara, Rehm, & Campbell, 1983). There also has been found to be a negative relationship between postnatal depression and the degree and quality of social support (McIntosh, 1993; Mercer, 1995).

Defining Social Support

Despite the amount of work done in the study of social support, there is no clear conceptual definition of the term (Brownell & Shumaker, 1984). The concept of social support has been operationalized in a diversity of ways: quantity or number of supporters, quality of support, utilization or amount of time spent with others, meaning or importance of having others in one's life, availability of support when needed, and satisfaction with support received (Brownell & Shumaker, 1984).

When studying the concept of social support, it is necessary to look at the theories that address the supportive aspects of interpersonal relationships. The social exchange

theory suggests that the exchange of interactions within a relationship is important because as more exchanges occur, individuals become more confident that others are likely to provide assistance when needed. Social comparison theory suggests that an individual checks his or her own idea of reality by comparing opinions and performance against those of others. Personal control theories propose that interpersonal relationships found in social networks may enhance a sense of personal control because of the knowledge of availability of necessary resources in time of need. It is the actual perception, then, that offers the supportive function. Self-esteem theory suggests the importance of maintaining self-esteem as a social motive. By comparing oneself with others who are worse off, one obtains an enhanced sense of self (Wills, 1985).

Social support has been described as assistance given by persons who are part of one's social network, rather than help from professionals (Cohen & Hoberman, 1983; Stewart, 1993; Thoits, 1986). It is assistance that is in the form of instrumental, emotional, informational and appraisal aid (House & Kahn, 1985). Instrumental support is direct help, like the provision of resources such as child-care and housekeeping. Emotional support is defined as feeling loved, trusted and cared for. Informational support is the provision of information that is useful in dealing with a problem or situation; it allows the recipient to help him or herself. Appraisal support gives the recipient an idea of how she is doing in a certain situation, and allows the person to evaluate him or herself in relationship to others in the same role (Mercer, 1986).

Appraisal support, the availability of others to talk about an individual's problems, is felt to be predictive in the case of depression (Cohen & Hoberman, 1983). Having someone to assist in evaluating potential problems and developing strategies for

dealing with those problems, as is done in appraisal support, is an effective mode of coping (Cohen & Hoberman, 1983). Self-esteem support, another identified type of support, is the availability of others to boost an individual's self-esteem, and is pivotal in the prediction of general psychiatric symptoms. (Cohen & Hoberman, 1983).

Social support has been seen as help that is informal, that is, it is distinct from the help of professionals (Stewart, 1993). Shumaker & Brownell (1984, p. 13) described social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient". This definition conveys the idea that support is more than unidirectional, it implies a broad outcome and addresses the perceptions of both the provider and recipient of the support. The idea that the intention of the support is *perceived* does not necessarily imply that the support is positive (Shumaker & Brownell, 1984). Someone may perceive that they are offering help to another when, in reality, their attempts are doing more harm than good.

Recipient/Provider Relationship in Social Support

Level of distress, coping style and personal resources have been described as recipient factors for the provision of social support (Dunkel-Schetter & Skokan, 1990). Certainly, individual personality characteristics may affect the ability to develop supportive networks and also determine the way one responds to stressors (Wethington & Kessler, 1986). It has been demonstrated that severe distress shown over a long period of time can diminish the level of support. This means that support may ebb away for the individual suffering from a lengthy depression.

Coping patterns such as support-seeking behaviour and problem-solving also elicit more support. Effective problem-solving may be such that the individual realizes he or she needs assistance and then asks for it. Research has shown that people with good self-esteem, a sense of optimism, and those with hardiness also receive more social support (Dunkel-Schetter & Skokan, 1990).

Another factor to consider when examining the relationship between the provider and recipient of support is the implied reciprocity. The provider of support may gain social approval and intrinsic satisfaction for support given. The recipient may receive supportive resources, but a potential disadvantage is that he or she may also gain a sense of obligation to repay the debt incurred (Shinn, Kessler, & Asseltine, 1984; Wills, 1985). If the recipient is unable to reciprocate, there is the possibility that she or he will hesitate to seek further support when needed. Additionally, receiving assistance may affect one's sense of self-worth if the relationship between provider and recipient is perceived as one of superiority and inferiority (Shinn et al., 1984).

Effects of Social Support

When studying social support, it is often implied that having a relationship with another is equivalent to getting support from that relationship (Lazarus & Folkman, 1984; Shinn et al., 1984). Shinn et al. (1984) documented the negative effects of social support. Instead of helping, the supporter put obstacles in the way for the recipient. Also, well-meant efforts of the supporter may backfire if the type of support is not suited to the circumstance. Sometimes the perception of the recipient may be that the support is more harmful than helpful.

The effects of negativity in supportive relationships have been studied. Women tend to be more emotionally reactive to negative interactions with relatives other than a spouse than do men, which suggests that the kinship portion of a social network may be more important to women (Schuster, Kessler, & Asseltine, 1990). It appears that negative interactions with the most intimate confidant, such as spouse, are the most significant type of interactions. That is, interactions with a spouse are more important for mental well-being than interactions with friends or relatives (Schuster et al., 1990).

Thoits (1986) identified that the most effective support comes from others who are socially similar and have experienced the same type of stressors. Values and social similarities with another increases the perceived appropriateness and applicability of their opinions and advice (Thoits, 1986).

The positive effects of social support have been well documented. The association between stressful life events and psychological and physical disorders has been recognized (Cohen & Hoberman, 1983; Wills, 1985). Social support is seen to act as a buffer or moderator against the effects of life stressors (Cobb, 1976; Cohen & Hoberman, 1983; Cohen & Wills, 1985; Lazarus & Folkman, 1984). It is felt that adequate social support can also act as a protective mechanism for people in crisis psychiatric situations such as depression, and can facilitate coping with change while moderating the effects of a major life transition (Cobb, 1976). An underlying assumption has been that an individual has better physical and mental health, and functions better if she or he believes she or he would receive social support when it is needed (Cobb, 1976; Cohen, Sherrod, & Clark, 1986; Lazarus & Folkman, 1984; Logsdon, McBride, & Birkimer, 1994).

Perceived Social Support

Perceived social support is considered to be the generalized sense that the individual is cared for and valued. Perception influences how the supportive transactions are interpreted and remembered. The perception of a low degree of support is associated with a tendency to see the occurrence of helpful supportive behaviours as being infrequent. Also, when support is offered, it is seen as unhelpful (Stewart, 1993). Perceived social support is also related to some particular personality traits and may be influenced by mood states of the recipient (Procidano & Heller, 1983). For example, an individual with traits of dependency may want more support to fulfill his or her needs so may frequently perceive that not enough support is being given.

The perception that support is available has been shown to buffer the effects of stress on psychological state (Wethington & Kessler, 1986). In fact, perceived support affects psychological adjustment regardless of whether an actual transaction of support occurs (Wetthington & Kessler, 1986). When practical problems arise that have the potential to either cause problems or reach successful resolution, the mere knowledge that help is available if needed is important (Wethington & Kessler, 1986).

Cohen and Hoberman (1983, p. 100) argued that if the "buffering qualities of social support are cognitively mediated", that is, the individual has an accurate perception of the stressor, has knowledge of effective coping strategies, and has good self-concept, then the individual's perception of the availability of support is a more accurate reflection of the buffering effect than the mere accessibility to a *supporter*. An individual's interpersonal relationships act as buffers to stress only when the nature of the support resources offered match the coping requirements evoked by the stressor. Therefore, it is

important not only to assess the availability of support resources, but also to assess the type of coping requirements needed (Cohen & Hoberman, 1983).

When studying perceived social support it is important to distinguish between support given by family members and support given by friends. Networks made up of family members tend to be longer in duration and have been found to be relatively stable and independent of attitudinal changes (Procidano, 1992; Procidano & Heller, 1983). A high perception of support from one's family has been found to be inversely related to several indicators of psychopathology in some populations (Procidano, 1992; Procidano & Heller, 1983).

Social Support in the Puerperium

As mentioned above, social support is seen to facilitate the adaptation to change in one's life such as the role change that childbirth brings. Mastery of any new task, or role, takes place best in supportive conditions (Cobb, 1976). Stressful life events experienced in pregnancy and in the puerperal period, the immediate weeks following childbirth, are considered by some to be predictors of PPD (O'Hara et al., 1983; Paykel, Emms, Fletch, & Rassaby, 1980).

Variables of social support in the puerperal period have been studied. Several factors have been identified as being quite important in the event of a depressive illness. Marital difficulties as well as the absence of a husband or significant other are considered to be significant (O'Hara et al., 1983). Worldwide studies have shown most women with PPD experience difficulties within the marital relationship (Mauthner, 1998). These depressed women report a lack of emotional support and little assistance with household chores and childcare (Mauthner, 1998; O'Hara, 1986; O'Hara et al., 1983; Paykel et al.,

1980). Studies have shown that depressed women report a lower degree of marital satisfaction (Graff et al., 1991; Misri et al., 2000; O'Hara et al., 1983), indicate they are less likely to discuss problems with their spouses/partner (O'Hara et al., 1983; O'Hara, 1986), and express that communication with a spouse is generally poor (Paykel et al., 1980). Depressed women see their husbands as unhelpful and unsympathetic and express negative feelings towards them (Pitt, 1968) and express incongruence between their expectations of how their relationship with their husband would be post-delivery and reality (Logsdon et al., 1994). It appears that marital dissatisfaction could be a factor even prenatally in non-depressed women who become depressed after delivery, but sometimes marital satisfaction may improve after recovery from depression (Gotlib, Whiffen, Wallace, & Mount, 1991).

Work outside the home, social /cultural constraints or even the woman's desire to do the work herself may lead to the perception that the spouse is not sharing the responsibility (Mauthner, 1998). What becomes evident is the need for good communication between partners. Depressed women have described themselves as withdrawing from their spouses as a result of being depressed. They may be reluctant to ask for support for fear of being misunderstood or from not wanting to overburden their partner. This may be partly due to gender-role differences; the partner cannot empathize, having not personally experienced childbirth (Mauthner, 1998).

Social support from those other than a spouse/partner has also been shown to be important during the postpartum period, although to a lesser degree. Postpartum depression has been associated with less support from a confidant who is not a spouse/partner (Paykel et al., 1980) as well as having no confidant at all (Stein, Cooper,

Campbell, Day, & Altham, 1989). Mothers with PPD report having greater frequency of contacts with members of their social network than mothers who are not depressed (O'Hara et al., 1983). As stated previously, quantity of social support, or size of an individual's network, do not necessarily equate with quality of support. Quality of social support varies widely even within the same type of social relationship such as marriage (Lazarus & Folkman, 1984), as personality variables, mental health status and cultural variables came into play.

Transition to Motherhood

Many cultures recognize the transition to motherhood with socially prescribed rites of passage. These rituals have three explicit stages: the separation of the individual from her old environment, a period of time spent between old and new role, and the celebration of the woman's new status as mother (Hung & Chung, 2001; Stuchbery, Matthey, & Barnett, 1998). The purpose of the ritual is to offer structure and meaning to a socially significant event, and to ensure that the new mother feels supported at the time of role transition. The ritual provides validation of the woman's experience and conveys a sense that she is valued and respected by her family and the community at large (Stuchbery et al., 1998).

The rites of passage practiced in non-Western societies are indicative of a formal and organized social support system that suggests the provision of a protective mechanism against psychological distress (Stuchbery et al., 1998). Western society does not prescribe the use of such practices and many immigrant women are forced to modify or relinquish these rituals in their new homes. However, there is no conclusive evidence

either supporting or not supporting the belief that relinquishment of these rituals in Western society contributes to the incidence of PPD (Kumar, 1994).

The support and love of partner and other intimates within a woman's support network are seen as important factors in maternal role attainment, and the new mother closely gauges and evaluates the response of others to her mothering in order to determine how her performance is perceived (Konak-Griffin, 1993; Meighan, Bee, Legge, & Oetting, 1998). If the mother perceives that others are showing approval of her ability to mother, then she gains confidence in the role (Koniak-Griffin, 1993). Difficulties in interpersonal relationships and disturbances in mood can hinder adjustment to the maternal role. A serious mood disturbance, such as depression, can contribute to the development of negative perceptions and faulty cognitions (Whiffen & Gotlib, 1989). A depressed mother may misinterpret normal fussiness of her baby as an indication of her poor or inadequate mothering skills. She may feel she is unable to correctly interpret cues that her infant is giving her. The sense of satisfaction a woman gains in her perceptions of being able to perform mothering tasks and in interacting positively with her child are motivational components in the maternal role (Mercer, 1995). Feeling that she is unable to read cues is ungratifying and disappointing and can lead to role strain. In turn role strain may contribute to the feelings of dysphoria (Mercer, 1995).

One goal of nursing is to assist in the process of role transition, such as occurs in pregnancy and the postpartum period. It is apparent from the literature that a woman's perception of how supportive her spouse or partner is, has significant impact on her ability to adapt to her new role of motherhood. It has also been suggested that the experience of PPD impacts on maternal role attainment, and that a woman's perception of

her spouse/partner's supportive attempts may be related to PPD. This study provided a further examination of the relationship between postpartum mood state and how a new mother perceives the amount of support she receives from her husband/partner. The literature seems to suggest that successful treatment, or even prevention, of postpartum mood disturbance may be to focus on the relationship between the mother and her spouse/partner. The questions examined in this study were whether or not there is a relationship between PSS and mood state of primiparous postpartum women, whether or not there is a relationship between PSS and any of the dimensions of mood as identified by the PDSS, and whether there is a relationship between PSS and inferred maternal role identity.

CHAPTER 3

Methodology

Research Design

The study was conducted using a descriptive correlational design. The purpose of this particular design was to facilitate the examination of the relationship between the mood state of postpartum women and the degree of their perception of spousal social support, as well as the relationship between inferred maternal role identity and perceived spousal support (Burns & Grove, 1997; Polit & Hungler, 1997). Correlational designs are useful in that they may provide the foundation for further, more rigorous studies as well as providing information for application in the clinical setting (LoBiondo-Wood & Haber, 1994).

Subjects

The participants of the study were primiparous women who had given birth to a healthy infant between 4 weeks and 7 months prior to their participation. The desired sample size for moderate effect was estimated to be 30 participants. The actual sample size was 21 participants due to difficulties recruiting subjects from the obstetrical practice.

Selection Criteria

The participants of the study were drawn from a sample of convenience. Postpartum women were recruited from two sources including the 'Just Moms and Babies' group of the Windsor-Essex County Health Unit (WECHU) and a private prenatal educator in the Windsor-Essex County area. The private prenatal educator was a certified fitness instructor who held prenatal fitness classes at a local women's gym.

Attempts to recruit women from a 3-doctor obstetrical practice were fruitless during a 7-week period. Eligibility criteria included primiparous women who were 18-years of age or older, were married or living with the father of the infant, were at least 4-weeks but no more than 7-months postpartum, were literate and who had fluency in the English language. Exclusion criteria were single women, women who had given birth to children with serious health problems, who had experienced a perinatal loss, or had lost a child to Sudden Infant Death Syndrome (SIDS).

Procedure and Data Collection

The participants recruited through a private prenatal educator were contacted by the researcher after being recruited by the educator. One participant requested the questionnaires, the letter containing information about the study (Appendix A) and consent form (Appendix B) be dropped off at her home for completion at a time convenient to her. The completed questionnaires and signed consent were returned to the researcher in a stamped, self-addressed enveloped via mail. The other participant requested the researcher bring the questionnaires to her home, where they were completed while the researcher waited.

Women participating in the groups sponsored by the WECHU were approached at the end of the initial session of each group. It was important that contact be made at the initial session, as one of the purposes of the *Just Moms and Babies* programme is the formation of peer support groups for postnatal women. Those women interested in participating after a verbal explanation from the researcher were given an explanatory letter about the study to read prior to signing a consent form and completing the questionnaires.

The coded questionnaires included the demographic questionnaire (Appendix C), Postpartum Depression Screening Scale (PDSS) (Appendix D), and the Perceived Social Support – Family (PSS-Fa) scale (Appendix E). Also included was a coded separate page for the participants name, address, and phone number (Appendix F). It was explained to the participants that the page listing contact information would allow the researcher to mail a summary of the results of the study to each participant. Also, if a participant were to obtain a score of 60 or more on the PDSS, the researcher would inform her in order that she could choose to seek further evaluation for depression if she wished. A page containing information about postpartum mood disorders, tips for self-help, and a list of community agencies where help can be obtained was also included in the package (Appendix G).

Completed questionnaires will be kept in a locked file for a period of 5-years. At that time, all questionnaires will be destroyed. Confidentiality was maintained by not identifying participants by name on any of the questionnaires. The pages listing names, addresses and phone numbers are to be destroyed after a summary of study results has been forwarded to participants.

Demographics

Data on participant characteristics were collected. The information included ages of the woman and her baby, and information about marital status, such as length of time married. If the woman was not married but living with the father of her child, she was asked to indicate how long they have lived together. Information about age of the child and length of marriage/cohabitation was gathered in order to determine their effect on the relationship between scores on the PDSS and PSS-Fa. Additional information collected

included cultural background and length of time between ceasing work outside the home and date of delivery.

Measures

Two questionnaires were used in the study: the Postpartum Depression Screening Scale (PDSS) (Beck & Gable, 2002) and the Perceived Social Support – Family (PSS-Fa) (Procidano & Heller, 1983).

Postpartum Depression Screening Scale

The PDSS (Beck & Gable, 2002) is a 35-item Likert response scale consisting of seven dimensions with five items per dimension. The PDSS was developed from several qualitative studies conducted by Beck and was based on the conceptual definition of postpartum depression being a mood disorder that occurs at any time within the first year of childbirth. This scale measured mood state ranging from wellness to major depression. The authors had granted permission for use of the scale in this study.

The seven dimensions of mood measured were Sleep/Eating disturbances, Anxiety/Insecurity, Emotional Lability, Guilt/Shame, Mental Confusion, Loss of Self, and Suicidal Thoughts. The women were asked to indicate their degree of either agreement or disagreement with each of the questions on a scale ranging from (1) strongly disagree to (5) strongly agree. They were asked to confine their answers to how they had felt during the past 2 weeks. Scores could range from 35 to 175. A score of ≥ 60 indicated the presence of symptoms of PPD and ≥ 80 indicated major PPD.

The reliability of the entire PDSS scale was determined using Cronbach's alpha. Cronbach's alpha measures how well a set of items measures a single construct – in this case, postpartum mood. A reliability coefficient of .80 or higher is generally considered

as acceptable. The PDSS was found to have excellent reliability with a Cronbach's alpha of .94. Alpha reliability coefficients had been determined for each of the seven distinct dimensions, and ranged from 0.83 to 0.94. The PDSS has demonstrated a high combination of sensitivity and specificity (Beck & Gable, 2001). Using a cut-off score of 80, sensitivity has been demonstrated at 94%, and specificity at 98% (Beck & Gable, 2001). Construct validity refers to the ability of a test, or test items, to measure theoretical psychological characteristics. Beck and Gable (2002) had conducted interscale correlations of each of the seven dimensions identified as comprising postpartum mood. The construct validity of the PDSS is somewhat dependent on the degree of inter-relatedness among the dimensions (Beck & Gable, 2002). All dimensions were highly correlated with the total PDSS score with a range of $r = .74$ to $r = .93$. Most of the scales are moderately to highly correlated with each other. Particular attention was paid to the dimensions suggested as inferring maternal role identity – Anxiety/Insecurity, Guilt/Shame, and Loss of Self. Each of these dimensions are highly correlated with each other and highly correlated with the PDSS total score (Loss of Self – Anxiety/Insecurity, $r = .79$; Guilt/Shame – Anxiety/Insecurity, $r = .70$; Guilt/Shame – Loss of Self, $r = .79$).

Inferences regarding the achievement of maternal role identity were made from individual items on several of the dimensions of the PDSS. For example, questions on the Guilt/Shame dimension inferred maternal attachment to the infant (e.g. " I felt like I was not the mother I wanted to be", "I felt like so many mothers were better than me", "I felt like a failure as a mother") (Beck & Gable, 2002). Items on the Anxiety/Insecurity dimension inferred a sense of maternal competence (e.g. "I got anxious over even the

littlest things that concerned my baby", "I felt really overwhelmed") (Beck & Gable, 2002). An overall sense of maternal role identity was inferred in the Loss of Self dimension in questions such as " I felt as though I had become a stranger to myself", "I did not know who I was anymore", and "I felt like I was not normal" (Beck & Gable, 2002).

Perceived Social Support – Family Scale

The PSS-Fa (Procidano & Heller, 1983) has been described to measure the degree to which an individual perceives that his or her needs for support, information and feedback are satisfied by family. Clarification between the concept of perceived support and the availability of support needs to be made. The perception of social support is likely to be influenced by personal factors including personality characteristics and temporal changes in mood and attitude.

For the purpose of this study, and with permission of the authors, the wording of the questions were altered to specify *spouse/partner* instead of *family*. The scale consists of 20-questions to which the participant responded by circling *yes*, *no* or *don't know*. When scoring the instrument, one mark was given for every yes answer and no marks were given for any other response. Five of the questions were worded inversely so when coding the scores, the answers had to be reversed. A score of zero indicated no perceived social support and a score of 20 indicated maximum perceived social support.

Items on the PSS-Fa were developed from an original pool of 84-items to reflect the dimensions of social support such as provision, information, feedback and reciprocity. Upon completion of a preliminary study involving 220 college students, the original number of items was decreased to 35. The refinement was accomplished through

determining the "magnitude of correlations between the item and the scale total (minus the item)" (Procidano & Heller, 1983, p. 3). Further revisions were accomplished in a similar way to reach the final 20-item form.

During the development process, it was determined that the PSS-Fa had a high test-retest reliability over a 1-month interval and showed internal consistency with a Cronbach's alpha of .90 (Procidano & Heller, 1983). The PSS-Fa has been used in many research settings with disparate groups of subjects (e.g. adolescents with cancer, spouses of patients with cancer, hospitalized school-age children, HIV positive gay men, and females with a history of incest). After analysis of many different studies using PSS-Fa, there has been no evidence that perceived social support decreases with age, there has been a significant difference shown between clinical and non-clinical groups, and a strong association has been shown between items of the PSS-Fa and characteristics of family environment such as cohesion (r = .67), expressiveness (r = .51), and conflict (r = -.44) such as measured by the Family Environment Scale (Moos, 1974).

Data Analysis

The research questions posed in the study were:

1) Is there a relationship between perceived spousal social support and mood state of primiparous postpartum women? (Note: mood state being defined as score on the PDSS.)
2) Is there a relationship between perceived spousal social support and each individual dimension of postpartum mood state as described in the PDSS?
3) Is there a relationship between perceived spousal social support and certain items of the PDSS inferring maternal role identity in primiparous postpartum women?

Using SPSS software, data were analyzed. Means and standard deviations were determined. In order to address the questions, a simple correlation was determined using the Pearson product-moment correlation coefficient. A correlation coefficient was calculated in order to determine to what degree two variables were related to each other. An alpha reliability of $p \leq .05$ was used for all statistical tests.

Ethical Considerations

The research proposal had been presented to the University of Windsor Research Ethics Committee and ethical approval was obtained. Permission for the study to proceed in their areas was sought and obtained from the WECHU, participating obstetricians and a prenatal educator in the community.

Prior to participation in the study, participants were given a verbal explanation of the purpose of the study along with a written description in the form of a letter. The office phone numbers of the principal advisor, Dr. Laurie Carty, and also the researcher, were included in the letter in the event that any women wished to seek verification of the study or ask any other questions. All participants were required to sign a consent form prior to being given a package of questionnaires.

Finally, written information describing postpartum mood disorders was given to all participants upon completion of the questionnaires. Included in the material was a synopsis of local resources and community agencies which could be contacted for further information and/or help. All participants were requested to provide contact information in the event that the researcher needed to contact them about their scores on the PDSS. It was clearly explained, both verbally and in written form, that if a subject scored high on the PDSS, the researcher would contact her by phone. It was explained to the participants

that a high score on the PDSS was by no means a definitive diagnosis of PPD, but may have indicated that further professional evaluation for depression was advisable. If indicated, the researcher reviewed community resources available to postpartum women. If a woman indicated that she might have been contemplating self-harm or harm to another, it was explained in the letter of information that this would be reported to the appropriate professional helpers.

CHAPTER 4

Results

The data were coded and analyzed using SPSS software. All of the data analyzed concentrated on the research questions outlined previously, and the reported results addressed those specific questions. The acceptable level of significance was set at $p \leq .05$.

Twenty-one (n = 21) primiparous women participated in the study. All women were either married to, or living with the father of the baby. The age of participants ranged from 24 - 37 years with a mean age of 30.5 years (SD = 3.3). All participants had given birth to a single, healthy infant. The age of the infants at the time of participation in the study ranged from 4 - 28 weeks with a mean age of 10.4 weeks (SD = 5.3). The average length of time married or cohabiting with the father of the baby ranged from 1 - 7 years with a mean length of time of 3.2 years (SD = 1.5) (Table 1). One hundred percent (n = 21) of participants identified themselves as being at least first generation Canadian. Ninety point five percent (n = 19) of the participants were recruited from the Just Moms and Babies group run by the WECHU and 9.5% (n = 2) were recruited from a private prenatal educator.

Research Question #1

1. Is there a relationship between perceived spousal support and mood state of primiparous postpartum women?

The range of possible scores on the PDSS was 35 - 175. Actual study scores on the PDSS ranged from 36 - 115 with a mean of 69.7 (SD = 22). A score of 59 or less indicated normal adjustment in the postpartum period, scores of 60 - 79 suggested the

presence of symptoms of PPD, and scores of 80 or over indicated positive screening for PPD. Thirty-eight point one percent (n = 8) of participants scored in the low range indicating positive adjustment, 28.6% (n = 6) were in the mid *symptomatic* range and 33.3% (n = 7) were in the positive range for PPD.

Table 1

Demographic Data of Participants

Subject	Age of Mum in Years	Age of Baby in Weeks	Length of Time Married/Cohabiting in Years
1	30	7.5	2.5
2	25	13.5	2.0
3	30	28.0	4.5
4	24	6.0	1.5
5	34	10.0	5.0
6	33	14.0	4.0
7	32	8.5	7.0
8	27	6.5	2.0
9	29	10.0	4.0
10	37	14.0	1.25
11	27	4.0	1.0
12	27	16.0	3.5
13	32	5.0	5.0
14	30	6.0	2.5
15	32	10.0	4.0
16	31	11.0	2.0
17	33	7.0	4.0
18	28	7.5	3.0
19	32	6.0	2.0
20	35	13.5	4.0
21	32	8.0	2.0

To measure participant inconsistency in scoring, an inconsistency scale (INC) had been built into the questionnaire. Ten pairs of questions were scored separately, and for every 2-point difference between scores of each pair, one mark was given for inconsistency. Inconsistency scores of ≥ 4 were considered to be significant and indicated

that there was the likelihood that test items were not completed in a manner that consistently reflected the test's content. Two participants scored significantly high on the INC. The participant with a total PDSS score of 111 had a score of 4 on the INC indicating there was an 85% chance that her responses were inconsistent, and the participant who scored 67 on the PDSS had an INC score of 5, indicating there was a 94% likelihood that her responses were inconsistent (Table 2).

Participant scores on the PSS-Fa ranged from 10 - 20 with a mean of 17.5 (SD = 2.8); the possible score range of the PSS-Fa was 0 - 20. A score of *0* would have indicated the perception of no spousal support and a score of *20* would have indicated the perception of total support. As can be seen, the lowest score in the study, which was 10 indicated that there was the perception of at least moderate support (Table 2).

A Pearson Correlation was conducted to determine the strength of relationship between scores on the PSS-Fa and PDSS. Included in the analysis of all data were the age of the baby and length of marriage/cohabitation. A score of $r = 1$ or $r = -1$ would have indicated a perfect correlation or relationship. The further the score was from either 1 or –1, the weaker the relationship. The correlation between PSS-Fa and PDSS was $r = .392$, $p = .079$. Although acceptable significance had been determined at $p \leq .05$, $p = .079$ indicated marginal significance. Controlling for the age of the baby and length of marriage/cohabitation, the relationship between scores of PSS-Fa and PDSS was $r = .325$, $p = .175$, indicating the relationship was not significant.

The relationship between PSS-Fa and age of the baby was determined as $r =$

-.498, $p = .02$ indicating a strong inverse relationship – the older the baby, the less the degree of PSS. The relationship between PDSS and age of the baby was not significant ($r = -.257, p = .261$).

Table 2

Participant Scores on INC, PDSS and PSS-Fa

Subject	INC	PDSS	PSS-Fa
1	-	36	20
2	-	43	10
3	-	43	16
4	-	45	19
5	-	49	19
6	-	52	16
7	-	58	18
8	-	59	20
9	-	60	16
10	-	61	12
11	5	67	18
12	-	74	14
13	-	79	18
14	-	80	18
15	-	81	16
16	-	84	19
17	-	84	20
18	-	88	19
19	-	94	20
20	4	111	20
21	-	115	20

Research Question #2

2. Is there a relationship between perceived spousal social support and any of the dimensions of postpartum mood as defined on the PDSS?

Scores of each of the 7-subscales of the PDSS were measured separately. Each subscale measured one of the dimensions of postpartum mood as identified by Beck & Gable (2002a). The lowest score possible on any subscale was 5 and the highest score

possible was 25. A summary of participant scores for each dimension was listed in Table 3.

Table 3

Range of Scores for Each Dimension of PDSS

Dimension	Lowest Score	Highest Score	Mean Score	Standard Deviation
Sleeping/Eating	5	23	9.4	4.4
Anxiety/Insecurity	5	20	11.7	3.7
Emotional Lability	5	22	12.2	4.4
Mental Confusion	5	18	11.3	3.9
Loss of Self	5	20	9.2	4.7
Guilt/Shame	5	20	9.9	4.9
Suicidal Thoughts	5	11	5.8	1.4

Sleeping/Eating

The scores for Sleeping/Eating ranged from 5 - 23 with a mean of 9.4 (SD = 4.4). High scores indicated significant disturbance in normal appetite and/or sleeping habits. For example, the mother may have found that she was unable to sleep even when the baby was sleeping. Score of $\geq$14 were considered to indicate significant disturbance in normal appetite or sleeping habits, and 14.3% (n = 3) scored in the high range. The correlation between PSS and Sleeping/Eating was $r = .307$, $p = .176$. However, with an alpha level of $p \leq .05$, the relationship was not significant.

Anxiety/Insecurity

Scores for Anxiety/Insecurity ranged from 5 - 20 with a mean of 11.7 (SD = 3.7). The scale measured the level of anxiety symptoms including feelings of being overwhelmed, psychomotor agitation and feelings of isolation. A score of $\leq$14 indicated there was no significant problem with anxiety. Twenty-three point eight percent (n = 5) of participants scored significantly high on the scale. The relationship between PSS and this dimension measured $r = .232$, $p = .312$, and were considered to be not significant.

Emotional Lability

The Emotional Lability scale measured the degree to which a mother reported her emotions to be unstable and frequently changing. Changing moods may also have been accompanied by periods of tearfulness. A score of $\leq$ 14 indicated no problem. Emotional Lability scores ranged from 5 - 22 with a mean of 12.2 (SD = 4.4). Thirty-three point three percent (n = 7) of participants scored $\geq$15.The relationship between PSS-Fa and Emotional Lability was $r = .429$, $p = .05$. The relationship could be considered to be fairly strong and statistically significant. Again, the direction of the relationship was positive, indicating that the greater the amount of emotional lability, the greater the perception of support.

Mental Confusion

The Mental Confusion scale measured ability to focus and sustain attention to tasks, as well as the ability to control thought processes. Those women who were experiencing obsessive thoughts would have scored high on this scale. The range of scores for Mental Confusion was 5 - 18 with a mean of 11.3 (SD = 3.9). A score of $\geq$14 is significant, and 28.6% (n = 6) scored significantly high. The correlation between this

dimension and PSS-Fa was $r = .201$, $p = .383$ meaning the relationship was not statistically significant.

Loss of Self

Loss of Self measured the mother's perception that she had somehow changed as a person since childbirth. She now viewed herself as possibly strange or even abnormal in comparison to how she was before childbirth. Scores for Loss of Self ranged from 5 – 20 with a mean of 9.3 (SD = 4.7). A score of ≥13 indicated the woman had significant change in her sense of self and 28.6% (n = 6) scored in the high range. The relationship between Loss of Self and PSS-Fa was $r = .382$, $p = .088$, indicating there was a fair relationship and one that was approaching significance. The direction of the relationship was positive indicating Loss of Self was greater in women with higher levels of PSS.

Guilt/Shame

The Guilt/Shame scale measured how the new mother judged her performance in the new role. A woman who scored high on this scale endorsed feelings of guilt or shame about not measuring up to her own standards of what she considered to be a good mother. Guilt/Shame scores ranged from 5 - 20 with mean of 10.0 (SD = 4.9). A score of ≥13 on this scale indicated the mother showed significant levels of guilt or shame and 28.6% (n = 6) scored in the high range. The correlation between PSS-Fa and this dimension was $r = .357$, $p = .112$. The relationship between Guilt/Shame and PSS was not statistically significant.

Suicidal Thoughts

Items on the Suicidal Thoughts scale measured the degree of a mother's consideration of harming herself as a way of escaping from PPD. Because of the serious

nature of this thought process, any score above that of the baseline score of 5 was considered to be noteworthy. A score of 5 would only be obtained if a participant was vehement in her denial of any suicidal ideation. Score for Suicidal Thoughts ranged from 5 – 11 with a mean of 5.8 (SD = 1.4), and 31.8% (n = 8) of participants scored above the baseline score. The correlation between Suicidal Thoughts and PSS was the lowest at r = .157, and not statistically significant at p = .498.

It was concluded that there was a fairly strong relationship between perceived social support and the dimensions Emotional Lability and Loss of Self. As the direction of the relationships was positive for both dimensions, it was determined that a higher level of PSS was related to increased Emotional Lability and also increased Loss of Self.

Research Question #3

3. Is there a relationship between perceived spousal social support and inferred maternal role identity in primiparous women?

The total scores for the subscale previously identified as inferring maternal role identity (Anxiety/Insecurity, Loss of Self, Guilt/Shame) had a possible range of 15 - 75. Actual scores ranged from 15 - 55 with a mean of 31.0 (SD = 11.2) (Table 4). It was proposed that a high score for the combined dimensions would have implied increased distress and therefore poor maternal identity.

Table 4

Score Range for Inferred Maternal Role Identity

	Lowest Score	Highest Score	Mean Score	Standard Deviation
Role Identity Combined Subscale	15	55	31	11.2

Using a Pearson Correlation, the relationship was found to be $r = .393, p = .078$. The relationship was considered to be fairly strong and also approaching significance. However, again the direction of the relationship was positive, implying that increased PSS was correlated with decreased maternal role identity.

Individual Item Analysis

Considering that the relationship between PSS-Fa and only 2 dimensions of the PDSS – Loss of Self and Emotional Lability – approached significance, an individual item analysis was conducted to determine the relationship between individual items on those dimensions and perceived social support.

Only two items on the Loss of Self dimension yielded a fairly strong and significant correlation with PSS-Fa. "I was afraid I would never be my normal self again" had a correlation of $r = .418, p = .06$, and "I felt like I was not normal" had a correlation of $r = .429, p = .052$ (Table 5). The direction of both relationships was positive. This indicated that the participants fear of not feeling their normal selves again and /or the feeling of not being normal actually increased with a greater degree of perceived social support.

Only one individual item on the Emotional Lability dimension had a fairly strong relationship with PSS-Fa. The item "I have been very irritable" had a positive correlation of $r = .467, p = .033$ (Table 6) indicating that an increase in participant irritability was related to a greater degree of perceived support.

Data analysis was conducted on one other individual item on the Guilt/Shame dimension – "I felt like I was not the mother I wanted to be". The relationship between

this item and PSS-Fa was also quite strong at $r = .449$ and of statistical significance at $p = .041$). This demonstrated that an increase in this belief was related to an increase in the level of perceived social support.

Table 5

Loss of Self Dimension

'Loss of Self' Items	PDSS		PSS-Fa	
I was afraid that I would never be my normal self again	$r = .863$	$p = 0$	$r = .418$	$p = .06$
I felt as though I had become a stranger to myself	$r = .655$	$p = .001$	$r = .228$	$p = .320$
I did not know who I was anymore	$r = .674$	$p = .001$	$r = .288$	$p = .206$
I felt like I was not normal	$r = .878$	$p = 0$	$r = .429$	$p = .052$
I did not feel real	$r = .307$	$p = .175$	$r = .096$	$p = .680$

Table 6

Emotional Lability Dimension

'Emotional Lability' Items	PDSS		PSS-Fa	
I felt like my emotions were on a roller coaster	$r = .533$	$p = .009$	$r = .180$	$p = .435$
I was scared that I would never be happy again	$r = .864$	$p = 0$	$r = .371$	$p = .098$
I cried a lot for no real reason	$r = .548$	$p = .01$	$r = .361$	$p = .108$
I have been very irritable	$r = .643$	$p = .002$	$r = .467$	$p = .033$
I felt full of anger ready to explode	$r = .451$	$p = .04$	$r = .105$	$p = .650$

CHAPTER 5

Discussion

This study examined the relationship between mood state of postpartum women and their perception of spousal social support. It also looked at the relationships between PSS and individual dimensions of postpartum mood, as well as the relationship between PSS and inferred maternal role identity. The subjects were all first-time mothers with infants of 7-months of age or less. Mothers were at least 18-years of age and were all either married or living with the father of the infant. All infants were healthy and single, meaning there were no multiple births. Mothers of infants greater than 7-months were not included as it has been shown in the literature that mothers' moods may become depressive at around 8-months postpartum (Mercer, 1985). All participants were at least first generation Canadian, and all except one was of European heritage. The participants had all worked outside of the home prior to childbirth. The discussion summarizes the main findings of the study, their clinical significance and the implications of the results.

A review of the literature showed difficulties within the marital relationship to be a contributing factor to postpartum mood disturbances (Mauthner, 1998; O'Hara, 1986; O'Hara et al., 1983; Paykel et al., 1980; Pitt, 1968). However, faulty cognitions possibly manifested during mood disturbance could cause a depressed woman to perceive she had little social support from her spouse and, in turn, increased marital tension (Whiffen & Gotlib, 1989). In this study, perceived spousal social support was measured by the PSS-Fa, a 20-item self-report questionnaire. To measure postpartum mood, the researcher used the PDSS, a 35-item self-report questionnaire. The advantage of using the PDSS was that it measured moods ranging from wellness to major depression. Seven dimensions of

mood were measured with five questions per dimension. The study separated out each of the dimensions of mood state identified by Beck and Gable (2002) in order to determine the relationship between perceived social support and each individual dimension of mood. Finally, the study looked at the relationship between perceived social support and the inference of maternal role identity - identity being the final stage of maternal role attainment as identified by Mercer (1985). Mercer (1985) identified several factors leading to maternal role identity - maternal attachment, a sense of competence in the mothering role, and gratification. Items in the scales for Guilt/Shame, Anxiety/Insecurity, and Loss of Self were considered to infer the identified factors. Mercer (1985) stated that the perception of strong spousal support could reduce the chance of postpartum mood disturbance and contribute positively to maternal role attainment. In using the PDSS with clearly delineated mood dimensions, this study was able to illustrate the strength of relationships between perceived social support and each of the dimensions of mood.

The mean score on the PDSS was higher than expected at the start of the study. In fact only 38.1% (n = 8) of participants scored in the low range indicating positive adjustment in the postpartum period. This was contrary to the previously cited 10-20% incidence of PPD (Bright, 1994). The sample group was recognized as being homogeneous in that most of the participants were recruited from the Just Moms and Babies group of the WECHU. Only 2 participants were recruited outside of that group and they both had a score of less than 60 on the PDSS. Factoring out the scores of those individuals, 68.42% of participants of the WECHU group showed symptoms of postpartum mood disturbance. This suggested that mothers who experienced symptoms

of depression were drawn to the WECHU programme. This could have been due not so much for child-care information but for the opportunity to connect with other new mothers or for contact with a health professional. Many postpartum women have been reluctant to acknowledge their feelings of depression, and therefore have avoided contact with mental health professionals in the past. Contact with a public health nurse may have been more attractive in that it provided the opportunity for professional support from a more *socially acceptable* health care provider. The WECHU group would also have provided the woman an unthreatening milieu in which to see if other new mothers were experiencing the same emotions. The researcher, via telephone, contacted participants whose scores showed significant symptoms of PPD. Two participants were receiving medical treatment of PPD in the form of antidepressant medications. One of those two women was under the care of a psychiatrist. None of the women admitted to thoughts of harming themselves or others.

Scores on the PSS-Fa ranged from 10 - 20, indicating that women felt they had moderate to high support from their spouses. This result, too, was rather surprising to the researcher, as the response to the verbal description of the study was generally met with laughter and comments about the lack of supportive partners. Examination of the relationship between scores on the two scales showed that the greater the PSS, the higher the score on the PDSS, or the higher the level of depression. This result had several implications. First, the level of depression in the participants could have affected the way they perceived spousal support through the effect of faulty cognitions. Secondly, the women may have been feeling guilty about the way they were feeling and therefore responded to the items on the PSS-Fa in a way that showed their partners, and their

relationship with their partners, in a more positive light. Thirdly, self-report inventories have been generally acknowledged to be sometimes unreliable, therefore causing an inaccurate reflection of the relationship with the partner. Finally, the benefits of social support have been identified as not always being positive. Negative interactions with a spouse/partner are considered the most important type of interactions, and contribute significantly to diminished mental well being (Schuster et al., 1990). The participants of the study may well have perceived that they had very supportive husbands/partners, however arguments and criticisms, particularly about parenting, may have influenced postpartum mood. The women in the study may have felt that they and their spouses/partners were so involved in the adaptation to parenthood as a couple, that there was little room to develop an individual mothering style. This could have led to frustration and, in turn, depressed mood.

Individual items on three dimensions have been shown to have a fairly strong relationship with PSS-Fa. The relationship between *Irritability* and PSS on the Emotional Lability dimension was fairly strong indicating that the perception of high PSS was related to increased irritability. The finding may be explained by the strength of the relationship between the new parents; the woman was so comfortable and secure in the relationship she felt free to be irritable without repercussions. On the other hand, was the new father making suggestions or participating in child-care duties to the point that the mother felt he was interfering, and she was not being allowed to mother, thus causing irritability? Two items on the Loss of Self dimension had fairly strong and significant relationships with PSS-Fa – "I was afraid I would never be my normal self again" and " I felt like I was not normal". The former phrase may have been associated with a

husband/partner reminding the mother that her life was now changed forever. The latter may have been the result of being purposely or inadvertently compared to other mothers.

As outlined previously, maternal role identity, the final stage of maternal role attainment, begins with the integration of the maternal role into the woman's sense of self and the development of feelings of mastery and competence (Koniak-Griffin, 1993). As she becomes more accomplished in the new role, the mother gains confidence and a sense of satisfaction or pleasure in carrying out mothering tasks and in interacting with her infant. The sense of satisfaction is important as it provides motivation to continue mothering. Many emotions are experienced during the transition into motherhood. Guilt is one emotion that many women experience. A woman may feel she is not fulfilling her own expectations or the expectations of others in her new role. Individual analysis of the item " I felt like I was not the mother I wanted to be" on the Guilt/Shame dimension showed a fairly strong relationship with PSS. The first stage of maternal role attainment has been shown to be the anticipatory stage. During this stage the woman engaged in visualization and fantasy about herself as a mother (Mercer, 1985). It would have stood to reason that part of this process would have included envisioning the role of her husband/partner. If the fantasized ideals were inconsistent with reality, frustration and possibly depression could have occurred regardless of the perception of spousal support after childbirth.

Data analysis was conducted to examine the relationship between PSS and the three dimensions of the PDSS identified by this researcher as inferring maternal role identity: Guilt/Shame, Loss of Self, and Anxiety/Insecurity. The relationship between

inferred maternal role identity and PSS was fairly strong, however, the relationship was a positive one, indicating that a higher level of PSS was related with a more fragile sense of maternal role identity. This result meant that PSS could have actually impeded the development of maternal role identity. The implication could possibly have been that the new mother needed to perceive that she was being allowed to get on with the job of mothering without too much interference.

A significant and fairly strong relationship was determined between level of PSS and the age of the baby. As the age of the baby increased, the perception of support decreased. This result may be been due to the father resuming normal activities outside of the home and being less attentive to the mother and child, or it may have been due to the mother becoming less sensitive to the support of her partner, with a resulting decreased perception. There was no significant relationship between the age of the baby and mood state of the mother.

Information about the length of time between stopping work outside the home and date of delivery was also collected on the demographic questionnaire. It had been observed over time, by the author and other nursing staff, that women admitted to the acute Mental Health unit of a local hospital for PPD had often worked almost to the date of delivery. Nursing staff had wondered whether this might be a contributing factor to the development of PPD in that there was little time for physical rest and maybe emotional preparation for childbirth. It was seen that many of these women tended to concentrate using their maternity leave during the postpartum period instead of taking time off work before delivery. However, no relationship was found.

Limitations of the Study

There were several limitations to the study. First, the sample group was small. It was hoped that a larger sample could be obtained but unfortunately the researcher was not able to recruit participants from the obstetrical practice. Secondly, the group was homogeneous in nature in that most participants had been recruited from the WECHU group. This was unfortunate, as the results of the study could not be considered to be generalizable. The inclusion of participants from the obstetrician's office would have provided a more diverse subject group. At the request of the doctors' office staff, the questionnaires were left at the office and one of the nurses at the practice was to take the lead in recruiting participants. The researcher met with the office nurse twice prior to initiation of the study in order to explain the purpose and protocol. Attempts at recruitment lasted for 7 weeks. During the first 4 weeks, women were asked to participate while in the general waiting area. Seating was crowded and there were many distractions in the area. During the last 3 weeks, women were asked to participate while they were waiting to see the doctor in the examination rooms. The office nurse stated that many of the women told her they had waited for so long and they didn't want to prolong their office visit. It would have been ideal if the researcher had been able to speak with the woman herself in order to recruit, as the obstetrical practice was a very fast-paced environment and it was possible that women who were approached to participate did not have a full understanding of the study.

The third limitation of the study was that the questionnaires were generally completed in an uncontrolled environment. Participants recruited from the WECHU groups were asked to complete the questionnaires at the end of the first session. All of the

women had their infants with them, so their attention was not fully spent on answering the questions. Participants may have felt hurried to complete the study, thereby not being fully attentive to their responses. Some women were conversing with others while they completed the surveys. The participant who completed the questionnaires in her home and returned them by mail, may have done so with the input of her husband.

Another limitation was that the measure of maternal role identity was only an inference. A scale specifically designed to measure this dimension was not available. It is believed by the researcher that interviews with participants would have helped enrich the data. In fact, interviews regarding PSS would also have been useful. During the explanation of the purpose of the study, comments made by prospective participants were remarkably inconsistent with scores on the PSS-Fa.

Recommendations for Future Research

This study made a contribution to the advancement of nursing knowledge in that it confirmed there is a relationship between postpartum mood state and perceived spousal social support, as well as a relationship between how a new mother perceives support from her partner and an inferred sense of maternal role identity. However, the direction of both of these relationships was positive, indicating that high PSS was related with increased degree of PPD, and that high PSS was related with a hampered sense of maternal role identity. Because of the small sample size, there was limited power in the data analysis so future studies should be done incorporating a larger and more heterogeneous sample. Also the participant group lacked richness in cultural and socio-economic diversity. It would be beneficial to further explore the mother's perception of support in order to determine if there are specific aspects of perceived social support that

interfere with the formation of maternal role identity, as well as increase the level of postpartum distress. Further examination of the mother/father/infant triad is important if nursing interventions are to be designed to enhance the emotionally supportive role of the husband/partner.

Implications for Nursing

Several implications for nursing can be made from the results of this study. It has been confirmed that there is a relationship between the amount of perceived spousal support and emotional lability, the sense of self, and overall mood state of the new mother. It has also been shown that maternal role identity is related to perceived spousal social support. It would stand to reason that a focus on the role of the father would be pertinent. Most women in our society have access to prenatal education. Formal educational programmes are offered in a variety of settings from midwives and private educators to public health units, some of which are provided free of charge. Much of the focus of prenatal education has been on the stages of pregnancy, childbirth and care of the infant. Information is usually presented about emotional changes that the new mother may experience (i.e. postpartum blues and depression), and partners are encouraged to be supportive in the postpartum period. Formal prenatal education, at the present time, however, is not as effective as it could be due to little emphasis being placed on the emotional aftermath of childbirth (Kermeen, 1995). There is generally no opportunity for deeper discussion about expectations of the parenting role and changes in the relationship between the woman and her partner.

There are other sources of information about pregnancy and childbirth: popular literature, the media, midwives, doulas and physicians. Many regions in the province of

Ontario are experiencing a shortage of physicians. As a result, office appointments have generally been time-limited and not conducive for extensive health teaching. The availability of midwives has not been consistent in all regions of the province. Where available, a midwife may follow a woman throughout pregnancy, childbirth and the immediate postpartum period and can been an excellent source of information for new or expectant mothers. However, the expertise of midwives is centred on the process of childbirth. Because, in many jurisdictions midwives are not required to be nurses, they may not have the same level of knowledge about mental health issues that nurses have.

Another group of care providers that has gained popularity in our culture has been doulas. A doula is fee-for-service, lay person who assists a couple throughout the woman's labour and delivery by providing emotional support and comfort measures. Contact with a doula prior to delivery has generally been limited to a home visit, at which time a brief history is obtained and a birth plan formulated or revised. Formal training for doulas is very brief and focuses on stages of labour and delivery.

Couples are encouraged to attend prenatal classes in the second trimester of pregnancy, a few months before childbirth. At the present time, most educational programmes offered by agencies in this community provide no follow-up sessions after the birth. Follow-up sessions would provide couples the opportunity to discuss problem areas they have encountered in their new roles. They would provide an opportunity for new parents to meet and share their feelings about their adjustments to parenting in a supportive environment. Following a couple in the postpartum period could possibly prevent the formation of postpartum distress in the mother.

The results of this study showed that 68% of the participants attending the Just Moms and Babies group of the WECHU showed symptoms of PPD. One suggestion has been that new mothers with a depressed mood may be drawn to this group. This could be seen as an opportunity to connect with depressed mothers who otherwise would not seek professional help. A group for women with PPD was formed in the autumn of 2002 in the mental health outpatient department of a local hospital. Despite promoting the group in the media, as well at physicians' offices, the group had difficulty attracting enough women with PPD to remain viable and it was cancelled as part of that particular programme. This occurred in spite of the fact there were an estimated 5,000 births per year in the geographic region resulting in a conservative estimate of about 500 women with PPD. It has been documented in the literature that women with PPD often are subject to guilt and shame about their feelings and may be too embarrassed to seek help from mental health professionals. The social stigmatization surrounding mental illness prevents many from admitting to depression.

Based on the results of this study, it has been suggested that women with PPD are more likely to attend programmes run by the Public Health Unit. Screening for depression could be done at the beginning of each new session to identify women with symptoms of depression. Community partnering of public health and mental health specialists in programmes such as Just Moms and Babies could provide therapeutic support to women in distress in a non-threatening milieu. In addition, groups for expectant mothers and fathers could also be designed to provide education about emotional needs of new parents. Attention should be paid to practicing communication skills in order to facilitate the transition into new roles more easily.

There is a wealth of literature about postpartum mood disorders, contributing factors, and effects on the child and family unit. However, the incidence of PPD has not decreased in our society, and tragedies still occur when new mothers attempt to harm themselves and sometimes harm their children. More work needs to be done in prevention of the disorder, not just with focus on the mother, but with focus on educating both parents and working on strengthening the interpersonal relationship between both parents. Improved health care programmes implemented before childbirth and in the early postpartum period will be rewarded in the long-term with better-adjusted parents and children. This makes sense not only fiscally, but also from a humanistic view.

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APPENDIX A

UNIVERSITY OF
WINDSOR

INFORMATION LETTER

November 2003

Dear Participant

You are asked to participate in a research study conducted by Jane Reiha, from the Faculty of Nursing at the University of Windsor under the supervision of Dr. Laurie Carty. The results of this study will contribute to the thesis requirements of a Master's of Science (Nursing) degree.

I am looking for participants who are either married or living with the father of their baby. The baby must be at least 4 weeks old and less than 7 months of age. I would like participants to be at least 18 years old, and to be able to read and answer questions in English.

The purpose of the study is to examine the relationship between a new mother and her husband/ partner from the woman's point of view, and to see if it affects the emotional mood of the mother.

If you volunteer to participate in this study, I will ask you to do the following things:

- complete a questionnaire giving information about yourself such as your age, cultural background and last day you worked prior to childbirth
- complete a 35-item survey about your mood called the 'Postpartum Depression Screening Scale'
- complete a 20-item survey called the 'Perceived Social Support - Family' about how you see your relationship with your husband or partner.

It will take you approximately 15 minutes to complete the questionnaires.

The Postpartum Depression Screening Scale measures your emotional mood and the scores range from absolute wellness to possible depression. If your score is high on this scale, the researcher will contact you. **Please note**, that a high score on this test does **not** necessarily mean that you are depressed, but it may indicate that you could benefit from seeing your family physician to discuss how you are feeling. It is important to know that

if your answers indicate that you are contemplating causing harm to your baby, yourself or another person, the research is obligated by law to report this to the authorities.

The benefit you receive from this study will be the assurance that you have helped to identify ways to strengthen the relationship between partners, thereby potentially improving education about parenting for others. The results of the study will be submitted for publication in nursing journals. It is hoped that the results will ensure that prenatal education is as effective as possible in addressing the emotional needs of new parents.

Any information that is obtained in this study, and that can be identified with you, will remain confidential and will be disclosed only with your permission. A code number and not your name will be on the questionnaires. A separate sheet will list your name with your phone number, address and the code number. I will ask for your address so that I can mail you a summary of the results at the end of the study. All questionnaires and the code sheet will be kept in a locked file. As soon as the results of the study have been sent to you the list with your name, address, phone and code numbers will be shredded. The completed questionnaires will be shredded after 5-years.

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so, such as too many questions not answered.

If you have any concerns about the research, please feel free to contact either Dr. Laurie Carty, Faculty Supervisor, at 253-3000 ext 2271, or Jane Reiha at 945-8499.

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research subject, contact:

Research Ethics Coordinator
University of Windsor
Windsor, Ontario
N9B 3P4

Telephone: 519-253-3000, ext 3916
Email: ethics@uwindsor.ca

Thank-you very much for your assistance in this worthwhile project.

Respectfully,

Jane Reiha, RN, BA (Hons. Psych.), Msc(c)

APPENDIX B

UNIVERSITY OF
WINDSOR

CONSENT TO PARTICIPATE IN RESEARCH

An Examination of the Relationship Between Perceived Spousal Social Support and Mood State of Postpartum Women and the Subsequent Effect on Maternal Role Identity

You are asked to participate in a research study conducted by Jane Reiha, from the School of Nursing at the University of Windsor. The results of this study will be contributed to the thesis requirements of a Master's of Science (Nursing) degree.

If you have any concerns about the research, please feel free to contact either Dr. Laurie Carty, Faculty Supervisor, at 253-3000 ext 2271, or Jane Reiha at 945-8499.

The purpose of the study is to examine the relationship between a new mother and her spouse/ partner from the woman's point of view, and to see if it affects the emotional mood of the mother.

If you volunteer to participate in this study, we would ask you to do the following things:

- complete a questionnaire giving information about yourself such as your age, cultural background and last day you worked prior to childbirth
- complete a 35-item survey about your mood called the Postpartum Depression Screening Scale
- complete a 20-item survey about how you see your relationship with your husband or partner.

It will take you approximately 15 minutes to complete the questionnaires.

The Postpartum Depression Screening Scale measures your emotional mood and the scores range from absolute wellness to possible depression. If your score is high on this scale, the researcher will contact you. **Please note**, that a high score on this test does **not** necessarily mean that you are depressed, but it may indicate that you could benefit from seeing your family physician to discuss how you are feeling. It is important to know that it your answers indicate that you are contemplating causing harm to your baby, yourself or another person, the research is obligated by law to report this to the authorities.

The benefit you receive from this study will be the assurance that you have helped to identify ways to strengthen the relationship between partners, thereby potentially improving education about parenting for others. The results of the study will be submitted for publication in nursing journals. It is hoped that the results will ensure that prenatal education is as effective as possible in addressing the emotional needs of new parents.

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission. A code number and not your name will be on the questionnaires. A separate sheet will list your name with your phone number, address and the code number. I will ask for your address so that I can mail you a summary of the results at the end of the study. All questionnaires and the code sheet will be kept in a locked file. As soon as the results of the study have been sent to you the list with your name, address, phone and code numbers will be shredded. The completed questionnaires will be shredded after 5-years.

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so, such as too many questions not answered.

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research subject, contact:

Research Ethics Coordinator
University of Windsor
Windsor, Ontario
N9B 3P4

Telephone: 519-253-3000, ext 3916
Email: ethics@uwindsor.ca

I understand the information provided for the study "An Examination of the Relationship Between Perceived Spousal Social Support and Mood State of Postpartum Women" as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

SIGNATURE OF RESEARCH SUBJECT

_____
Name of Subject

_____ _____
Signature of Subject Date

SIGNATURE OF INVESTIGATOR

_____ _____
Signature of Investigator Date

APPENDIX C

Demographic Questionnaire

I would like to gather some information about you. Please answer the following few questions. Please do **not** write your name or the name of your spouse/partner on any of these pages. All answers will remain strictly confidential.

- How old are you? _____
- How old is your baby? _____
- How long have you been married or living with the father or your baby? _____
- Did you work outside the home before you had the baby? _____
- What was the last date you worked? _____
- What is your cultural background? _____

APPENDIX D

Postpartum Depression Screening Scale

The answers on this questionnaire will be measured on a scale ranging from 1 to 5. The number 1 means you strongly disagree to the statement, 2 means you disagree, 3 means you neither agree nor disagree, 4 means you agree, and 5 means you strongly agree. There are no right or wrong answers. Please answer each question by circling the appropriate answer. The questions address how you have felt during the past 2 weeks.

During the past 2 weeks:	strongly disagree				strongly agree
1. I had trouble sleeping even when the baby was asleep	1	2	3	4	5
2. I got anxious over even the littlest things that concerned my baby	1	2	3	4	5
3. I felt like my emotions were on a roller coaster	1	2	3	4	5
4. I felt like I was losing my mind	1	2	3	4	5
5. I was afraid that I would never be my normal self again	1	2	3	4	5
6. I felt like I was not the mother I wanted to be	1	2	3	4	5
7. I have thought that death seemed like the only way out of this living nightmare	1	2	3	4	5
8. I lost my appetite	1	2	3	4	5
9. I felt really overwhelmed	1	2	3	4	5
10. I was scared that I would never be happy again	1	2	3	4	5
11. I could not concentrate on anything	1	2	3	4	5
12. I felt as tough I had become a stranger to myself	1	2	3	4	5
13. I felt like so many mothers were better than me	1	2	3	4	5
14. I started thinking that I would be better off dead	1	2	3	4	5
15. I felt like I was jumping out of my skin	1	2	3	4	5

	strongly disagree				strongly agree
16. I cried a lot for no real reason	1	2	3	4	5
17. I thought I was going crazy	1	2	3	4	5
18. I did not know who I was anymore	1	2	3	4	5
19. I felt guilty because I could not feel as much love for my baby as I should	1	2	3	4	5
20. I wanted to hurt myself	1	2	3	4	5
21. I tossed and turned for a long time at night trying to fall asleep	1	2	3	4	5
22. I felt all alone	1	2	3	4	5
23. I have been very irritable	1	2	3	4	5
24. I had a difficult time making even a simple decision	1	2	3	4	5
25. I felt like I was not normal	1	2	3	4	5
26. I felt like I had to hide what I was thinking or feeling toward the baby	1	2	3	4	5
27. I felt that my baby would be better off without me	1	2	3	4	5
28. I knew I should eat but I could not	1	2	3	4	5
29. I felt like I had to keep moving or pacing	1	2	3	4	5
30. I felt full of anger ready to explode	1	2	3	4	5
31. I had difficulty focusing on a task	1	2	3	4	5
32. I did not feel real	1	2	3	4	5
33. I felt like a failure as a mother	1	2	3	4	5
34. I just wanted to leave this world	1	2	3	4	5
35. I just wanted to leave this world	1	2	3	4	5

APPENDIX E

Scale for Perceived Social Support – Family

The following questions have to do with your relationship with your husband or partner. Please answer all of the questions by circling 'yes', 'no', or 'don't know'. There are no right or wrong answers. Remember that all answers will be kept strictly confidential.

1. My husband/partner gives me the moral support I need
   yes no don't know

2. I get good ideas about how to do things or make things from my husband partner
   yes no don't know

3. Most other women are closer to their husband/partner than I am
   yes no don't know

4. When I confide in my husband/partner, I get the ideas that it makes him uncomfortable yes no don't know

5. My husband/partner enjoys hearing about what I think
   yes no don't know

6. My husband/partner share many of my interests
   yes no don't know

7. My husband/partner comes to me when he has problems or needs advice
   yes no don't know

8. I rely on my husband/partner for emotional support
   yes no don't know

9. I could go to my husband/partner if I were just feeling down, without feeling funny about it later. yes no don't know

10. My husband/partner and I are very open about what we think about things
    yes no don't know

11. My husband/partner is sensitive to my personal needs
    yes no don't know

12. My husband/partner comes to me for emotional support
yes no don't know

13. My husband/partner is good at helping me solve problems
yes no don't know

14. I have a deep sharing relationship with my husband/partner
yes no don't know

15. My husband/partner gets good ideas about how to do things or make things form me
yes no don't know

16. When I confide in my husband/partner, it makes me uncomfortable
yes no don't know

17. My husband/partner seeks me out for companionship
yes no don't know

18. I think that my husband/partner feels that I'm good at helping him solve problems
yes no don't know

19. I don't have a relationship with my husband/partner that is as close as other women's relationships with their husbands/partners
yes no don't know

20. I wish my husband/partner was much different
yes no don't know

APPENDIX F

RESEARCH SUBJECT CONTACT INFORMATION

Please provide the following information in order that you can be sent a summary of the research study "An Examination of the Relationship Between Perceived Spousal Support and Mood State in Postpartum Women and the Subsequent Effect on Maternal Role Identity"

You will also be contacted by phone if your score is high on the Postpartum Depression Screening Scale. A high score does not necessarily mean that you are depressed, but it is an indicator that you may benefit from further evaluation of your mood by your family physician.

Please print

NAME: _____

ADDRESS: _____

_____

_____

PHONE: _____

APPENDIX G

POSTPARTUM MOOD DISORDERS INFORMATION

Many women experience changes in their mood after childbirth. Most often it takes the form of the 'baby blues'. The 'blues' usually happen a few days after delivery and last for about a week or two. Here are some signs of the 'blues':

- Suddenly crying for no reason
- Feeling sad sometimes
- Feeling irritable
- Feeling frustrated

As many as 1 in 5 women experience emotional changes after childbirth that last longer than the 'blues'. Some women may feel depressed, some may become anxious, and some may start to have panic attacks. These mood disturbances usually start between 3 weeks to 1 year after delivery. Some of the symptoms are the same as the 'blues', but may also include:

- Feeling overwhelmed or anxious
- Having a change in appetite
- Having difficulty sleeping, even when the baby is sleeping
- Having no feelings about the baby
- Fearing that you may hurt yourself or the baby
- Feeling "out of control"
- Having panic attacks (being afraid, racing heart, sweating a lot)
- Having difficulty concentrating
- Not enjoying things that you generally like to do
- Feeling distracted
- Having frightening thoughts about things happening to the baby

If you have any of these symptoms and feel that you may be suffering from a postpartum mood disturbance, there are things that you can do to help yourself.

- Take care of yourself – eat right, sleep when the baby sleeps, go for a walk, take time to relax
- Accept your feelings – feeling bad does *not* mean that you are a bad person or a bad mother
- Talk to someone about how you are feeling – sometimes telling someone else helps
- See your physician
- Contact a community support agency
    - Distress Centre of Windsor-Essex County 256-5000
    - Community Crisis Centre 973-4435
    - Windsor-Essex County Health Unit 258-2146 ext. 1350
    - Postpartum Depression Support Group (HDGH) 973-4411 ext. 3354

VITA AUCTORIS

Jane Reiha was born in 1953 in Weymouth, Dorset, England. She graduated from Sir John A. Macdonald High School, Ottawa, in 1971. She attended the Nightingale School of Nursing, Toronto, and graduated with a Diploma in Nursing in 1973. She attended the University of Windsor, earning a B.A. in Social Sciences in 1993, and a B.A. (Honours Psychology) in 1998. The main focus of Jane's nursing career has been in the area of acute adult mental health. She is currently a candidate for a Master's of Science degree at the University of Windsor, and hopes to graduate in June 2005.