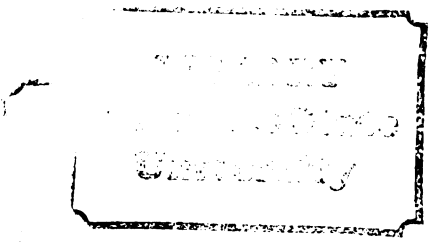

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THE RELATIONSHIP AMONG FIRST-TIME MOTHERS' ANTICIPATORY SOCIALIZATION FOR PARENTHOOD, ACCURACY OF PRECONCEPTIONS OF THE POSTPARTUM PERIOD, AND EASE OF TRANSITION INTO THE PARENTAL ROLE

presented by

Roxann Rohrs Hamblin

has been accepted towards fulfillment
of the requirements for

Master of Science degree in Nursing

Barbara Given

Major professor

Date 8/12/82

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By

Roxann Rohrs Hamblin

A THESIS

Submitted to
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in partial fulfillment of the requirements
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College of Nursing

1982

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ABSTRACT

THE RELATIONSHIPS AMONG FIRST-TIME MOTHERS' ANTICIPATORY SOCIALIZATION FOR PARENTHOOD, ACCURACY OF PRECONCEPTIONS OF THE POSTPARTUM PERIOD, AND EASE OF TRANSITION INTO THE PARENTAL ROLE

By

Roxann Rohrs Hamblin

A longitudinal, correlational study was conducted to explore the relationships among first-time mothers' anticipatory socialization for parenthood, accuracy of preconceptions of postpartum, and ease of transition into parenthood. Hypotheses were that accurate preconceptions of postpartum would be related to ease of transition into parenthood, and that anticipatory socialization for parenthood would be related to accuracy of preconceptions and to ease of transition into parenthood.

A convenience sample of 44 healthy first-time mothers completed Prenatal and Postnatal Questionnaires. Prenatally, subjects described their preconceptions of postpartum and their anticipatory socialization experiences; postnatally, they described their postpartum experiences and the amount of "bother" these caused. Product-moment correlation demonstrated that the higher the Difference between preconceptions and experiences, the higher the Bother for several aspects of postpartum. The expected negative relationships between Anticipatory Socialization and Difference, and between Anticipatory Socialization and Bother, were not found.

To my husband, Jug, whose love, faith, and encouragement sustained and nourished me throughout my graduate education.

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I am immeasurably grateful to my research consultants. Without Rita Gallin's expert advice, constructing my own questionnaires would have been a futile endeavor. And Rob Hymes' patience in assisting me with my data analysis will always be remembered and appreciated.

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Finally, I thank my loving parents for instilling in me a love of learning and a desire to excel.

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CHAPTER I

INTRODUCTION

Background of the Problem

Traditionally, nursing's primary interest in the beginning of a new family has been the successful outcome of the pregnancy -- healthy mother, healthy baby. Health care professionals encouraged regular prenatal care and hospital, as opposed to home, births toward that end. Nurses cared for mothers and babies in doctors' offices and clinics, in labor and delivery departments and postpartum units of hospitals. After the postpartum stay in the hospital, with the exception of a few "high risk" families for whom public health referrals might have been made, mothers and their babies were lost to nursing and the health care system for the next 4 to 6 weeks.

More recently, nurses have added an additional goal in caring for new families: assisting them to adjust to the stress of incorporating a new member. Assistance is needed because, as studies show, many new parents are unprepared for the experience of raising a child. LeMasters stated that "most parents do not actually know what they are getting into until they are already fathers and mothers. This creates many problems when the role proves to be more frustrating than they had expected" (1974, p. 32). Dyer, in a retrospective study of 32 couples and the impact of first-time parenthood on their lives, concluded, "While a majority said they had thought they were adequately prepared

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before their child arrived, still a large majority (80 percent) admitted that things were not what they had expected after the child was born" (1963, p. 22). After interviewing 37 primigravidas during the postpartum period, Pellegrom and Swartz concluded that "the expectations of new mothers are different than [sic] the actual experiences during the first three to four weeks after the birth of the infant" (1980, p. 26).

Why do the realities of parenthood come as a surprise to new parents? One explanation is the lack of anticipatory socialization for parenthood made available to young people. Anticipatory socialization occurs when a person learns what a role is like and what behaviors the role requires before actually being in a situation to carry out the role (Burr, 1972; Thornton & Nardi, 1975). Opportunities for such learning are scarce in today's society. Learning about the parental role can take place in child care or marriage and the family classes. However, although most people will become parents, there is a lack of classes designed to prepare high school and college students for that role (Hill & Aldous, 1969; LeMasters, 1974). Learning can also occur by observing and practicing child care before becoming a parent. Such learning is limited in part because modern families tend to be small and isolated from the extended family, affording few opportunities for older children to care for infant siblings, nieces, or nephews (LeMasters, 1974). Learning is also restricted by the lack

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of opportunity during pregnancy for rehearsal for parenthood, in contrast with the "trying on" of expected marital roles that occurs during courtship (Hill & Aldous, 1969; Rossi, 1968).

Another explanation for new parents' astonishment upon experiencing the realities of parenthood is that our society tends to romanticize parenthood to such an extent that a young person's preconception of the role may bear little resemblance to reality (LeMasters, 1957; Peck, 1971; Whelan, 1975). LeMasters states, "When a social function is relatively rigorous, as parenthood seems to be in our society, a rich ethos or romantic folklore evolves to assure that the role is not avoided by most adults." This point is illustrated by one young mother who said the following:

> My first baby was colicky. I was miserable. I thought I was a terrible mother because I couldn't comfort him. I was exhausted from his crying, and my husband was edgy from lack of sleep. On top of everything, I was nursing and my nipples became cracked and sore. In frustration, I called my mother long distance and cried, "Why didn't you tell me it would be like this?" And she replied, "If we mothers told our daughters how horrible those first weeks are, they would never have a baby."

Romanticizing parenthood may meet society's goal of inducing people to have children, but it is likely that the unrealistic preconceptions engendered by such a folklore will promote difficulty in assuming the parental role. The results of some research comparing preconceptions of and adjustments to professional, marital, and retirement roles

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support the concept that people who hold unrealistic expectations of their new role may experience difficulty adjusting to it (Curley & Skerrett, 1978; Kramer, 1974; Thompson, 1958).

Kramer (1974) describes a phenomenon which she calls "reality shock": "the specific shocklike reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared, and then suddenly find they are not." She found that student nurses who had relatively realistic expectations of their professional role functioned more effectively in a work setting than their more "idealistic" classmates, who either were less effective, or left hospital nursing. Kramer's definition of reality shock may be aptly applied to Dyer's (1963) subjects who thought they were, but later found they were not, prepared for parenthood. It seems likely, then, that these parents will be less than optimally effective in carrying out their new role, since the choice of actually leaving their parental job is not socially acceptable.

Curley and Skerrett (1978) interviewed 15 Midwestern, college-educated couples 3-6 months, and again one year, after they had married. Couples were asked about their premarital expectations of marriage, and about whether they had discussed these with each other. The authors concluded: "the degree of stress during the first year seemed to be determined by personality, <u>the agreement between</u>

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expectations and the reality of marriage, and the duration of the premarital relationship" (p. 120, emphasis added). Thus, congruence between expectations and reality decreased stress and presumably facilitated transition into the marital role.

Thompson (1958) conducted a study to determine whether pre-retirement expectations affected adjustment to retirement. A year prior to retiring, male participants were asked questions related to their attitude toward retirement, preconception of retirement, and plans for retirement. During the year following retirement, participants were asked questions designed to measure their adjustment to retirement. The findings suggested that the two most important anticipatory factors facilitating adjustment to retirement were a positive attitude toward and an accurate preconception of retirement (Thompson, 1958).

To summarize, there is substantial evidence indicating that many parents are unprepared for the realities of parenthood (Dyer, 1963; LeMasters, 1957; Pellegrom & Swartz, 1980). This lack of preparation may be due to a paucity of available anticipatory socialization experiences (Hill & Aldous, 1969; LeMasters, 1957; Rossi, 1968), and to the romanticizing of parenthood (LeMasters, 1974). Studies of various populations suggest that holding unrealistic preconceptions of a role can lead to a difficult transition into that role (Curley & Skerrett, 1978; Kramer, 1974; Thompson, 1958). Therefore, it seems reasonable to assume

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that holding inaccurate preconceptions about the parental role may be one factor contributing to difficulty adjusting to parenthood.

Purpose and Importance of the Study

As health care providers who are accessible to new mothers before, during, and immediately after the birth of their babies, nurses are in a unique and ideal position to assist women in the preparation for and the adjustment to the parental role. The studies previously discussed would suggest that nurses need to know what first-time mothers expect their new role to be like, what it is like, and whether discrepancies between preconceptions and reality do contribute to difficulty in assuming the parental role in the postpartum period.

In previous studies, researchers have described the experiences and concerns new mothers report during the postpartum period (Adams, 1963; Gruis, 1977; Williams, 1977). In one study (Pellegrom & Swartz, 1980), researchers asked primigravidas in the postpartum period whether they had expected their current concerns. The primary purpose of the current study is to use a longitudinal design to determine the relationship between preconceptions of and experiences during the postpartum period, and ease or difficulty of transition into the parental role during that period. A further purpose is to examine the relationship between the amount of anticipatory socialization a woman

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Research Questions

The research questions are as follows:

1. How accurate are first-time mothers in anticipating their postpartum experiences?
2. How difficult is transition into the parental role for first-time mothers?
3. What are the relationships among selected sociodemographic variables and a) congruence of preconception/experiences and b) ease of transition into the parental role?
4. Is there a relationship between the accuracy of a first-time mother's preconceptions of the postpartum period and her ease into the parental role?
5. What is the effect of past anticipatory socialization experiences on a) congruence of preconceptions/experiences and b) ease of transition into the parental role?

Hypotheses

1. The more congruent a first time mother's preconceptions of the parental role are with her actual postpartum experiences, the easier will be her transition into parenthood.
2. The more selected anticipatory socialization experiences a first-time mother has had for the parental role, the more congruent her preconceptions of the postpartum period will be with her subsequent experiences.
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a first-time mother has had for the parental role, the easier will be her transition into that role.

Definition of Concepts

Parental Role

The word "role" has been used in so many different ways that it is difficult to present a comprehensive, satisfactory definition. An attempt to do so is made in Chapter II. For now, "role" is defined both as a social position and as the behaviors, values, attitudes and goals expected of an individual occupying that position (see for example, Conway, 1978; Hardy, 1978; Heiss, 1976; Nye & Gecas, 1976). The parental role, then, is the set of culturally prescribed behaviors, values, attitudes, and goals expected of an individual who has a child.

Role Transition

Role transition is a move into or out of a role (Burr, 1972). It involves taking on the new activities and learning the new knowledge, skills, and attitudes required to perform the new role (Meleis, 1975). Adding a new role to one's social definition of self also requires integrating the required activities of that role into one's current lifestyle.

Ease of Role Transition

Ease of role transition can be assessed by the effectiveness with which the role occupant carries out the role requirements. It can also be assessed by the amount of difficulty the role occupant experiences in adjusting to

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the new role while balancing the activities required in carrying out both new and old roles. In one study, effectiveness of new registered nurses as determined by their supervisors was used to measure how well the nurses were adjusting to their role (Kramer, 1976). In studies examining transition into the parental role, the degree of crisis (Dyer, 1963; LeMasters, 1957) or bother (Hobbs, 1965) resulting from the birth of a first child was the measure of how well parents adjusted to their new role. In this study, ease or difficulty of transition to the parental role will be determined by the amount of bother the new mother experiences as a result of her postpartum experiences.

Preconceptions of the Parental Role

A preconception of a role is the idea or expectation a person has of what the role will be like before actually occupying the role. Pregnant first-time mothers may picture many scenarios when imagining what it will be like to be a parent. The focus of this study is on whether, in picturing themselves as parents, these mothers expect to experience those common postpartum concerns reported in the nursing literature. To take such an approach to examining preconceptions of the postpartum period is not to deny the joys and rewards of first-time parenthood. It is rather to acknowledge that experiences commonly perceived as "negative," that is, as a source of concern, are more likely than "positive" experiences to hinder smooth transition

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into the parental role. This is especially the case if these concerns are unexpected.

Postpartum Experiences

New mothers have a variety of postpartum experiences. As stated above, the focus of this study is on postpartum experiences that commonly concern first-time mothers. Specifically, the postpartum experiences examined in this study are those related to child care concerns, and to the effect of becoming a parent on the mothers as individuals and on their other roles and relationships.

Anticipatory Socialization Experiences for the Parental Role

Socialization. In general, socialization is "the process by which someone learns the ways of a given society or social group so that he can function within it" (Elkin & Handel, 1972, p. 4, cited in Hurley, 1978, p. 31). Socialization for a specific role involves learning "to behave, feel, and see the world in a similar manner as other persons occupying the same role as oneself" (Lum, 1978, p. 142). As a result of socialization for a role, the individual comes to know and understand what behaviors, knowledge, skills, and attitudes are appropriate for performing that role.

Anticipatory Socialization. Socialization for a role is a continuous and cumulative process (Hurley, 1978). It begins even before the individual actually occupies the role in question. Learning what to expect of a role and what is required to fulfill that role before actually

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becoming a role occupant is called "anticipatory socialization" (Thornton & Nardi, 1975). Knowledge about a role comes from several sources: the mass media, current role incumbants, e.g. parents, and future reciprocal-role others, e.g. children (Thornton & Nardi, 1975).

In the anticipatory stage of socialization, future role occupants may have opportunities to "try on" or rehearse the aspired-to role. Caring for infants, observing parents (one's own and others) care for infants, reading about the parental role, and taking formal classes relating to child care and family life, are examples of experiences that provide a chance for individuals to learn about and practice in advance the skills, knowledge and attitudes they will need when they become parents. These pre-parenthood experiences are considered "anticipatory socialization experiences." Anticipatory socialization for the parental role will be examined in this study, as this should affect first-time mothers' preconceptions of and ease of transition into that role.

First-time Mothers

First-time mothers are women for whom the current pregnancy is the first to continue past the first trimester. The participants in this study were between 36 and 40 weeks pregnant when completing the first questionnaire, and between 6 and 8 weeks postpartum when completing the second questionnaire. Since neither "primigravida" nor "primipara"

accurately described participants throughout the study, "first-time mother" was chosen as the single identifying term.

Assumptions and Limitations

This study is based on the following assumptions:

1. First-time mothers in the third trimester of pregnancy form preconceptions of what the postpartum period will be like.
2. First-time mothers at 6 to 8 weeks postpartum are able to reflect objectively on their experiences during the postpartum period.
3. Respondents were able to read and understand the questionnaires.
4. Respondents replied honestly to questionnaire items.
5. Respondents did not consult with others while completing the questionnaires.
6. Questionnaire items accurately reflect preconceptions of and experiences during the postpartum period.
7. The amount of bother postpartum experiences caused respondents is an accurate reflection of how difficult they found transition into the parental role to be.

The following limitations apply to this study:

1. A small convenience sample was used, limiting application of findings to other populations.
2. The failure to use a random sample means that unknown extraneous variables may affect study results.
3. Possible initial differences between women who agreed to

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participate in the study and those who chose not to participate may affect study results.

4. Respondents completed the questionnaires at home, and may have consulted with others about their answers.

5. Respondents may have answered questionnaire items in a manner conforming to their ideas of social acceptability, instead of responding honestly.

Overview of Chapters

This study is presented in six chapters. In Chapter II, the concepts of role theory as the basis for studying transition into the parental role, and their articulation with nursing theory, will be described. In Chapter III, the pertinent literature relating to the study questions will be reviewed. The research design and methodology, the construction of the instruments, and the rationale for data analysis will be explained in Chapter IV. In Chapter V, the results of the data analysis will be presented. Study findings, conclusions, recommendations, and nursing implications will be explained in Chapter VI.

CHAPTER II

CONCEPTUAL FRAMEWORK

Background

There has been a change in the family sociology literature over the past 25 years regarding the nature of first-time parenthood. In 1957, LeMasters published results of a study showing that the birth of the first child resulted in extensive or severe crisis for 83% of white middle-class respondents. LeMasters used Hill's definition of crisis: "Any sharp, decisive change for which old patterns are inadequate" (LeMasters, 1957, p. 353). In 1963, Dyer re-studied LeMasters' hypothesis, with a slight change in methodology, and found that 53 percent of couples questioned had experienced extensive or severe crisis, and 38 percent had experienced moderate crisis (Dyer, 1963). Following reports of these studies, "parenthood as crisis" became the catch phrase in later studies.

However, three later attempts to replicate these studies failed to confirm the findings that first-time parenthood is a crisis (Hobbs, 1965; Hobbs, 1968; Hobbs & Cole, 1976). In two studies, none of the respondents reported extensive or severe crisis (Hobbs, 1965; Hobbs, 1968). In another, only 2.3 percent of couples reported extensive crisis, and none reported severe crisis (Hobbs & Cole, 1976). The differences in findings may have been a function of the different methods used to score and report degree of crisis, or of the variations in the size and

composition of the samples (Jacoby, 1969). Whatever the reason, the discrepencies between findings of the early and later crisis studies indicated to some authors the shortcomings of using a crisis model to explain the normal event of first-time parenthood (Jacoby, 1969; Rossi, 1968).

In a classic article, Rossi (1968) redefined the nature of first-time parenthood from a crisis to a normal developmental task in the family life-cycle. She viewed the concept of "parenthood as crisis" as too narrow in focus and encouraged researchers to use instead a "conceptual system which can deal with both successful and unsuccessful role transitions" (p. 274). Parenthood viewed from this perspective becomes, not necessarily a crisis, but a transition into a new role which can be either smooth or stressful.

Jacoby (1969) supported using a role transition perspective in studying first-time parenthood. He contended that studies based on a crisis framework assumed that the need to adjust to parenthood led to a crisis, and therefore failed to differentiate between the behavioral changes required of new parents and the degree of distress these changes caused them. He asserted that research based on a role transition framework could make this differentiation and thus account for the affectively positive and neutral, as well as negative, aspects of parenthood.

After the articles by Rossi and Jacoby, there was a transformation in the literature from "parenthood as crisis"

to "transition to parenthood." Maternal-child nurses, as well as family sociologists, found the new concept useful to their practice and research (Hobbs & Cole, 1976; Russell, 1974; Stranik & Hogberg, 1979; Sweeny et al., 1979; Wente & Crockenberg, 1976). A role transition framework is the basis for this study as well. The hypotheses set forth in Chapter I concerning the relationship among anticipatory socialization, accuracy of preconceptions about the post-partum period, and ease of transition into parenthood flow from a role transition model. The remainder of this chapter is devoted to explicating such a model, describing its relationship to the hypotheses, and demonstrating how it articulates with a theory of nursing.

Role Transition

Before presenting a model of role transition, it is necessary to define what a role is, and what role transition in general means. The concept of "role" has so many dimensions that it is difficult to define (Hinshaw, 1978). There are two main categories of definitions. Central to the first group of definitions is that a role is a set of behaviors that is expected of a person who occupies a certain position in a society (Hardy, 1978; Heiss, 1976; Gross, Mason & McEachern, 1958, cited in Thornton & Nardi, 1975; Nye & Gecas, 1976). Similar definitions include the values, goals, or attitudes that guide behavior as intrinsic to the concept of "role" (Scott, 1970, cited in Hinshaw, 1978; Turner, 1959, cited in Meleis, 1975). A role, then,

is a set of culturally prescribed behaviors, values, goals and attitudes that is expected of a person in a given position.

In contrast to the above definitions is a second group which defines "role" as the basic structural and functional unit of society (Hinshaw, 1978) where the "relationship between roles and the social structure...is similar to that which exists between organs and functions in the biologic system" (Conway, 1978, p. 20). When role is defined this way, it is synonymous with "position" -- "a location in a social structure" (Hardy, 1978, p. 75) -- and indicates not the behaviors expected of a person in a position, but the position itself.

The example of the parental role can be used to explain how two definitions, which seem disparate, are actaully two aspects of one concept. Applying the first definition, the parental role consists of the culturally prescribed behaviors, goals, and values a parent is expected to demonstrate, for example, taking care of and loving his or her child. According to the second definition, "parent" is the social role, or position, a person occupies by virtue of having one or more children. A definition combining these two aspects of the concept of "parental role" would be "the position in society occupied by an individual who has at least one child, and the attendant socially-prescribed behaviors, values, attitudes and goals that individual is expected to demonstrate."

The purpose of separating out, and then bringing together again, these two aspects of the concept "role" is to synthesize the numerous definitions ascribed to "role" in the literature. Blending the definitions clarifies what is meant by "role" in this study, and aides in understanding the meaning of "role transition."

Role transition is the "moving in and out of roles in a social system" (Burr, 1972, p. 407). The meaning of "role" in this definition is in line with the second definition presented above, that is, it is synonymous with "position." Yet transition to a new role does entail acquiring new behaviors, knowledge, and expectations (Meleis, 1975, p. 265). Thus, role transition does not simply occur at the moment an individual moves into a new position, but also entails the process during which he or she learns and demonstrates the skills, knowledge, behaviors and attitudes society expects of persons occupying that position, or role. The degree to which there is freedom from difficulty in moving into a new role (or out of an old one), is called "ease of role transition" (Burr, 1972, p. 407).

The Model

The concept of "role transition" is useful in describing the move into first-time parenthood. In an attempt to explain the role transition process, Burr (1972) proposed a model of role transition that may explain why transition into parenthood is a "crisis" for some couples and a relatively smooth process for others. Burr

hypothesized that several factors positively and inversely influence ease of role transition. Figure 1 is an adaptation of Burr's model, and shows the relationships among these factors.

For the sake of clarity, factors that positively influence ease of role transition will be called "facilitating factors"; those that inversely influence ease of role transition will be called "inhibiting factors." The major facilitating factors in the model are anticipatory socialization, role clarity, the definitiveness and/or importance of the transition procedure, and the degree to which the role facilitates goal achievement. Role compartmentalization facilitates role transition by mitigating the effects of role strain, an inhibiting factor (Burr, 1972).

The major inhibiting factors are role strain and the amount of normative change required by role transition. Role incompatibility and the amount of prescribed activity a role demands inhibit ease of role transition indirectly by increasing role strain. Role conflict contributes to hindering ease of role transition by decreasing role clarity, a facilitating factor (Burr, 1972).

In the following section, concepts from the model will be defined, and transition to the parental role will be used as an example. One of the concepts, anticipatory socialization, will then be developed in order to show how the hypotheses for this study were derived from that specific variable from Burr's model of role transition.

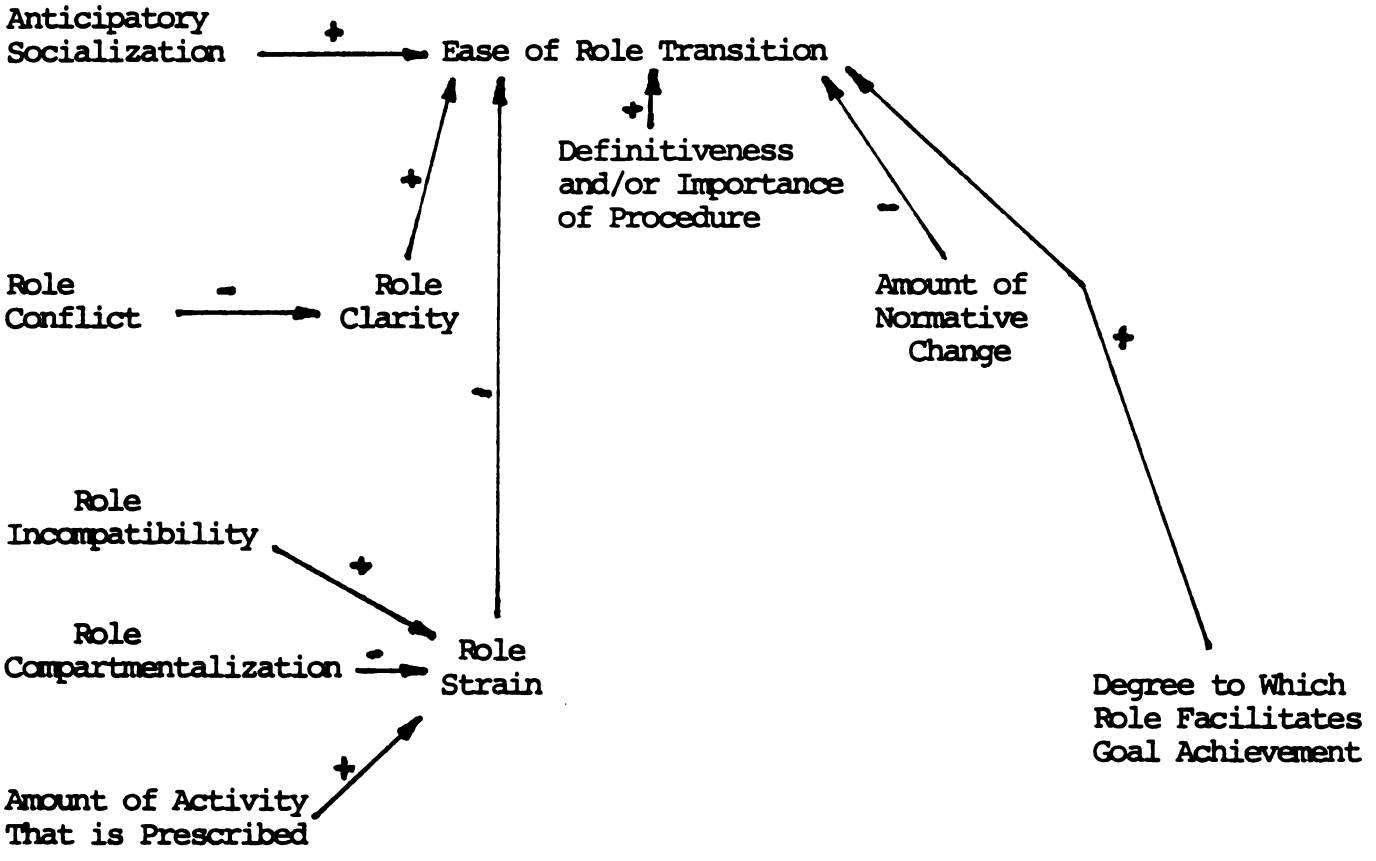

Figure 1. Factors Facilitating or Hindering Role Transition *

*Adapted from Burr, W. R. Role transitions: A reformation of theory. Journal of Marriage and the Family, 1972, August, 407-416.

The first facilitating factor to be discussed is anticipatory socialization. Socialization is the process whereby an individual learns the appropriate norms, attitudes, self-images, values, and role behaviors necessary for taking on a new role (Mortimer & Simmons, 1978). Anticipatory socialization is the "process of learning the norms of a role before being in a social situation where it is appropriate to actually behave in the role" (Burr, p. 408).

There has been much written about the paucity of opportunities to learn how to fulfill the role of parent beforehand. Insufficient formal education for parenthood (Hill & Aldous, 1974; LeMasters, 1974) and the inherent lack of opportunity for rehearsing the parental role during pregnancy (Hill & Aldous, 1969; Rossi, 1968) are two factors resulting in deficient anticipatory socialization for parenthood. Other factors are a decrease in opportunities to care for infant siblings in small modern families, and a "romantic complex" which blinds even couples seeking information about parenthood to its true and sometimes problematic nature (LeMasters, 1974).

While availability of anticipatory socialization experiences is limited, those couples who do manage to learn about parenthood in advance seem to undergo an easier adjustment to their new role. Dyer (1963) found that crisis scores were lower for new mothers and fathers who had taken preparation for marriage courses in school. The birth of a first baby resulted in more gratifications for fathers who

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had prepared for parenthood by going to classes, caring for infants, or reading about child care than for unprepared fathers (Russell, 1974). Mothers who participated in a prenatal class emphasizing the psychological and social adjustments of parenthood experienced less postpartum emotional disturbance than mothers participating in a class about baby care alone (Gordon & Gordon, 1960). These studies support Burr's proposition that anticipatory socialization facilitates role transition.

The second variable proposed to ease role transition is role clarity. Role clarity refers to the definitiveness of the expected behaviors, attitudes, and knowledge needed to fulfill the role (Burr, 1972). Many sociologists suggest that the role expectations for parenthood are far from clear. Parents are confused as to how to raise their children to become the type of competent adults society values (Rossi, 1968). They have been advised to reject traditional child-rearing methods, but receive no guidance in replacing them with new methods based on scientific theory (LeMasters, 1974). Parents may believe that they alone are responsible for the outcome of their parenting, but they do not have full authority or influence over their children. Schools, churches, hospitals, and the legal system supersede parental authority in some circumstances (LeMasters, 1974). Transition to the parental role can be hindered by such a lack of role clarity.

Role clarity is hindered by role conflict (Burr, 1972). Role conflict occurs when there are simultaneous and incompatible role expectations associated with a position. A new mother who decides to breastfeed her baby on the advice of her physician may experience role conflict if her husband, mother, employer, or other significant person expects her to bottlefeed her baby. These conflicting expectations lead to difficulty in assuming the maternal role because what is expected of the mother is unclear. That is, role transition is hindered by role conflict through its negative effect on role clarity.

The third facilitating factor is the definitiveness with which one moves into the role, and the importance attached to the role by society (Burr, citing Cottrell, 1942). Unlike some role transitions in our society, e.g. into adulthood, the move into parenthood occurs at a specific moment--the birth of the child. The importance of parenthood to society, however, is open to question. On one hand, young couples are surrounded by "pro-parenthood propaganda" (Whelan, 1975). The media, churches, infant-care-product industries, family, and friends exert subtle or overt pressure on the young couple to start a family. On the other hand, LeMasters (1974) contends that parenthood is not supported as a priority in our society. We claim to be a family-oriented society, but our actions frequently belie this assertion. Employers do not grant paternity leaves, nor do they consider the effect on the

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family of multiple geographic moves, or of a job that takes the father away from home during the week. Job sharing, flexible work hours, in-house day care, and other options provided in some foreign countries to facilitate workers' carrying out family obligations, are almost unheard of in this country. Even the Federal government has been accused of undermining the family by requiring the father of an indigent family to be absent before welfare support is offered. So although the move into the parental role is definitive, the importance of the role to society is open to question.

The final facilitating factor is the degree to which the role promotes goal achievement (Burr, 1972). (The original model shows various factors that mitigate the effect of this variable, but these do not have to be considered for an understanding of the adapted model). Parenthood itself is a goal for many couples, but even when children are planned, they can interfere with other life goals, for example, financial security, upward mobility, an active social life, or career development. Conversely, parenthood may promote such life goals as providing a raison d'etre for the wife, enhancing self-esteem, and giving and receiving love.

In contrast to factors facilitating ease of role transition are those variables proposed by Burr (1972) as inhibiting factors. The two major inhibiting factors are

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role strain and the amount of normative change required by role transition.

Role strain is defined as the stress a person feels when he or she has difficulty carrying out either various aspects of one role, or carrying out many roles at once (Burr, 1972). Factors contributing to role strain are role incompatibility and the amount of prescribed behavior associated with a role (Burr, 1972).

Role incompatibility refers to the degree to which the demands of one role a person is supposed to carry out interfere with that person's ability to perform another role (Burr, 1972). This can occur if a mother becomes so absorbed in her child-care role that she neglects her marital role. Or she can experience role incompatibility if her employer expects her to return to work full time before the baby is weaned from the breast. These pressures hinder ease of role transition by their contribution to role strain.

Role compartmentalization is a factor which facilitates ease of role transition by mitigating the adverse effects of role incompatibility (Burr, 1972). If one is expected to perform two incompatible roles at the same time, or in the same setting, anxiety and frustration ensue, and transition into the new role is difficult. Burr proposes that if one can arrange to separate the conflicting roles in time or space, transition is facilitated. Staying in the hospital 3-5 days postpartum separates the new mother from her usual setting, where other roles are to be performed. Asking a

relative or friend to provide help at home for awhile keeps her from having to attend fully to her other roles at first. These strategies should assist the new mother to adjust more easily to her new role by decreasing the negative effects of role incompatibility.

The amount of prescribed activity expected of a role occupant also increases role strain. The more behaviors one is "supposed" to do, the greater the stress the person feels to get them all done. One thinks of all the advice given to new mothers about cord care, bathing, formula or nipple preparation, diaper care, provisions for infant safety, and so on. All these prescribed activities can increase role strain and promote difficulty in adjusting to the parental role (Burr, 1972).

The second major inhibiting factor is the amount of normative change required of new role occupants (Burr, 1972). If the norms of a couple's social group include frequent entertaining, travel, lavish spending, or being able to "pick up and go" spontaneously, the new parents will experience a great deal of normative change. They may find transition to parenthood more difficult than a couple whose social group already includes many parents who value family activities.

To summarize, Burr's model is an attempt to explain variations in ease of role transition by describing and relating some of the factors that may promote or hinder the process of moving into a new role (Figure 1). The model

is a starting point from which tentatively to explain and predict why transition into parenthood presents difficulty for some couples, but not for others. A study designed to test the entire model would measure all the variables for a group of individuals undergoing transition into parenthood and compare these measurements with their ease of role transition. Such a study would be difficult to conduct because of the multiplicity of variables to consider. A partial test of the model could be conducted, however, by measuring one of the variables and comparing it to ease of transition into parenthood. To be such a partial test is the goal of this study. The variable to be measured and compared with ease of transition into the parental role is anticipatory socialization.

Anticipatory Socialization

Anticipatory socialization is the process by which individuals learn the norms, attitudes, self-images, and behaviors appropriate to a new role before actually moving into that role (Burr, 1972; Mortimer & Simmons, 1978). It involves all mental, behavioral, and social activities that are performed in preparation for taking on a new role, including fantasy, play, daydreaming, practicing, and forecasting future situations (Lum, 1978; Mortimer & Simmons, 1978). Anticipatory socialization results in a role aspirant's having an idea about what will be expected of him or her (role expectations) and what the role will be like (role conceptions) (Thornton & Nardi, 1975).

It seems logical that having an understanding of what a role will be like in advance should have, as Burr (1972) predicts, a positive effect on ease of role transition. Goffman (1959, p. 72, cited in Thornton & Nardi) concurs: "When we come to be able to properly manage a real routine we are able to do this in part because of anticipatory socialization, having already been schooled in the reality that is just coming to be real for us."

It is equally obvious that, in order to be useful, anticipatory socialization must result in an accurate conception of what the role will be like. Inaccurate role conceptions may actually hinder role transition because the new role occupant must unlearn information in addition to learning the correct norms, behaviors, and attitudes needed for acceptable role performance (Thornton & Nardi, 1975). Role conceptions obtained during the anticipatory stage of learning a new role tend, in fact, to be stereotyped, idealized, and incomplete (Thornton & Nardi, p. 874). Inaccurate role conceptions may result especially if a society intentionally romanticizes an arduous but essential role, such as parenthood seems to be in our society (LeMasters, 1974). Idealized, romanticized, and generally incorrect and incomplete information about a role may entice an individual into accepting the role, but the resultant unrealistic role conceptions he or she will hold are a barrier to ease of role transition. "The degree of congruity between what individuals learn to anticipate and what they

subsequently experience will likely determine how quick and smooth the process of adjustment will be" (Thornton & Nardi, 1975, p. 875, emphasis added).

Burr's model of ease of role transition shows anticipatory socialization exerting a positive effect on ease of role transition. Based on Thornton and Nardi's observation, it may be concluded that there is also a mediating factor between anticipatory socialization and ease of role transition: congruence between preconceptions about the role and later experience. That is, accurate anticipatory socialization results in an accurate picture of what the role will be like; the accuracy of this preconception, in addition to the anticipatory socialization itself, positively influences ease of role transition (see Figure 2).

Conversely, when anticipatory socialization is inaccurate, it leads to an inaccurate picture of what the role will be like. An inaccurate, or unrealistic, preconception of a role is apt to inhibit ease of role transition (see Figure 2).

The purpose of this study is to examine the parental role to discover whether the relationships diagrammed in Figure 2 exist. The primary hypothesis is that congruence of role conceptions acquired during anticipatory socialization - i.e. preconceptions of the parental role - with later experience will facilitate ease of role transition. The second hypothesis is that exposure to selected anticipatory socialization experiences promotes congruence of

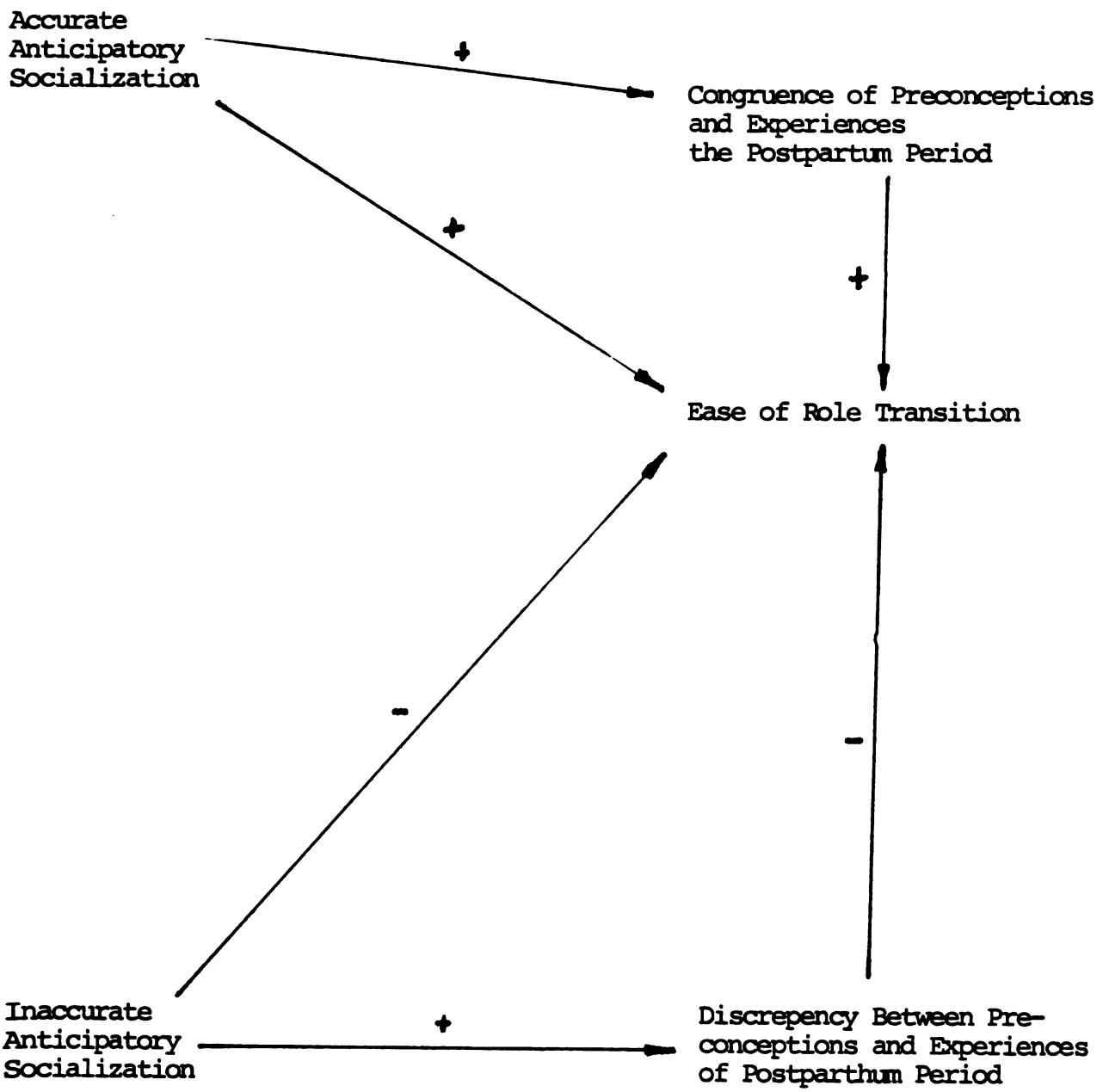

Figure 2. The Proposed Relationships Among Anticipatory Socialization, Congruence of Preconceptions and Experiences of the Postpartum Period and Ease of Role Transition

preconceptions/experiences. The third hypothesis is that there is a direct relationship between selected anticipatory socialization experiences and ease of role transition.

Role Transition and Health

Consequences of Difficult Transition into the Parental Role

The primary purpose of this study is to determine whether there is a relationship between the accuracy of a first-time mother's preconceptions of the postpartum period and her ease of transition into the parental role. Ease of role transition is defined, in part, as the degree of "freedom from difficulty" a role occupant experiences in taking on a new role (Burr, p. 407). Previous researchers have explored the ease or difficulty of transition into the parental role by measuring the amount of "bother" the necessary adjustments caused new parents (Hobbs, 1965; Hobbs, 1968; Hobbs & Cole, 1976; Russell, 1974; Wente & Crockenberg, 1976). In each study, the assumption was clearly present that a difficult move into parenthood would lead to undesirable results, but in no case were these results spelled out. In the following section, the parental role will be used to illustrate the consequences of difficult role transition.

The result of a smooth and easy transition into parenthood should be good social and psychological adjustment to the role. Social adjustment denotes "the adequate meeting of role expectations and performance in accordance with them" (Thornton & Nardi, 1975, p. 873). Psychological

adjustment denotes "the achievement of congruity between individual psychological needs and desires and the role" (Thornton & Nardi, 1975, p. 873). Poor adjustment in either of these two areas have implications for individual and family health.

Poor social adjustment, as defined by Thornton and Nardi (1975), is equivalent to the concept of "role insufficiency" found in the nursing literature: "Any difficulty in the cognizance and/or performance of a role or of the sentiments and goals associated with the role behavior as perceived by the self or by significant others" (Meleis, 1975, p. 266). If, because of a difficult role transition, a new parent has difficulty carrying out the role, both family health and the health of the infant may be in jeopardy.

A family unit is healthy in part to the extent it is functioning adequately. One criterion for adequate family functioning is whether family roles are enacted acceptably according to the family's own standards as well as those of the community (Glasser & Glasser, 1960; Janosik & Miller, 1980). If transition into the parental role is difficult, leading to role inadequacy, family disruption may result (Janosik & Miller, 1980).

The health of the infant as well as the family is at stake when parents experience role insufficiency secondary to difficult transition into the parental role. The child's health depends on the family, especially on the parents

(see for example Orem, 1980; Pless and Satterwhite, 1973). This is the case because society's role expectation of parents is that they will take care of and nurture their children (Nye & Gecas, 1976). Parents who cannot fulfill this role expectation (i.e. experience role insufficiency) may have difficulty safeguarding their infants' health.

Failure adequately to meet the demands of a role is one result of role insufficiency. There are also psychological consequences when a role occupant knows he or she has not met role expectations: "anxiety, depression, apathy, frustrations, grief, powerlessness, unhappiness and/or aggression, and hostility" (Meleis, 1975, p. 267). These feelings clearly can interfere with the new parent's sense of well-being, and could, in turn, lead to further difficulty in functioning adequately in the role.

While poor social adjustment results directly in the inability adequately to meet role expectations, poor psychological adjustment is manifested by an inability to fulfill simultaneously one's personal psychological needs and the demands of the role. In this case, either one's own needs are not met, leading to frustration, anxiety and unhappiness, or role performance is inadequate. In either case, the health of the parent, the infant, and the family is at risk (see Figure 3).

The health of the family and of its individual members is of concern to all nurses. The family nurse specialist possesses knowledge about family roles and

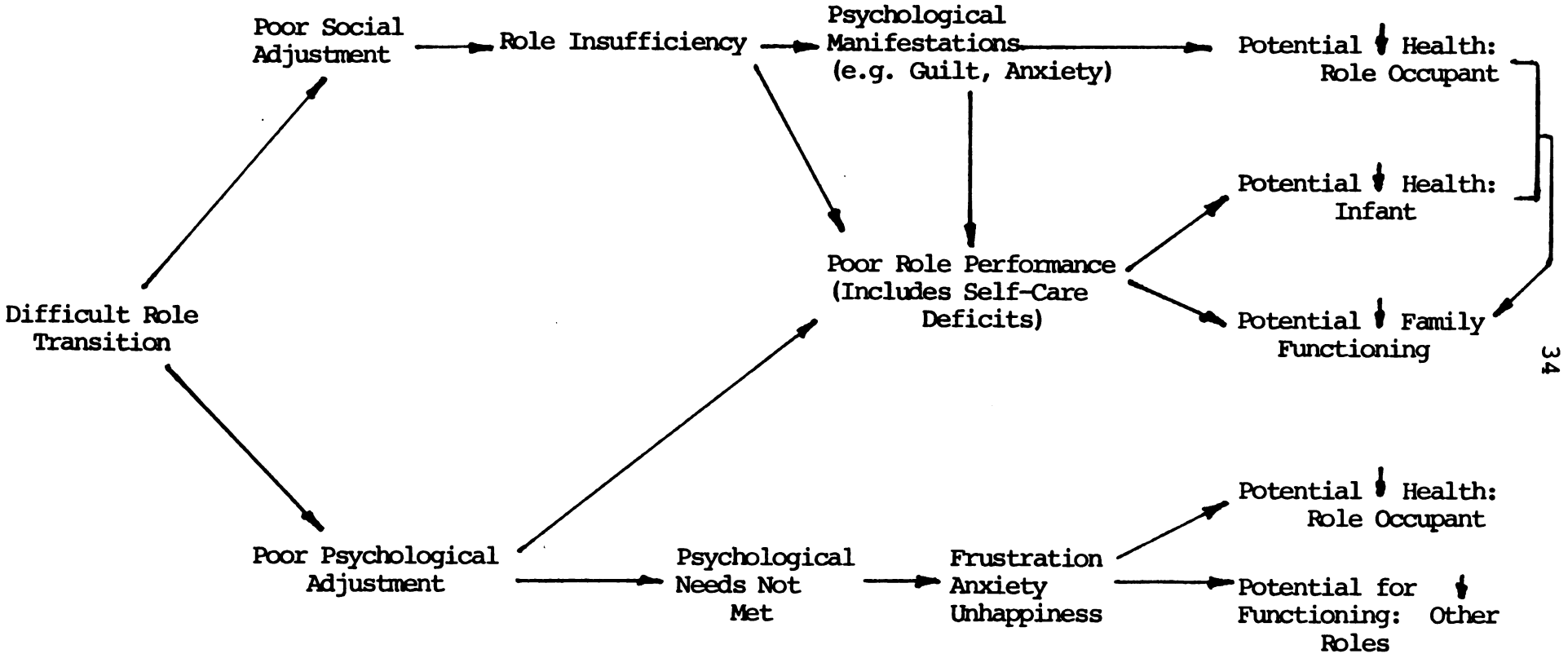

Figure 3. Propositions Concerning Health Consequences of Difficult Role Transition

functions as well as skill in promoting health through teaching, counseling, and anticipatory guidance. In addition, nurses are accessible to new parents throughout the perinatal period. Thus, nurses are in a key position to help new parents experience a smooth role transition and thus avoid or minimize the health risks associated with difficulty adjusting to the parental role. In the next section, the relationship between the conceptual framework for this study, role transition, and nursing will be explained.

Relationship Between Nursing and Role Transition

Burr's model (1972) predicts a difficult transition to the parental role if inhibiting factors prevail, or if facilitating factors--e.g.accurate anticipatory socialization--are missing. However, neither Burr's model, nor the role theory concepts on which it is based, can explain how helping professionals can assist new parents in avoiding a difficult role transition. Another theory is needed to put role theory concepts into action. A theory of nursing can meet this need. Following is a brief explanation of Dorthea Orem's theory of nursing, and an interpretation of its articulation with role theory.

According to Orem (1980), nursing is concerned with "the individual's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects" (Orem, p. 6). Self-care is

"the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (Orem, p. 35). Self-care is the responsibility of every adult, and if it is not carried out, the result is "illness, disease, or death" (Orem, p. 6). Infants and children need the assistance of an adult to perform self-care activities (Orem, 1980).

An individual is in need of nursing care when there is an "absence of the ability to maintain continuously that amount and quality of self-care which is therapeutic in sustaining life and health, in recovering from disease or injury, or in coping with their effects" (Orem, p. 7). Children are in need of nursing care when their parents or guardians cannot maintain therapeutic care for them (Orem, p. 7). Therapeutic means "supportive of life processes, remedial or curative when related to malfunction due to disease processes, and contributing to personal development and maturing" (Orem, p. 7). Orem defines health as "the state of physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 120).

Orem conceptualizes three categories of self-care requisites: Universal, Developmental, and Health-Deviation. Universal self-care requisites are related to the maintenance of life processes and are common to all human beings (Orem, 1980). Developmental self-care requisites are related to developmental process over the life-cycle (Orem, 1980). Health-Deviation self-care requisites are related

to problems with human structure and functions, the effects of these health problems on the individual, and their medical diagnosis and treatment (Orem, 1980).

Nursing intervention is appropriate when an individual is unable to carry out those acts that are necessary for self-care. Orem describes three nursing systems from which interventions are accomplished: a wholly compensatory system for situations in which a person is totally unable to care for him or herself; a partly compensatory system for situations in which a person needs some help in accomplishing and removing obstacles to accomplishing self-care; and a supportive-educative system for situations in which a person is able to accomplish self-care with some support, guidance, or education (Orem, 1980).

Orem's theory can be related to role theory because some of the concepts of each are equivalent. For example, Orem says that self-care is the responsibility of every adult (Orem, p. 6). A corollary to this statement is that providing self-care for one's children is the responsibility of every parent. Provision of self-care for one's children is thus a parental role expectation the fulfilling of which leads to adequate parental role performance. Failure to provide self-care for one's children leads to poor role performance, or role insufficiency. The relationship between role insufficiency and a difficult role transition has been described (see Figure 3).

Orem states that a need for nursing care exists when an individual has difficulty engaging in self-care activities adequate for maintaining health. Thus, a parent experiencing role insufficiency secondary to a difficult role transition, and who is therefore unable to provide adequate self-care for his or her child, can benefit from nursing care. Preventive nursing care can, in fact, be offered before the self-care deficit (role insufficiency) is manifested. Orem specifically states that new parents can benefit from nursing care because of the anatomical, physiological, and psychological changes associated with parenthood (Orem, 1980, p. 137).

Nursing care of new parents would derive from the supportive-educative nursing system, which consists of assisting the client with "decision making, behavior control, and acquiring knowledge and skills" (Orem, 1980, p. 101). The goal of nursing intervention would be to ease role transition by enhancing the facilitating factors and modifying or removing the inhibiting factors (see Figure 1).

The relationship between nursing according to Orem's model and role transition is shown in Figure 4.

Summary

The ease or difficulty individuals experience when moving into the parental role has implications for family and individual health. Nurses who work with families in the perinatal period should therefore concern themselves

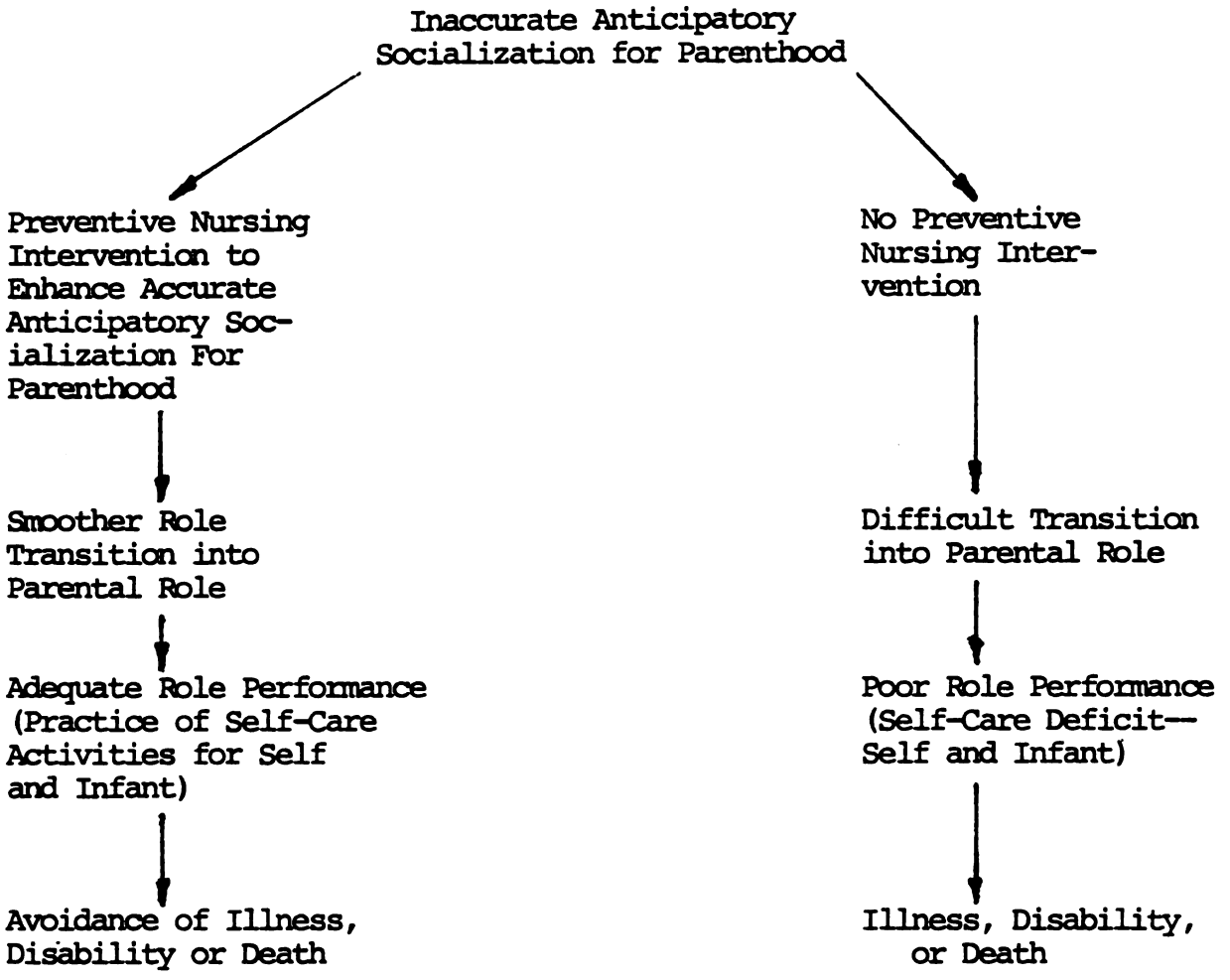

Figure 4. Relationship Between Role Transition Concepts and Nursing Theory (Orem)

with easing role transition. Burr's model (1972) showing the relationship among variables affecting ease of role transition can be used in the assessment phase of the nursing process to identify couples who may be at risk for a difficult transition into parenthood. However, the model should be used with caution until it has been thoroughly tested. The present study is designed to test the relationship between one variable, anticipatory socialization, and ease of transition into the parental role (see Figure 2). The results of this study will indicate whether, as proposed, ease of transition into the parental role can be predicted by assessing 1) the number of anticipatory socialization experiences a first-time mother has had and 2) the accuracy of preconceptions of the parental role a first-time mother holds. If the relationship between anticipatory socialization and ease of role transition is supported, nurses will have confidence that interventions designed to enhance anticipatory socialization for the parental role will increase the ease of transition into parenthood.

CHAPTER III

REVIEW OF THE LITERATURE

The purpose of the present study is to describe the relationships among first-time mothers' anticipatory socialization for the parental role, the accuracy of their preconceptions of the postpartum period, and their ease of transition into parenthood.

Research linking all the study variables is sparse. However, literature linking two or more of these concepts, or examining a single concept was found; these studies will be reviewed. Nursing and sociology literature describing the postpartum experiences and concerns of first-time mothers will be considered first.

Postpartum Experiences

There is a wealth of research describing the postpartum concerns and experiences of new mothers reported in both the nursing literature (e.g. Adams, 1963; Gruis, 1977; Summer & Fritsch, 1977) and the family sociology literature (e.g. Dyer, 1963; Hobbs, 1965; LeMasters, 1957; Russell, 1974). Concerns tend to be related to child care, and to the effects of birth and the presence of the infant on the mother's physical and emotional self, on her ability to carry out other social roles, and her ability to manage her time. Nursing studies, followed by sociology studies, will be reviewed.

In a descriptive study of new mothers' infant-care concerns (Adams, 1963), 40 primiparas were interviewed at 2

days, one week, and one month postpartum. The greatest area of concern was infant feeding, followed closely by crying. Mothers had the most questions at one week, the fewest at one month, and had nearly as many questions at 2 days as at one week. Mothers who had rooming in had more questions at 2 days, but only a third as many questions at one week, as mothers who had not had rooming in. The most common spontaneous comment regarding what was "most upsetting" was the upset in their schedule that the infant caused. Adams concluded that, in order to reduce postpartum concerns and increase new mothers' confidence in their ability to care for their newborns, nurses should encourage rooming-in and should use the postpartum stay to do more specific teaching about infant feeding (Adams, 1963).

In another study, Gruis (1977) developed a questionnaire consisting of potential concerns generated from the literature. The questionnaire was sent to an unspecified number of mothers in the Seattle area who had delivered normal, healthy newborns. Respondents were asked to identify their areas of concern and to rank them "major" or "minor." Returns were received from 17 primiparas and 23 multiparas. Since the percentage of questionnaires returned cannot be determined from this report, it is not possible to determine whether it is appropriate to generalize the results of this study (Polit & Hungler, 1978). However, an interesting finding was that the concern listed most often by this group was "return of figure to normal."

Sixty-five percent said this was a major concern; 30% said it was a minor one (Gruis, 1977).

In all, thirty-two concerns were reported. Most can be categorized as concerns about physical recovery from labor and delivery, and incorporating the infant into the family (Gruis, 1977). After "return of figure to normal," the most common concerns reported were regulating demands of husband, housework and children (90%), emotional tension (80%) and fatigue (83%). Forty-three percent of women listed feeding as a minor concern; 25% said it was a major concern. "Crying" was not a separate item, but infant behavior as a whole was reported as a minor concern by 47%, and a major concern by 33% of respondents (Gruis, 1977).

Gruis' findings show that more women were concerned with some of the physical and emotional effects of new motherhood than they were with infant feeding and behavior. This contrasts with Adams' (1963) findings that the most common postpartum concerns related to infant feeding and crying. The apparent discrepancy is easily explained by noting that Adams' study asked only about infant-care concerns, while Gruis' study was broader in scope.

In another attempt to discover the nature of mothers' postpartum concerns, Summer and Fritsch (1977) tallied all telephone calls made by newly-delivered mothers to their health care agency during a one month period. The type of question, infant's age and sex, and parity of the mother were noted for each call. Questions were categorized into

those relating to feeding, gastrointestinal problems, skin, sleep/cry, postpartum problems, and "other." Eighty-eight percent of primiparas and 25% of multiparas called the agency during the study period; most calls were made when the infant was three weeks old. Of all questions asked, most (31%) were about infant feeding. Questions related to babies' gastrointestinal problems comprised the next most common category (21% of all questions). Postpartum concerns, including mother's anxiety, breast problems, and sexual relations, comprised only 9% of all questions, and sleep/cry questions were the least frequent, comprising 8% of all questions (Summer & Fritsch, 1977).

Summer and Fritsch concluded that since one half of all new mothers receiving care at the health care agency under study called the nurse with questions, support and teaching are definitely needed in the postpartum period. They also suggested that offering postpartum classes would be a more efficient way to assist mothers than answering questions individually by phone (Summer & Fritsch, 1977).

A convenience sample of mothers who spontaneously called the nurse with postpartum concerns cannot be assumed to be representative of all new mothers. However, the very fact that expression of their concerns was not specifically solicited leads to one potential advantage over studies that require women to respond to certain categories of concerns. That is, the researcher, in devising such categories, may not include all concerns pertinent to new mothers. Summer

and Fritsch devised categories in advance, but concerns were placed in these categories after the mothers asked the questions; the categories thus could not place constraints on the type of concerns mothers could report.

A disadvantage of this design is that mothers may have concerns that they believe are inappropriate to discuss with the nurse. Thus, women in this sample may actually have had more concerns than they reported in this study. This assumption may account for the fact that Gruis (1977) found personal concerns to be those most commonly expressed, while Summer and Fritsch found these concerns almost the least frequently expressed.

In summary, nursing researchers have found that infant behavior (especially feeding and crying), physical recovery from labor and delivery, and incorporating the infant into the family are concerns that new mothers have in the postpartum period.

Family sociologists have also examined the concerns of new mothers, especially in relation to how these experiences affect the women's ease of transition into parenthood. Transition into parenthood will be discussed later in this chapter. For now, this body of literature will be reviewed solely in terms of the postpartum experiences or concerns described therein.

In a classic study, LeMasters (1957) interviewed a non-random sample of first-time parents to discover whether they considered first-time parenthood to be a crisis. In

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addition to the major findings, to be discussed later in this chapter, LeMasters reported that mothers expressed the following concerns: exhaustion; confinement to the home; missing the satisfaction and income of previous employment; additional laundry; a decline in housekeeping standards; feelings of guilt over not being a "better" mother; the unremitting nature of child care; and appearance and excess weight (LeMasters, 1957).

It is notable that the specific worries about feeding, crying, and other infant activities noted in the nursing research reviewed above, are absent in LeMasters' report. It is unclear whether mothers were asked specifically to respond to a list of concerns, or whether their concerns were spontaneously expressed. If the former was the case, it may be that infant-care concerns were not presented to the mothers. If the latter is the case, the absence of infant-care concerns may be accounted for by the fact that women whose children were up to five years old at the time of the interviews were included in the sample. Memories of having had infant-care concerns may fade faster then memories of the concerns reported.

In a study designed to determine the effects of the arrival of a first child on family roles and relationships (Dyer, 1963), questionnaires were administered to a convenience sample of married, middle-class couples who had their first child within two years prior to the study. Questions fell into the following categories: husband-wife

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division of labor; husband-wife division of authority; husband-wife companionship patterns; family income and finances; homemaking; social and recreational activities; husband-wife mobility and freedom of action; child care and rearing; health of family members; and extra-family interests and activities (Dyer, 1963). Respondents were instructed to mark a Likert-type scale, ranging from 0 (experience caused no crisis) to 4 (experience caused severe crisis) for each item. Findings were, in part, that mothers reported the following experiences, problems, and reactions in adjusting to their child: tiredness (87%), loss of sleep (87%), neglecting husband (67%), feelings of inadequacy as a mother (58%), inability to keep up with the housework (35%), and difficulty adjusting to being tied to the home and curtailing of social activities (35%). These concerns are related to physical and emotional feelings, changes in relationship with husband, and difficulty adjusting to a change in lifestyle. As with LeMasters' findings (1957), there is a notable lack of reference made to infant-care concerns, even though child-care and child-rearing items were included (Dyer, 1963). Children of parents included in this study were up to two years old, so again, a possible explanation for their failure to report this type of concern is the increased confidence in their child care ability that over time may have led to their selectively forgetting any earlier difficulties in caring for their infant.

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Another study used a checklist, comprised of items found by LeMasters and other clinicians to cause new parents difficulties, as a tool to measure the ease or difficulty of assuming the parental role (Hobbs, 1965). These questionnaires were mailed to a 50 percent random sample of white, urban, married, first-time parents drawn from birth records in Greensboro, N.C. Sixty-five percent of couples returned usable questionnaires. Age of the babies at the time of the study ranged from 3 to 18 weeks, with a mean age of 9.8 weeks. This age range is in comparison with ages up to five years old and up to two years old in the studies described above (LeMasters, 1957; Dyer, 1963, respectively).

Respondents were asked to mark on a 3-point scale how much each experience bothered them: none, somewhat or very much. A majority of mothers marked either "somewhat" or "very much" in response to four items: the interruption of routine habits (74%); tiredness and fatigue (68%); increased money problems (66%); and feeling "edgy" or emotionally upset (60%). When a crisis index was computed, the following items were found to be the most discriminating for mothers (reported in descending order): interference from inlaws; decrease in sexual responsiveness; physical tiredness; feeling emotionally upset; decreased contact with people at work; worry about loss of figure; worry about personal appearance; interruption of routine habits; decline in

neatness of the house; and doubting own self-worth as a parent (Hobbs, 1965).

Problems and concerns relating to infant care or behavior evidently did not contribute to these women's "bother" scores. Since the average age of infants of mothers in this study was only 9.8 weeks old, the explanation of failing memory of infant-care concerns offered as a reason for the absence of these concerns in the earlier studies reviewed is not plausible in this case. It may be that questions of this nature were not asked. It is impossible to determine whether this is the case, as the entire questionnaire was not included in the report. However, it is likely that child care questions were not asked, as the instrument used was devised in accordance with LeMasters' findings (Hobbs, 1965), which did not include child care concerns (LeMasters, 1957).

Hobbs' checklist was used in another study designed to determine both the concerns and the rewards of first-time parenthood (Russell, 1974). It was mailed to a 20 percent random sample of married couples who had become first-time parents between July, 1970, and June, 1971. Questionnaires were returned by 57.9% of the mothers. Babies' ages at the time of the study ranged from 6 to 56 weeks old, with a mean of 29 weeks old.

Mothers most frequently checked five items as bothering them either somewhat or very much: worry about personal appearance (64%); physical tiredness and fatigue (78%); baby

interrupted sleep and rest (76%); worry about loss of figure (61%); and feeling "edgy" or emotionally upset (68%). These items relate to the woman's physical and emotional self (Russell, 1974). Child care worries were not reported, probably because Hobbs' checklist, which likely did not include them, was used.

In summary, nursing and family sociology researchers have attempted to describe the nature of new mothers' postpartum concerns. In general, new mothers were found to be concerned about infant behavior and child care, and about the effects of childbirth and acquisition of a new family member on the physical and emotional self, on other social roles and relationships, and on their lifestyle in general. It is clear that nursing and sociology researchers reported some findings in common. However, there are some differences. Sociology researchers failed to find child care concerns; some nursing researchers failed to find concerns related to the mother's self and her other roles and relationships. This disparity may be accounted for by the different perspectives of the two disciplines, which are reflected in the types of questions asked. This explanation cannot be confirmed, however, as a complete list of the questions asked in the sociology research was not provided.

It may be concluded that new mothers have a variety of experiences that concern them during the postpartum period. The preconceptions pregnant mothers have about the

postpartum period, especially about the experiences they expect to have, will be discussed in the next section of this chapter.

Preconceptions of the Postpartum Period

In the previous section, postpartum experiences and concerns were described. The question now to be addressed is the extent to which pregnant women accurately anticipate the experiences and concerns they are likely to have when they become mothers. This question is pertinent to the present study, as holding accurate preconceptions about a role is thought to enhance adjustment to the role (Thornton & Nardi, 1975).

Unfortunately, few well-designed studies describing pregnant women's preconceptions about the maternal role in the postpartum period have been conducted. However, the literature available does indicate that many women are unprepared for the realities of motherhood.

Some researchers report as an incidental finding parents' retrospective assessment of their readiness for parenthood. In a study of the nature of transition into parenthood, Dyer (1963) reported that 80% of first-time parents confessed that "things were not as they expected them to be after the child was born" (p. 200). No mention was made concerning what these parents had expected.

At the conclusion of a longitudinal study designed to determine the effect of prenatal psychological factors on adjustment to the maternal role, subjects were invited to

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participate in a tape-recorded discussion (Shereshefsky & Yarrow, 1973). The discussion is characterized as follows: "Almost all of the women indicated that they had not anticipated their fatigue, their disorganization, the physical complications following delivery and their feelings of inadequacy in the face of the infant's demands and the demands of their husbands" (Shereshefsky & Yarrow, 1973, p. 174, citing Liebenberg).

In contrast to the above studies, where findings of inaccurate expectations were reported incidentally, one retroactive study was undertaken expressly to determine first-time mothers expectations and perceptions of the postpartum period (Pellegrom & Swartz, 1980). The researchers obtained names of new mothers from newspaper birth announcements in a suburban Michigan county. Thirty-seven married primiparas whose infants accompanied them home from the hospital were included in the study. They were interviewed at 3 to 4 weeks postpartum. A questionnaire designed by the researchers contained items suggested to them by the research of LeMasters, Dyer, and Gruis. Inquiries focused on the concepts of time for household tasks, time for husband, time for self, time for recreation, feelings about body shape, and number of continuous hours of sleep. Women were also asked two open-ended questions regarding their most important experience and their least expected experience since the baby's birth.

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Presentation and analysis of data concerning subjects' expectations and experiences were lacking. However, the authors reported that mothers spent less time than expected doing household tasks, being with their husbands, being by themselves, and/or engaging in recreational activities (Pellegrom & Swartz, 1980). The least expected experiences mothers reported having included the "rapid growth and responsiveness of the infant, lack of available time alone with their husband, loss of sleep, and lack of available time for self" (p. 26).

An interesting finding was the relationship between mean hours of continuous sleep and discomfort expressed both about "body shape" and about "time spent with husband." Women who reported "a lot" or "slight" discomfort with "body shape" reported significantly fewer hours of continuous sleep than women reporting "no" discomfort ($p<.05$). Women who reported "a lot" of discomfort about "time with husband" also reported significantly fewer hours of continuous sleep than women who reported "slight" or "no" discomfort ($p<.05$) (Pellegrom & Swartz, 1980). Pellegrom and Swartz drew no conclusions from these findings, but a possible conclusion is that postpartum concerns are exacerbated by loss of sleep.

Pellegrom and Swartz (1980) concluded that the mothers' expectations were different from their experiences in the postpartum period. They correctly cautioned against generalizing the results of this study, due to its small

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sample size and the homogeneity of the population from which it was drawn. However, their findings are consistent with the research described previously in this chapter which also found that fatigue, body shape, and insufficient time for other roles and tasks were areas of difficulty for new mothers (e.g. Gruis, 1977; LeMasters, 1957).

Two prospective studies examining prenatal expectations about events or experiences in the postpartum period will be reviewed next. In an ambitious longitudinal study, the relationships between first-time parents' experiences during pregnancy and the quality of their childbirth and early parenting experiences were explored (Entwisle & Doering, 1981). A minor aspect of the study included examining some preconceptions and plans pregnant mothers had concerning the postpartum period. One preconception almost all the women in this study had, for example, was that their baby would be completely weaned by one year of age. Thirty-five percent expected their baby would be six months old or younger when ready to wean (Entwisle & Doering, 1981). The study ended when the infants were six months old, so no determination could be made about the accuracy of this preconception for these women. The authors assumed, however, that this expectation was unrealistic.

Another expectation was related to the age at which their babies would sleep through the night. Fifty-two percent expected this would occur by or before 8 weeks (Entwisle & Doering, 1981). Unfortunately, the authors

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did not report when the babies in this study in fact slept through the night.

A third preconception examined concerned postpartum employment plans. Before delivery, 33% of respondents intended either not to stop working at all, or to resume work by six weeks postpartum. When contacted at 6 months postpartum, only 24% were working full or part-time. Six percent had tried working but had stopped. The correlation between plans and actual behavior was .43 ($p<01$) (Entwisle & Doering, 1981).

The conclusion drawn was that the women in this study were overly optimistic about infant care. "While optimism in young people is the rule, more realistic assessments of current problems and more down-to-earth expectations about their coming infant probably would have been helpful for these young pregnant women" (Entwisle & Doering, 1981, p. 35).

In a study with the stated purpose of investigating how new fathers arrive at a definition of their paternal role, Humitz & Perrone (1977) attempted to describe both fathers' expectations of infant behaviors, of degree of bother caused by these behaviors, of change in lifestyle, and their actual experiences in regard to those three factors. A convenience sample of 29 middle class, college-educated couples was obtained by telephoning clinics and physicians' offices. Both the husband and wife completed a Neonatal Perceptions Inventory and a Degree of Bother Inventory

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(both scales modified from Broussard & Hartner, 1971) at three points in time: prenatally, at 2 weeks postpartum, and at 6-8 weeks postpartum. The mothers' responses were said to be used as a control.

The Neonatal Perceptions Inventory directed parents to respond to items regarding various aspects of infant behavior, and one item regarding the infant's impact on their lifestyle. Prenatally, parents estimated the amount of crying, spitting up, sleeping, and so on, they expected their infant to do. At 2 and 6-8 weeks postpartum, parents reported their infant's actual behaviors. The Bother Inventory asked parents to relate how much bother they anticipated (prenatally) and actually experienced (at 2 and 6-8 weeks postpartum) secondary to their infant's crying, spitting up, sleeping, elimination, and lack of a predictable schedule (Humitz & Perrone, 1977).

Data presentation and analysis were lacking, and reported findings were difficult to interpret. The authors reported that both parents found that the baby cried, spit up, and slept less than expected, and that feeding and diapering frequencies were the same as expected. Mothers and fathers both reported significantly less bother in response to infant behaviors over time, except for crying and lack of a predictable schedule; these two aspects of infant behavior caused the greatest bother, and the amount of bother was persistent through 6-8 weeks postpartum (Humitz & Perrone, 1977). The authors also reported that fathers

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perceived that the infant changed their lifestyles significantly less than mothers perceived their own lifestyles to be changed as a result of the infant (Humitz & Perrone, 1977). Again, no figures were presented to document these findings, so an evaluation of the validity of the authors' interpretation of the data is impossible to make.

A final conclusion drawn by the authors was that the two infant behaviors that stayed the most bothersome over time - crying and lack of a predictable schedule - were some of the same behaviors that after birth did not coincide with prenatal expectations (Humitz & Perrone, 1977). Since this conclusion supports the hypothesis of the present study, it is tempting to embrace it without further discussion. However, not only are data supporting this conclusion absent, but it appears to be contradicted by the reported finding that the babies cried less than expected.

In conclusion, the study by Humitz and Perrone comes closest to the present study in purpose and method--comparing prenatal expectations and postpartum experiences, using a longitudinal design--of the studies reviewed. It is disappointing that the data were not more clearly presented so as to permit the reader to draw meaningful conclusions.

To summarize, in few studies has the nature of primiparas' preconceptions of the nature of the postpartum period been examined. A frequent incidental finding of related studies is that new mothers proclaim that they were

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unprepared for the realities of parenthood. There is some evidence that women fail to anticipate such commonly occurring experiences as fatigue, lack of time for husband and self, and concern about body shape. The one study found that attempted to relate discrepancy between expectations and reality of infant behavior with the degree of bother experienced by the new parents was unfortunately reported in such a confusing manner that no confidence can be placed in its conclusions. The paucity of studies reporting new parents' preconceptions of their new role serves to emphasize the need for the present study.

Literature examining postpartum experiences and prenatal expectations of the postpartum period have been reviewed. In the present study, the relationship between the congruence of those two factors and the ease of transition into parenthood will be explored. Thus, studies in which transition into parenthood is described will be reviewed next.

Transition into Parenthood

Family sociologists have examined the effect of the first birth on new parents, and have attempted to characterize the event in terms of the ease or difficulty parents experience in adjusting to their new role (LeMasters, 1957; Dyer, 1963; Hobbs, 1965; Hobbs, 1968; Russell, 1974; Hobbs & Cole, 1976). The trend of studying the impact of a first birth on the family was begun by LeMasters (1957), who

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sought to determine whether adding a family member constitutes a crisis for the family.

LeMasters chose a convenience sample of 46 middle-class couples who had become first-time parents within the five years prior to the study. During unstructured interviews, the couple and the interviewer jointly assigned the couple a "crisis score" of from 1 (no crisis) to 5 (severe crisis). Eighty-three percent of the couples received a score indicating "extensive" or "severe" crisis, and LeMasters concluded that first-time parenthood is a crisis.

Dyer (1963) used the same crisis framework as LeMasters to examine the level of family organization up to the crisis of a first birth, the impact of the crisis on the family, and the subsequent level of family reorganization. He chose a convenience sample of 32 couples whose first child was two years old or younger at the time of the study. A questionnaire was constructed from items discovered by previous researchers to cause difficulties to new parents. Respondents marked on a 5-point Likert-type scale the degree of crisis the experience described by each item caused them. Dyer reported that the split-half reliability of his scale was .94, and that validity was tested by asking 6 young couples with children to evaluate the pertinence of the items. The findings of this study corroborated LeMasters' findings: no couple reported zero crisis, and a majority (53%) reported extensive or severe crisis. Dyer concluded that

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first-time parenthood is a crisis, and that people need more preparation for the parental role.

In 1965, Hobbs conducted a study to determine whether LeMasters' results would be found in a random sample of first-time parents drawn from public birth records. Hobbs' sample included first-time parents whose babies were from 3-18 weeks old (as compared to LeMasters' subjects whose children were up to 5 years old). The instrument used was a mailed questionnaire consisting of 23 items generated from LeMasters', and others', research. The split-half reliability of the checklist was .62 (Hobbs, 1965). Respondents were asked to mark how much they were "bothered" by each item. A total crisis score of 46 was possible. The wives' mean was 9.06; the husbands mean was 6.30. This difference was significant to the .005 level (Hobbs, 1965); nevertheless, each couple's score was combined before assignment to a crisis category. Using this scoring method, none of the couples reported "extensive" or "severe" crisis and 86.8% reported "slight" crisis (Hobbs, 1965). The conclusion was that these findings diverged from those of previous studies, and that there were problems in measuring the crisis of first birth that needed to be overcome.

In 1968, Hobbs undertook to replicate and extend his 1965 study. He used two different crisis measures to determine whether the different instruments used by previous researchers could account for the difference between their findings and those of Hobbs' 1965 study. A random sample

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of white married couples whose first child was between 6 and 52 weeks old was chosen from health department records. Twenty-seven of these couples fit the characteristics of the 1965 sample and were selected as the final sample. Subjects completed Hobbs' original checklist (1965) and also participated in taped interviews about the positive and negative aspects of parenthood. The checklist was objectively scored; the interview results were judged by two raters who were ignorant of the couples' checklist scores. The women's mean checklist crisis score was 9.30 (possible range, 0-46); their mean interview rating was 2.58 (possible range 1-4). A correlation coefficient of .64 ($p<.0006$) was obtained between the women's checklist scores and their interview ratings (Hobbs, 1968).

Hobbs (1968) concluded that the 1968 checklist results confirmed the 1965 conclusion that parenthood is not a crisis. He also concluded that the statistically significant correlation obtained between the checklist and interview results indicated that the interview ratings also supported that conclusion. However, a closer look at the 1968 data gives reason to question the latter conclusion.

Frequency distributions of the questionnaire responses show that 74.1% of the women indicated "none" or "slight" bother. Only 44.4% of women were placed in these categories by the interview raters. Conversely, only 25.9% of women indicated "moderate" or "severe" bother by their questionnaire responses, but the interview raters placed a

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majority (55.5%) of women in these categories. Thus, higher crisis scores were obtained on the basis of interviews than the questionnaire results revealed. There was no indication whether these differences were statistically significant. Without that information, it is as appropriate to conclude that the interview ratings refuted the conclusion that parenthood is not a crisis as it is that they supported that conclusion. Indeed, the fact that the mean interview rating (2.58) was slightly above the rating scale's mid-point suggests that the average amount of crisis revealed by the interview techniques was at least "moderate."

In a very thorough transition to parenthood study, Russell (1974) drew upon a large random sample to examine both the difficulties and the gratifications of first-time parenthood. Five hundred and eleven couples whose first baby was between 6 and 56 weeks old at the time of the study comprised the study sample. They were mailed Hobbs' (1965) checklist and a "gratification" checklist that included 12 experiences that new parents might enjoy about their new role (Russell, 1974). The split-half reliability of the gratification checklist was .93; validity was limited to face validity (Russell, 1974).

According to Hobbs & Cole (1976), Russell used a different method to calculate crisis scores than did Hobbs in 1965 and 1968, so the means of these three studies cannot be compared. Husbands' and wives' crisis scores in Russell's study were significantly different, and were

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reported separately. The majority of the wives (57.5%) and husbands (75.1%) reported only slight crisis. The conclusion was that there is only a slight or moderate degree of crisis associated with the birth of the first child.

To summarize, LeMasters (1957) and Dyer (1963) found that a majority of new parents experienced "extensive" or "severe" crisis as a result of the birth of their child. Conversely, Hobbs (1965) and Russell (1974) found that a majority of respondents reported only "slight" crisis upon becoming parents for the first time. Within one study (Hobbs, 1968) two data collection methods were used and yielded different results. Questionnaire findings showed that a majority of new mothers reported slight or no crisis after the first birth. Interview ratings of the same women, however, indicated that a majority of women experienced moderate or severe crisis.

Discussion

The purpose of the studies reviewed in this section was to examine and describe the effect of beoming parents on the individual mothers and fathers, and on their relationship. In addition, the researchers attempted to characterize the nature of this impact as "a crisis" or "not a crisis." Results of the studies and the conclusions drawn by the researchers are in conflict. Based on these studies, it is not possible to conclude whether or not parenthood is a crisis.

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There are several possible explanations for these conflicting findings that relate to sample, measuring, and scoring variables. Each category of explanations will be considered below.

Sample variables. It has been suggested that differences in findings may be related to the subjects' social class (Jacoby, 1969; Russell, 1974). Researchers whose study samples were middle class (LeMasters, 1957; Dyer, 1963) obtained higher crisis scores than those who used a random sample (Hobbs, 1965; Hobbs, 1968; Russell, 1974). However, neither Hobbs nor Russell found a significant difference in scores according to social class within their samples.

Another variable related to study samples was the age of the babies at the time of the study. Studies that included older children (LeMasters, 1957; Dyer, 1963) found higher crisis scores than those including babies under one year old (Hobbs, 1965; Hobbs, 1968; Russell, 1974). Perhaps there is a relationship between amount of difficulty adjusting to parenthood and the babies' age (Russell, 1974). Or perhaps there exists a "baby honeymoon" during which time parents are unaware of or are reluctant to admit to problems (Jacoby, 1969). However, neither Russell (1974) nor Hobbs (1968) found any relationship between babies' ages and degree of crisis within their samples, and Dyer (1963) found a negative relationship between age of baby and crisis.

Measuring variables. To date, no standardized instrument to measure the impact of the first birth on new parents has been developed. Validity, always a problem for behavioral researchers, has not been established for any of the instruments used in the studies reviewed. It is possible that researchers using different tools are measuring different concepts and that their results should not be compared (Jacoby, 1969).

Another measurement variable that could account for this body of literature's divergent results is the use of an interview or a questionnaire to measure crisis. In general, studies in which an interview technique was used to measure crisis resulted in higher crisis scores than studies in which the instrument was a mailed questionnaire (Russell, 1974). One explanation for this difference is that during an interview, rapport can be built, enabling respondents more readily to admit to experiencing difficulty in the parental role. Russell (1974) offered another explanation based on the analysis of non-respondents in her study. She found that more non-respondents than respondents had become pregnant premaritally, and speculated that these couples may be under a great deal of stress. Such couples might be more responsive to an empathetic interview technique than to a mailed questionnaire (Russell, 1974). If this is true, their participation in studies using interview techniques, but not studies using questionnaires, could

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account for the higher crisis scores found in the former type of study.

Scoring variables. Scoring methods may distort differences or hide similarities among study results. For example, Hobbs (1965 & 1968) and Russell (1974) used Hobbs' checklist as the study instrument, but each calculated the scores differently (Hobbs & Cole, 1976), making it inappropriate to compare these studies' mean crisis scores. Also, assignment of scores to categories (i.e. "none," "slight," "moderate," etc.) appears to have been arbitrary, and differs according to the researcher (Jacoby, 1969). Comparing frequency distributions of crisis scores by category may therefore be misleading.

A final example of a scoring problem was alluded to earlier--Hobbs' (1965) reporting significantly different husband and wife scores as a combined crisis score. Such a scoring method could bury significant findings if, for example, husbands' low crisis scores obscured wives' high crisis scores when they were combined.

Summary

The results of the "transition into parenthood" literature are inconsistent; little confidence can be placed in concluding either that parenthood is, or that it is not, a crisis event in a family's life. Various possible explanations for the apparent discrepancies among study results have been presented. Variability of research results may represent true differences, or may be a function of the

different study samples, measuring techniques, or scoring methods used.

Because the research results regarding the degree of difficulty involved in becoming new parents are ambiguous, no hypothesis regarding the degree of difficulty was formulated for the current study. However, ease or difficulty of transition into the parental role was measured, and descriptive results will be reported in Chapter V.

The focus of the current study is whether or not having had anticipatory socialization experiences, and holding accurate preconceptions of the parental role, will correlate with ease of role transition. Studies examining ease of transition into the parental role have just been reviewed; studies that examine the relationship of anticipatory socialization and adjustment to the parental role will be reviewed next.

Anticipatory Socialization for Parenthood

Anticipatory socialization is the process whereby a prospective role incumbent learns, in advance, about a role and what will be required to fulfill it (Thornton & Nardi, 1975). In theory, anticipatory socialization teaches the future role incumbent what to expect of the role so that adjustment to the role becomes easier than if there had been no preparation (Burr, 1972; Thornton & Nardi, 1975). Assuming that this theory holds for parenthood, sociologists and others have decried the paucity of anticipatory socialization opportunities for new American parents (Hill &

Aldous, 1969; Rossi, 1968). Some researchers recommend more formal anticipatory socialization experiences for parents in order to facilitate their adjustment to the parental role (Dyer, 1963; LeMasters, 1957).

Hypotheses 2 and 3 of the current study are based on the assumption that anticipatory socialization for parenthood facilitates transition into the parental role. Therefore, it is appropriate to review the literature that examines the effects of anticipatory socialization for parenthood. Retrospective studies comparing the amount and kind of anticipatory socialization subjects had experienced to ease or difficulty of adjustment to parenthood will be reviewed briefly. More detailed consideration will then be given to prospective studies, including experimental studies in which an anticipatory socialization program was offered to an experimental group before comparing their scores on an outcome variable with scores of a control group.

Retrospective Studies

Three retrospective studies examining preparation for parenthood in relation to ease or difficulty of adjustment to the parental role will be reviewed. In a study of the effect of a first child on the family, Dyer (1963) examined the effect of a variety of factors on the amount of crisis parents experienced as a result of the first birth. He found that couples in which either the husband or the wife had taken a preparation for marriage course in high

school or college experienced less crisis than couples in which neither spouse had taken such a class (Dyer, 1963).

In another study, preparation for parenthood was determined by whether parents had taken classes, had read books, or had cared for other people's children (Russell, 1974). Ease of transition into the parental role was examined in terms of both the "bother" and the "gratification" experienced by the new parents. A statistically significant association ($p = .001$) was found between the husbands' preparation and their gratification scores: prepared husbands experienced more gratification from being fathers than did unprepared husbands. No associations were found between husbands' preparation and their bother scores, nor between wives' preparation and either bother or gratification (Russell, 1974).

The purpose of a third study was to relate fathers' difficulty adjusting to parenthood with their attendance at Lamaze classes (Wente & Crockenberg, 1976). This study's primary finding was that Lamaze fathers did not report an easier adjustment to their babies than non-Lamaze fathers. Additionally, Lamaze fathers indicated that while they were pleased with their Lamaze preparation for childbirth, they felt unprepared for the experience of being a father. The authors speculated that neither participation in the birth process (which most of the non-Lamaze fathers also experienced) nor Lamaze training may be sufficient to reduce the

difficulty of making the transition to fatherhood (Wente & Crockenberg, 1976).

A second finding relating to preparation for parenthood was that the amount of bother fathers reported feeling due to their lack of knowledge of parenting was correlated with their total adjustment scores ($r = .53$, $p < .001$) (Wente & Crockenberg, 1976). While this finding gives no indication of these fathers' adequacy of preparation for parenthood, it does suggest that concern about not being prepared contributes to overall adjustment difficulty.

Prospective Studies

In the only non-experimental study to be reviewed in this section, a longitudinal, correlational design was used to analyze the relationships among experiences before and during pregnancy, and the quality of the childbirth experience and early parenting (Entwisle & Doering, 1981). This study was ambitious and complex; many hypotheses were formulated, and a wealth of information was collected about the subjects in both the prenatal and postpartum periods. Only the hypotheses and variables relevant to the current study will be examined. A hypothesis similar to those of the current study was that the more prepared the woman, the more successful would be her coping for childbirth and child care (Entwisle & Doering, 1981). The relevant relationships are those among the independent variables, "previous baby care experience" and "preparation for childbirth" (which are

anticipatory socialization experiences) and the outcome variable, "quality of early parenting."

One hundred twenty first-time mothers and 60 of their husbands comprised the study sample. The sample was constructed so that equal numbers of middle and lower class couples were included. The sample was further structured so that couples with various levels of preparation for childbirth were included within each social class. Taped interviews were conducted with the wives in the 6th and 9th months of pregnancy and at 2-3 weeks postpartum. A follow-up phone call was made to the wives at 6 months postpartum. Husbands were interviewed just before their babies were born and again when their babies were 4-8 weeks old (Entwisle & Doering, 1981).

A primary goal of this study was to describe the perinatal variables that have an effect on the quality of early parenting. "Previous baby care experience" was one of these variables and was measured by both the amount of previous experience caring for newborns the parents reported, and the amount of confidence the parents had in their ability to care for a newborn. Another perinatal variable, "preparation for childbirth," was measured on a continuum from the lowest level (no preparation) to the highest level (Lamaze training). The outcome variable, "quality of parenting," was measured by several factors designed to tap dimensions of the researchers' conception of good early parenting: "breastfeeding of at least a few months' duration, both

parents' genuine enjoyment of the baby, a sensitivity of both parents to the infant's needs, and a deepened relationship between the husband and wife" (Entwisle & Doering, p. 263). While any definition of good parenting is open to controversy, it is to the researchers' credit that they made explicit their philosophy of, and criteria for, judging good parenting. The reliability of the scale measuring mothering behavior was .590; that of the scale measuring fathering behavior was .698 (Entwisle & Doering, 1981). No measure of validity was reported.

The statistical technique used to relate the independent and dependent variables was multivariate analysis. A casual model, based on research results and theoretical considerations, was hypothesized and was used to guide the analysis (Entwisle & Doering, 1981). The resulting statistics allowed the researchers to determine whether previous experience and preparation exerted a direct and/or an indirect effect on parenting. The findings regarding previous experience with babies will be reported first, followed by the findings relating to preparation for childbirth.

Previous baby-care experience had a positive, indirect effect on mothering behavior, that is, it was related to intermediate variables that themselves were directly related to mothering. For middle-class mothers, the direct effect of previous experience was on the quality of birth experience, which in turn was positively related to mothering behavior. For lower class mothers, previous baby-care

experience was positively related to breast-feeding, which in turn correlated with positive mothering behavior (Entwisle & Doering, 1981).

The relationship between previous experience and fathering behavior depended on class. The effect on fathering behavior was positive and direct for middle-class men, but was negative and direct for lower-class men. The researchers speculated as to why the results for lower class men were the opposite of what was expected, and concluded that more study is needed (Entwisle & Doering, 1981).

Preparation for childbirth had different effects on parenting for both mothers and fathers according to class. Middle class mothers experienced no direct effects from preparation on mothering, but did experience a positive indirect effect (1971): preparation was related to an increased level of awareness at birth, which in turn was highly related to the mother's evaluation of her birth experience (Entwisle & Doering, 1981). Both awareness and quality of birth experience were strongly related to mothering behavior (Entwisle & Doering, 1981). Thus, although preparation for childbirth had no direct effect on the quality of middle class women's parenting, it did affect other factors that in turn affected mothering behavior.

Lower class women experienced a direct negative effect of preparation on mothering (Entwisle & Doering, 1981). However, preparation exerted an indirect positive effect on mothering. Prepared lower-class women were more likely

to breast-feed than unprepared lower-class women, and breast-feeding was highly correlated with positive mothering behavior (Entwisle & Doering, 1981). The authors offered possible explanations for why preparation was negatively related to mothering in this group. One explanation was that prenatal classes may not be geared toward meeting the needs of lower-class parents (Entwisle & Doering, 1981). Another explanation was that a desire to be in control of her situation might lead a woman both to seek maximum preparation for childbirth and to try to control her baby's demands. Since mothering in this study was evaluated by how flexible the woman was in meeting her infant's needs, such a woman would obtain a low mothering score (Entwisle & Doering, 1981).

Both classes of fathers benefited from preparation for childbirth in terms of their fathering scores. For middle-class fathers, there was both a direct effect and an indirect effect. The indirect effect resulted from the fact that prepared fathers were more likely to participate in the birth experience, and participation was related to fathering. Lower-class men experienced only this indirect effect (Entwisle & Doering, 1981).

The researchers concluded that their finding a relationship between preparation and the quality of parenting "calls into question reports that attendance at preparation classes does not help in the adjustment to parenthood" (Entwisle & Doering, 1981). They cited as an example of

such studies Wente & Crockenberg (1976), whose research was reviewed earlier. It is important to note, however, that the outcome variables of the two studies were different. Wente and Crockenberg measured adjustment by how much fathers were bothered both by their babies and by their babies' impact on their marital relationships. Entwisle and Doering measured adjustment by how good a job the parents were doing in their new role. Given these different definitions of "adjustment," it seems inappropriate to compare the results of these two studies.

Nevertheless, Entwisle and Doering's ambitious and well-designed study presents strong evidence to support their hypothesis that preparation for childbirth exerts a positive influence on the quality of early parenting. In addition, the results support a conclusion that previous baby care experience is positively related to quality of parenting for both classes of mothers and for middle-class fathers. These findings offer partial support for the current study's prediction that previous infant-care experience and preparation for childbirth, as anticipatory socialization experiences, will ease transition into the parental role.

In the above study, a correlational design was used. The following studies use an experimental design to determine the effects of an intervention on a measure of adjustment to parenthood. The interventions were prenatal classroom instruction about the psychological and social

adjustment to a newborn (Gordon & Gordon, 1960), anticipatory guidance (Shereshefsky & Yarrow, 1973) and role supplementation (Meleis & Swendsen, 1978). Despite the differing names and content of these interventions, their common goal was to prepare first-time parents, during pregnancy, for their forthcoming role. Thus, they all belong in the category of "anticipatory socialization experiences."

One study was designed to determine whether antenatal classroom instruction of a group of prospective mothers about the social and psychological changes associated with their new role would reduce "postpartum emotional upsets" (Gordon & Gordon, 1960). An experimental and a control group were selected from women attending an existing prenatal class. Subjects were matched according to their backgrounds. The experimental group attended two 40 minute classes whose content consisted of information about common adjustment difficulties associated with parenthood, and sample methods the mothers could use to cope with these difficulties in the postpartum period. The control group attended only the regular prenatal classes (Gordon & Gordon, 1960).

The outcome variable, "emotional reactions", which was not explicitly defined in this report, was judged for each woman by her private obstetrician at 6 weeks and 6 months postpartum. The obstetricians, who were unaware of the

women's group assignments, rated the mothers' emotional reactions on a 4 point scale (Gordon & Gordon, 1960).

The findings were that experimental subjects reported using more of the suggested coping methods than the control group (who, of course, were not exposed to these methods). Experimental subjects also were rated as having fewer emotional upsets than the controls. The relationship between subjects' behavior (in terms of use of suggested coping methods) and their emotional reactions was .82 (Gordon & Gordon, 1960). Fewer experimental than control subjects experienced postpartum emotional upset ($p<.01$). The researchers concluded that the prenatal intervention was effective in helping mothers avoid postpartum emotional difficulties (Gordon & Gordon, 1960).

Because "emotional upset" was not defined in this report, caution must be used in deciding whether to accept the authors' conclusion. Nevertheless, this study suggests that anticipatory guidance can facilitate coping with a new role and can reduce the anxieties associated with role transition.

A second experimental study was designed, in part, to evaluate the effects of prenatal social work counseling on first-time mothers' adaptation to their infants (Shereshefsky & Yarrow, 1973). Sixty married, healthy, middle-class women and their husbands were enrolled in the study during the wife's third month of pregnancy. They were followed until the sixth month postpartum. One half of the couples

was assigned to a control group, and the wife received routine obstetric care only. The other thirty couples were divided into three separate experimental groups, each of which received one of the following types of social work counseling: anticipatory guidance, clarification of feelings, and psychoanalytic interpretation (Shereshefsky & Yarrow, 1973).

Of these three interventions, anticipatory guidance is most relevant to the current study. The conceptual basis for the anticipatory guidance approach was the hypothesis that "if a woman can be helped to see the difficulties inherent in parenthood ahead of time, their impact will be lessened when she becomes a mother" (Shereshefsky & Yarrow, 1973, p. 144). (This hypothesis closely resembles H_1 of the current study). The goal of anticipatory guidance was to prepare women in advance for the stresses of parenthood, and to discuss ways of coping with problems that might arise (Shereshefsky & Yarrow, 1973).

In reporting the findings, the control group was compared to the counseled groups, and the three counseled subgroups were compared with each other in terms of the outcome variable, "maternal adaptation." "Maternal adaptation" consisted of the factors "interaction with infant," "satisfying maternal role," "satisfying interactions with family," "quality of marital relationship" and other factors related to the mother's postpartum emotional state (Shereshefsky & Yarrow, 1973).

The primary finding of this portion of the study was that there was no difference between the control and experimental (counseled) groups' ratings on the outcome variable, maternal adaptation (Shereshefsky & Yarrow, 1973). To account for this finding, the researchers surmised that women who had problems may have agreed to be in the experimental group because they perceived a need for help. Thus, women in the experimental group could have been initially more troubled than women in the control group (Shereshfesky & Yarrow, 1973). Perhaps counseling raised these women's maternal adjustment ratings to a higher level than would have been observed had they not received counseling.

Although there was no difference between the experimental and the control groups on maternal adaptation, it was found that couples who had received anticipatory guidance experienced significantly higher ($p<.01$) levels of postnatal marital adjustment, compared to prenatal adjustment, than the control couples (Shereshefsky & Yarrow, 1973). The authors concluded that "postnatal marital adaptation improves...in those cases where couples were helped prenatally to anticipate the negative impact of the child" (Shereshefsky & Yarrow, 1973, p. 141).

Additionally, in comparing the three counseled groups, it was found that significantly more women receiving anticipatory guidance ($p<.01$) scored "above average" on the outcome variable "maternal adaptation" than women exposed

to either the clarification or the interpretation techniques. The authors concluded that anticipatory guidance was more effective than the other two counseling methods in promoting a high level of maternal adaptation (Shereshefsky & Yarrow, 1973).

In addition to the experimental findings of this study, a descriptive finding is relevant to the current study. It was found that a life history variable, "interest in children and experience with them" correlated significantly ($p<.01$) with maternal adaptation (Shereshefsky & Yarrow, 1973).

This study's findings support the hypotheses of the current study by suggesting that an anticipatory guidance intervention (which, like anticipatory socialization, teaches women what to expect when they become mothers) was related to two positive outcomes. The first was an increased marital satisfaction over the control group. The second was increased maternal adaptation over the other two experimental groups. In addition, previous experience with children, which is an anticipatory socialization experience, was related to maternal adaptation.

The purpose of the final experimental study to be reviewed was to test the effect of a nursing intervention called role supplementation on transition into the parental role (Meleis & Swendsen, 1978). Role supplementation was defined as a process of teaching potential role incumbents about their new role and its complement (Meleis & Swendsen,

1978). The study was based on the proposition that "if conditions and processes surrounding role transitions were well defined and well rehearsed and if resources to facilitate the transition were identified, role transition might be accomplished more smoothly" (Meleis & Swendsen, 1978, pp. 11-12).

The goal of the role supplementation program was role mastery (Meleis & Swendsen, 1978). The study questions related to the effects of role supplementation on 1) husbands' and wives' post-delivery anxiety, 2) congruence between husbands' and wives' perceptions of their dyadic relationships and 3) postpartum reactions to pregnancy and delivery as perceived by the wives (Meleis & Swendsen, 1978). The connection between these variables and role mastery was not made explicit in this report. However, in a previous article, Meleis (1975) identified that incongruence between one's own role performance and the role expectations of others can precipitate role insufficiency--the opposite of role mastery. Anxiety was identified as a result of role insufficiency (Meleis, 1975). Thus, it appears that post-delivery anxiety and discrepancy between husband-wife perceptions of their roles were designed to be measures of role insufficiency. Postpartum reactions were reportedly measured by a Postnatal Research Inventory, which was said to tap dimensions of the postpartum period relating to the maternal-infant relationship (Meleis & Swendsen, 1978). Although not made clear, it seems "postpartum reactions"

was meant to indicate role performance, i.e., role mastery.

The study methodology involved three groups of parents expecting their first child: the experimental group (role supplementation, or RS group); a group of couples enrolled in an existing support program conducted by nurse clinicians (FamCap); and a control group receiving routine prenatal care (Meleis & Swendsen, 1978). The RS group, consisting of 12 couples, was self-selected. There were 10 couples in the FamCap group and 36 couples in the control group. Each group completed a series of questionnaires pre- and postnatally designed to measure changes in the outcome variables. In addition, the RS group engaged in eight weekly two-hour group sessions during the last trimester--the role supplementation program.

The role supplementation program used three strategies designed to facilitate role mastery (Meleis & Swendsen, 1978). First, the group itself acted as a reference group wherein group members could share ideas, feelings, and experiences related to parenthood. Second, role modeling was provided by the nurse clinician leaders and by new parents who knew the behaviors, knowledge, and values expected in the parental role. Third, the group engaged in role rehearsal. During this process, the nurse clinician described possible postpartum scenarios and assisted the group in exploring how they might handle these situations (Meleis & Swendsen, 1978).

Most of the findings failed to confirm the researchers' expectations concerning the benefits of the role supplementation program. The mean postpartum anxiety level of RS wives was lower than that of control and FamCap wives, but the difference was not statistically significant. RS husbands were more anxious than the other husbands prenatally; postnatally, their score dropped significantly ($p<.01$) and became more comparable with the other men's scores. FamCap couples' scores revealed greater congruency of marital roles than either RS or control couples. FamCap couples and RS couples both held more positive attitudes toward their infants along three of the dimensions measured, but there was no difference between FamCap and RS couples on that score (Meleis & Swendsen, 1978).

The researchers recognized the small sample size, the lack of random assignment to groups, and lack of knowledge about the validity and reliability of the instruments used to measure the outcome variables as limitations. Another shortcoming was the researchers' failure to draw conclusions about the success or failure of the role supplementation program. Since the goal of the study was to test this nursing intervention (Meleis & Swendsen, 1978), a conclusion regarding its effectiveness would have been appropriate. Since the FamCap group and/or the RS groups scored better on several of the outcome variables than the control group, the researchers could have concluded that nursing intervention itself, and not the program's contents, may

have resulted in the different scores. Further research needs to be conducted to determine whether, and exactly how, nursing made a difference in this situation.

Summary

Studies exploring the effect of anticipatory socialization for parenthood on transition, or adjustment, to the parental role were reviewed. Conclusions about the benefits of anticipatory socialization experiences were mixed. For example, taking preparation for marriage classes was found to be associated with low postpartum bother by Dyer (1963), but not by Russell (1974). Wente and Crockenberg (1976) found that Lamaze training was not associated with fathers' adjustment to parenthood, but Entwisle and Doering (1981) reported the opposite finding (different measures of adjustment were used).

The results of experimental studies were also conflicting. Gordon and Gordon (1960) found that anticipatory guidance reduced postpartum anxiety; Meleis and Swendsen (1978) reported that their intervention was related to a reduction in anxiety for fathers only, and only to the level of the control fathers' anxiety. Shereshefsky and Yarrow (1973) found that prenatal counseling was not associated with good maternal adaptation, but that an anticipatory guidance intervention was associated with good marital adaptation.

A goal of the current study is to add to the body of knowledge about the effects of anticipatory socialization

on transition into parenthood. No intervention was planned, but subjects' past anticipatory socialization experiences were correlated with two outcome variables: accuracy of preconceptions about the postpartum period, and ease of transition into the parental role.

In Chapter IV, the hypotheses will be reiterated, and the concepts operationally defined. The study sample, instrumentation, procedure, and data analysis plan will also be discussed.

CHAPTER IV

METHODOLOGY AND PROCEDURES

Overview

A prospective, correlational study, using a longitudinal design, was conducted to determine the relationships among the accuracy of preconceptions first-time mothers hold about the parental role, their anticipatory socialization for the parental role, and their ease of transition into the parental role. A convenience sample of pregnant women were asked by employees at their health-care agencies to participate in the study. Those who agreed were contacted by the researcher by telephone.

Each participant then received two questionnaires by mail, one during the third trimester of pregnancy, the second at six weeks postpartum. The Prenatal Questionnaire contained questions about participants' anticipatory socialization experiences and their preconceptions of the postpartum period. Sociodemographic data were also elicited. The Postpartum Questionnaire contained questions about subjects' actual postpartum experiences. A scale designed to measure their ease or difficulty adjusting to the parental role was included as part of the Postpartum Questionnaire.

The difference between the women's preconceptions and their experiences was compared with the degree of difficulty they reported as a result of their experiences. The number of anticipatory socialization experiences for parenthood each woman had had was compared both with the amount of

difficulty experienced, and with the difference between her preconceptions and her postpartum experiences.

In this chapter, the study sample, the development of the questionnaires, the procedures used to collect and analyze the data, and the steps taken to ensure human rights will be described.

Hypotheses

1. The more congruent a first-time mother's preconceptions of the parental role are with her actual postpartum experiences, the easier will be her transition into parenthood.
2. The more selected anticipatory socialization experiences a first-time mother has had for the parental role, the more congruent her preconceptions of the postpartum period will be with her subsequent experiences.
3. The more selected anticipatory socialization experiences a first-time mother has had for the parental role, the easier will be her transition into that role.

Operational Definitions of the Variables

The study variables are Difference, Anticipatory Socialization (AS), and Bother.

Independent Variables

There are two independent variables in this study: the degree to which preconceptions of the parental role and actual postpartum experiences differed (Difference); and the amount of anticipatory socialization for the parental role the woman has had (AS). The first variable was measured by calculating the difference between a woman's score on a

Preconception Index and her score on an Experience Index. Both Indexes are comprised of the same items--descriptions of common postpartum experiences--grouped into scales relating to the woman's self, her social roles, and her confidence in her ability to perform child-care activities (see Instrumentation section). In completing the Preconception Index, each subject marked, on a 5-point Likert-type scale, the degree to which she agreed or disagreed that she was likely to have each experience (see Appendix A). In completing the Experience Index, each subject marked, on a 5-point Likert-type scale, the degree to which she agreed or disagreed that she actually had had each experience (see Appendix B). Preconception Scores and Experience Scores were calculated for each scale, and a Difference Score was derived. The Difference Score was the measure of the difference between preconceptions of the postpartum period and actual postpartum experiences (see Scoring section).

The second independent variable was the amount of anticipatory socialization for the parental role the woman had experienced. This variable was measured by questions 81-87 on the Prenatal Questionnaire (see Appendix A). These questions related to formal learning experiences the women had had regarding childbirth and child care, e.g. prenatal classes, marriage and the family classes, La Leche League meetings, and related reading materials. Questions also related to the women's informal life experiences that may have increased their knowledge about the parental role,

e.g. having children live with or regularly visit them, having close friends or relatives who have recently had babies, and having had a great deal of experience caring for infants in the past. An Anticipatory Socialization Score was calculated for each woman (see Scoring section).

Dependent Variables

The dependent variable for Hypothesis 1 and Hypothesis 3 is ease of transition into the parental role. Based on previous research (e.g. Hobbs, 1965; Russell, 1974), ease of transition was measured by the amount of bother mothers reported as a result of their postpartum experiences (Bother). Subjects were asked to mark, on a 5-point Likert-type scale, how much they were bothered by each experience they agreed they had had (see Appendix B). A high Bother Score indicated a more difficult transition into the parental role; a low Bother Score indicated an easier transition.

The dependent variable for Hypothesis 2 is the difference between preconceptions of the postpartum period and actual postpartum experiences (Difference). This variable was defined previously as the difference between a Preconception Score and an Experience Score (see Independent Variable section).

Sample

A convenience sample of 60 women were initially requested to participate in the study. In order to be

included in the study, the women had to meet certain criteria (see Appendix C). Subjects had to be married and living with their husbands, and due to deliver their first child during the data-collection period. Women who had experienced a first trimester spontaneous or therapeutic abortion were included. Women with the following health problems were excluded: diabetes, cancer of the cervix or uterus, hypertension, heart disease, history of rheumatic fever, chronic respiratory disease, chronic kidney disease, major endocrine disorder, pre-eclampsia/eclampsia, or a viral illness in the first trimester. Women who had been hospitalized for any reason during the pregnancy, or who were carrying multiple fetuses were also excluded.

After delivery, subjects were retained in the study if they had delivered a single healthy infant. Infants were assumed to be healthy if the mother reported that no abnormalities had been found on the newborn physical exam; if the infant accompanied the mother home on the fifth day or less postpartum; and if, by 6 weeks of age, the infant had not been re-hospitalized. A subject was dropped from the study if she had been hospitalized for more than five days postpartum; or if she had been re-hospitalized for any reason during the postpartum period.

Sixteen women were dropped from the study: one changed her mind about participating before she completed the Prenatal Questionnaire; one did not speak English; four had prenatal health problems or health histories requiring their

exclusion; six women delivered before they could complete the Prenatal Questionnaire; and four failed to meet the postpartum criteria of good health for themselves or their infants.

Before data collection, it was anticipated that women who had experienced a Cesarean birth might have to be dropped from the study. This expectation was based on the idea that, because most primiparas do not expect a Cesarean delivery, their Difference Scores might be higher than those of women experiencing a vaginal delivery. Also, it was thought that the additive effects of recovering from labor and major surgery might lead to their having higher Bother Scores than women who delivered vaginally. However, upon data analysis, it was discovered that there were no significant differences between these two groups' scores on Difference or Bother. Therefore, the nine women who experienced a Cesarean birth were included in the final sample of 44 women.

Settings

All 60 women who signed consent forms were receiving prenatal care at one of four health-care sites in an industrial Michigan community: a family practice office consisting of five family physicians; a family practice clinic where family practice medical residents are trained; a private OB-GYN clinic consisting of three gynecologist/obstetricians and an OB-GYN nurse practitioner; and a gynecologist/obstetrician in solo practice. Due to the

limited time available for data collection, no attempt was made to obtain a random sample of these practices' obstetrical patients. Instead, employees at these sites agreed to ask all married first-time pregnant mothers to sign consent forms.

Data Collection Procedures

The researcher wrote to four physicians, describing her study and requesting an appointment to discuss using their offices for data collection. The researcher included copies of a study abstract, questionnaires, and a consent form. Three physicians agreed to the proposal after meeting with the researcher; one agreed on the basis of the written correspondence alone.

The family practice residency clinic where the researcher sought to collect data is associated with a hospital. That agency's Institutional Review Committee was contacted for permission to use the clinic as a data-collection site. Provisional approval was given by the Chairman on July 6, 1981, providing each patient's physician approved (see Appendix D). The researcher presented her proposal at a regular meeting of the medical residents, and obtained each physician's written consent for their patients to participate in the study. On August 11, 1981, the researcher presented her proposal to the entire Institutional Review Committee, which gave its approval.

After permission was received from the physicians, the researcher met with the office nurses to describe her

research and what would be required of them. The office nurses were asked to identify the pregnant women at their sites who were married, whose EDC fell within the data-collection period, and whose current pregnancy was the first to progress past the first trimester. In addition to verbal instructions, the nurses were given an outline describing the study, the data-collection procedures, and their responsibilities. The office nurses received no pay for their assistance, but doughnuts, lunches, and a small Christmas gift were provided as incentives and as tokens of appreciation.

The nurses were given blank consent forms (see Appendix E) and stickers to place on the chart covers of eligible women as a reminder that these women were potential participants. The nurses were asked to have each eligible woman sign a consent form, which was then to be placed in a folder provided by the researcher.

The researcher collected signed consent forms weekly. The consent form briefly described the study and asked the women for permission to review their medical records to determine their eligibility for participation. It also asked their permission for the researcher to telephone them to ask if they would like to participate in the study. Included in the consent form was assurance of confidentiality and of their right not to sign the consent form, or to change their mind at any time about participation, without affecting their medical care (see Appendix E).

After receiving a signed consent form, the researcher reviewed the woman's medical record. Her EDC was noted, and if all eligibility criteria were met, the woman was assigned an identification number. The researcher then telephoned the woman as close to the 36th week of her pregnancy as possible. During the telephone call, the researcher reminded the woman of the way her name had been obtained, and asked if she had time to have the study explained to her. The researcher then explained that she was a graduate nursing student conducting a study of new mothers, that participation involved filling out two questionnaires, one then and one later, and that each questionnaire would take approximately 20 minutes of her time. The woman was told that the questionnaires would be mailed to her home for her to complete, and that she could return them to the researcher in an enclosed self-addressed, stamped envelope.

Only one woman declined to continue in the study. The rest were then asked whether they were married and living with their husbands, and whether they had been hospitalized during the current pregnancy. Their address was then obtained. An opportunity was given for the women to ask questions, and they were told that a cover letter with the researcher's name and telephone number would accompany the questionnaires. They were encouraged to call the researcher if they had questions about completing the questionnaires. Return of the questionnaires within one week was requested.

In the cover letter (see Appendix F), the purpose of the study, the nature of the questions, the approximate length of time required to complete the questionnaire, and the confidentiality of the responses were reiterated. The women were asked not to consult with anyone about their answers, and were reminded of their right to drop out of the study at any time without affecting the quality of their medical care. The women were informed that answering the questionnaire items could make them aware of issues related to motherhood they had not thought of before; they were encouraged to discuss any resulting concerns with someone they trusted, or with the researcher. No one called the researcher to express such concerns.

If the questionnaire had not been returned within two weeks, the researcher called the respondent to inquire whether she had received it, and whether she had any questions. Only four respondents (8%) required a follow-up telephone call for the Prenatal Questionnaire.

A short time after each woman's EDC, the researcher again checked her medical record to determine her actual date of delivery, and her continued eligibility in the study. The Postpartum Questionnaire was mailed when the respondent was six weeks postpartum. A follow-up telephone call was made if the questionnaire had not been returned within two weeks to inquire whether it had been received and whether there were any questions. Ten respondents (21%) needed a reminder to return the Postpartum Questionnaire.

Every woman who completed a Prenatal Questionnaire also completed a Postpartum Questionnaire, for an attrition rate of 0%.

When all the data were in, the researcher scored the responses, transferred the scores to computer coding sheets, and had the scores key-punched for data analysis.

Protection of Human Rights

In accordance with Michigan State University College of Nursing requirements, application was made to the College of Nursing Human Subjects Review Committee for permission to conduct this research. Permission was granted on June 12, 1981. Additionally, permission was sought from the Institutional Review Committee of a community hospital to collect data at an attached clinic. The Committee granted its approval on August 11, 1981.

All possible efforts were made to ensure protection of participants' human rights. The researcher did not read a patient's medical record until that patient had signed a consent form allowing her to do so. The consent form identified the researcher, briefly explained the nature of the study, and emphasized that consent was being given only to allow the researcher to examine the patient's medical record and to contact her about participating in the study. Confidentiality, as well as the patient's right to change her mind about participation, was assured (see Appendix E).

The points made in the consent form were reiterated during a telephone call. An opportunity to ask questions

was provided at that time. The cover letter accompanying each questionnaire again emphasized the confidentiality of the responses, and the fact that the respondent's medical care would not be affected by dropping out of the study (see Appendix F). Respondents were made aware of the only foreseeable risk to participation, i.e., their becoming aware of, and possibly being bothered by, new issues raised by the questionnaire. The respondents were urged to discuss any concerns thus engendered with a friend, their spouse, or their health care provider. The researcher also made herself available for discussing concerns related to the questionnaire.

In order to carry out the promise of confidentiality, each participant was assigned an identification number. Only the researcher was able to associate names with identification numbers. All data were recorded on computer sheets by number, not name. Questionnaires were sent and returned by U.S. mail, and were placed in the researcher's private file upon receipt; no one else had access to the completed questionnaires.

Instrumentation

A search of the literature failed to result in instruments capable of testing the study hypotheses. Therefore, both the Prenatal Questionnaire and the Postpartum Questionnaire were designed by the researcher. The Prenatal Questionnaire (see Appendix A) is comprised of a Preconception Index, an Anticipatory Socialization Scale, and

sociodemographic questions designed to describe the study sample. The Postpartum Questionnaire (see Appendix B) contains an Experience Index, a Bother Index, and questions designed to determine the subjects' continued eligibility after delivery.

The Preconception Index, the Experience Index, and the Bother Index consist of the same items. The Index items were derived from the nursing and family sociology literature that describes concerns mothers express during the postpartum period (see Appendix H). In addition, the researcher conducted four unstructured interviews of new mothers to elicit their past expectations of, and concerns during, the postpartum period. The researcher asked each mother about the experiences she had had since her baby's birth. She asked which of these had been the least expected, and which had been the most upsetting to her. Some of the answers the mothers gave were used to formulate questionnaire items (see Appendix H).

Each item of the Preconception Index, the Experience Index, and the Bother Index represents an experience or concern a mother may have during the postpartum period. In answering the Preconception Index, women were asked the extent to which they agreed or disagreed, on a scale of 1 to 5, that they were likely to have the experience described by the item during the postpartum period. In answering the Experience Index, women were asked the extent to which they agreed or disagreed, on a scale of 1 to 5, that they had had

the experience described by the item since their baby's birth.

The Bother Index, which is part of the Postpartum Questionnaire, is designed to measure the ease of transition into the parental role by measuring the amount of bother new mothers report as a result of their postpartum experiences. The idea for the Bother Index came from previous research that used the word "bother" to measure ease of transition into the parental role (e.g. Hobbs, 1965; Russell, 1974) and to assess parents' perceptions of their infant's behavior (Broussard & Hartner, 1971). Participants in the current study were asked to report a degree of bother, on a scale of 1 to 5, for each item on the Experience Index they agreed they had had (see Appendix B).

It is worth noting that all the Index items are expressions of "negative" postpartum experiences. Construction of all items in negative terms resulted in the possibility that the responses may reflect a response-set bias: not wishing to appear inept at being a parent, respondents may have tended to disagree with the negatively-worded items. The negative wording was used despite this limitation for two reasons. First, the goal was to determine mothers' preconceptions of the postpartum period in a quantifiable manner so that preconceptions could be accurately compared with later experiences. This requirement precluded asking open-ended questions about the mothers' expectations. Idiosyncratic responses to such questions would have been

difficult to correlate with responses to the same questions in the postpartum period. Hence, it was decided to present subjects with specific items with which they could agree or disagree. As described, the primary source for item content was the nursing and family sociology literature, which examines postpartum concerns, i.e. experiences causing the parents "crisis" or "bother." Thus, the resulting questionnaires asked mothers to agree or disagree whether they would, and did, experience some common concerns or "bothersome" events and feelings in the postpartum period.

The above rationale for use of all negatively-worded items is based on a methodological consideration. The second reason for asking solely about "negative" aspects of the parental role during the postpartum period is based on the study's conceptual framework. A major proposition of the conceptual framework is that accurate anticipatory socialization for a role, which leads to accurate preconceptions about the role, facilitates role transition. One hypothesis of the current study is that holding inaccurate preconceptions of the parental role hinders role transition, as measured by amount of bother. An assumption was made in designing the study that only unexpected "negative" experiences, not unexpected "positive" experiences, would hinder role transition. Thus, it was decided to ask only whether first-time pregnant mothers expected to have commonly-reported "negative" postpartum experiences.

Perhaps the optimal method to discover first-time mothers' preconceptions of the postpartum period would have been to conduct unstructured interviews. Such a procedure might have resulted in expressions of positive as well as negative expectations of that period. The responses might have more accurately and completely reflected the women's true ideas of what the postpartum period would be like than responses to the questionnaires. Certainly the problem of response-set bias as a result of negatively-worded items would have been avoided. However, the amount of time needed to conduct the interviews, and the difficulties anticipated in quantifying resulting data, precluded this option for the current study.

The Anticipatory Socialization Index (see Appendix G) is part of the Prenatal Questionnaire. It was designed to elicit from participants the kinds of experiences they had had that prepared them for parenthood. Items relate to formal and informal learning experiences that may be expected to prepare young people in advance for the parental role. Ideas for these items were derived from the literature and from clinical experience.

Sociodemographic variables included the respondents' age, educational level and major field of study, employment status, occupation, and the length of time married. The age, education, employment status, and social position of the respondents' husbands were also elicited.

Pretests

Pretests were conducted on both the Prenatal and the Postpartum Questionnaires. Three women meeting the prenatal criteria and five women meeting the postpartum criteria pretested the appropriate questionnaire. They were asked how long it took them to complete the questionnaire, whether they understood the directions, and whether the questions were meaningful to them.

The Prenatal Questionnaire required no revisions. However, three versions of the Postpartum Questionnaire were pretested before a final version was adopted. The problem was the format of the Bother Index (see Appendix B). The original Bother Index consisted of a 6-point Likert-type scale. Women who agreed they had had the experience described by the item were instructed to indicate how much the experience bothered them on a scale of 1 to 5, where 1 = "A Great Deal" and 5 = "None." Women who disagreed they had had the experience were instructed to circle the number 6, which was placed beneath a separate category entitled "Did Not Have the Experience." The pretesters were confused by these instructions, saying they thought the "6" indicated a degree of bother.

The second version of the Bother Index consisted only of a 5-point Likert-type scale, where 1 = "A Great Deal" and 5 = "None." Women were instructed not to make any mark on the Bother Index if they disagreed they had had the experience described by the item. The pretesters did not

understand these instructions, and indicated they wanted a place to mark on the Bother Index for each item, whether they agreed they had had the experience or not.

The final version of the Bother Index kept the same 5-point Likert-type scale as the first draft. However, instead of circling "6" underneath the heading "Did Not Have the Experience," women were instructed to circle an "X" under the same heading if they disagreed they had had the experience. This format did not eliminate the confusion entirely, but it did increase understanding sufficiently for it to be adopted so that data collection could proceed.

Reliability and Validity

The reliability of an instrument is a measure of its internal consistency, i.e., the extent to which it is measuring a single variable (Polit & Hungler, 1978). An instrument must be reliable in order for confidence to be placed in the resulting scores. The higher the reliability coefficient, the more confidence one can have that the instrument is measuring a unitary concept, and that variability in scores reflects true differences among individual respondents.

An examination of the postpartum experiences reported in the literature and by the mothers interviewed prior to construction of the instruments suggested categories under which these experiences might fall. The categories related to the effects of becoming a mother on the woman's physical and emotional self, on her ability to carry out other social

roles, on her career, and on her ability to manage her time. In addition, many concerns related to child care and infant behavior. It was surmised that the items fitting each category would comprise scales, each tapping a different dimension of transition into the parental role.

In order to determine the reliability of the predicted scales (Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care), an alpha coefficient was computed for each scale (see Chapter V). Alpha coefficient is a statistical method for determining the reliability of a scale by calculating a split-half correlation for all possible ways of splitting the scale in half (Polit & Hungler, 1978). In this manner, it can be determined whether each scale measures a unitary concept, and whether all scale items can be kept, or whether some items seem to be measuring a different concept and should be discarded.

There are no objective criteria to guide the determination of an acceptable reliability coefficient. However, Polit and Hungler (1978) suggest that when making group level comparisons, as was done in this study, coefficients above .60 are considered acceptable. Therefore, scales with coefficients of .60 or above were considered reliable for the purposes of this study.

Upon analysis, nine items of the Preconception and Experience Indexes did not seem to fit in with the other items, and were discarded before final reliability coefficients were computed. One additional item was discarded

because it produced no variance on the Bother Index. All the predicted scales had reliability coefficients of .60 or greater for all three Indexes--Preconception, Experience, and Bother. The reliability coefficients are shown in Appendix I (see Appendix J for the items comprising each scale).

The reliability of a scale is easier to measure than its validity. Validity is the extent to which an instrument is measuring what it purports to be measuring (Polit & Hungler, 1978). The two types of validity most relevant to the current study's instruments are content and construct validity. Content validity is the degree to which scale items are representative of the content to be measured (Polit & Hungler, 1978), in this case, postpartum experiences that bother or concern new mothers. A relatively high degree of content validity is assumed since Index items were derived from the literature and reviewed by the research committee members for pertinence.

Construct validity is the degree to which an instrument is actually measuring the concept under study (Polit & Hungler, 1978). In this case the question is whether the instruments truly measure mothers' preconceptions of postpartum, their postpartum experiences, ease of role transition, and anticipatory socialization for parenthood. The construct validity of instruments measuring abstract concepts such as these is difficult to ascertain (Polit &

Hungler, 1978); the degree to which the study instruments possess construct validity is unknown.

Scoring

Each respondent received five general scores: a Preconception Score for each scale; an Experience Score for each scale; a Difference Score reflecting the difference between her Experience Score and her Preconception Score for each scale; a Bother Score for each scale; and an Anticipatory Socialization Score.

Preconception Scores

Subjects marked on a 5-point Likert-type scale to indicate whether they Strongly Disagreed (1), Disagreed (2), Neither Agreed Nor Disagreed (3), Agreed (4), or Strongly Agreed (5) that they were likely to have the experience described by the item. By adding the numbered responses and dividing by the number of scale items, the individual's Preconception Score for each scale was calculated. A high score indicated agreement that the subject was likely to have many of the experiences listed; a low score indicated disagreement that she was likely to have many of the experiences listed.

Experience Scores

Subjects marked the same Likert-type scale to indicate the extent to which they agreed or disagreed that they had had the experience described by the item (items are identical to those comprising the Preconception Index). An Experience Score for each scale was calculated in the same

manner as the Preconception Score. A high score indicated agreement that many of the experiences had occurred; a low score indicated disagreement that many of the experiences had occurred.

Difference Scores

A Difference Score was calculated for each woman by subtracting her Preconception Score for a scale from her Experience Score for the same scale ($D_x = E_x - P_x$ where D = Difference Score, E = Experience Score, P = Preconception Score, and x indicates the scale in question). Difference Scores could range from -4 to +4. A score close to or equal to zero indicated little or no difference between preconceptions of and experiences during the postpartum period for the aspect of transition into parenthood measured by that scale. A Difference Score having a negative value indicated more agreement on the Preconception Index than on the Experience Index. The interpretation was that the woman anticipated having more experiences (high Preconception Score) than she actually had (low Experience Score). A Difference Score having a positive value indicated more disagreement on the Preconception Index than on the Experience Index. The interpretation was that the woman anticipated having fewer experiences (low Preconception Score) than she actually had (high Experience Score).

Bother Scores

If a respondent agreed she had had an experience described by an Experience Index item, she was directed to

mark, on a 5-point Likert-type scale, the amount of bother that experience had caused her. On this scale, 1 = A Great Deal and 5 = None. In scoring, however, these numbers were transposed so that a low number indicated low bother, and a high number, high bother. A response of "None" was scored as "0", so that there was, appropriately, no contribution to the Bother Score from that item. A response of "A Great Deal" was scored as "4".

A subject's Bother Score was calculated for each scale in the following manner: first, each score was transposed as described. The sum of the subject's converted scores for each scale was then computed. This sum was divided by the number of experiences in the scale the subject indicated she had had on the Experience Index. In other words, the scale items to which the subject had marked "Strongly Agree," "Agree," or "Neither Agree nor Disagree" on the Experience Index were counted; this number was the divisor in the equation used to calculate the subject's Bother score for each scale:

$$\text{Individual Bother Score}_x = \frac{\text{Total Bother Score}_x}{N_x}$$

N = number of experiences the subject had had (unique for each subject)
x = the scale in question

A difficulty was encountered when scoring the Bother Index. In designing the questionnaire, an attempt was made to differentiate between a woman who had had the experience described but was not bothered by it, and a woman who could

not have been bothered by the experience because she had not had it. Women were thus instructed to mark "None" on the Bother Index in the former case, and "Did Not Have the Experience" in the latter case (see Appendix B). These complex directions were not followed by most of the subjects, who often disagreed with an item on the Experience Index and yet marked "None" on the Bother Index instead of the logical response, "Did Not Have the Experience."

The prevalence of such errors led to the decision to ignore the Bother Index response for any item marked "Strongly Disagree" or "Disagree" on the Experience Index. In other words, if a woman disagreed that she had had the experience described by the item, scoring proceeded as if she had marked "Did Not Have the Experience" on the Bother Index.

Anticipatory Socialization Score

Seven items comprised the Anticipatory Socialization Index (see Appendix G). Each item described an experience that may prepare women for parenthood. No support in the literature could be found for weighting any experience more than any other. Therefore, a score of "1" was assigned for each response that indicated the subject had had the experience; a score of "0" was assigned for each response that indicated the subject had not had the experience.

Data Analysis

Data analysis was used to answer the study questions, to test the study hypotheses, and to discover any

relationships among sociodemographic characteristics of the study sample and the dependent variables.

Study Questions

The first study question was, "How accurate were first-time mothers in anticipating their postpartum experiences, or concerns?" This question was answered by performing a t-test for paired means for group Mean Preconception Scores and group Mean Experience Scores for each scale. The purpose of the t-test was to determine whether any differences found between the women's preconceptions and their experiences were significant, or whether they were no larger than would be expected due to chance alone. A finding of "no significant difference" between preconceptions and experiences would indicate accurate preconceptions; a finding of "significant difference" between preconceptions and experiences would indicate inaccurate preconceptions.

The second study question was, "How difficult was transition into the parental role for these first-time mothers, as measured by their Bother Scores?" Answering this question is essential, given the conflicting findings of previous research (see Chapter III). Amount of bother was determined in two ways: by Group Mean Bother Scores; and by Bother Categories. Group Mean Bother Scores for each scale were calculated by dividing the sum of Individual Bother Scores by the number of individual scores. The resulting number was a measure of the average amount of bother

the subjects experienced (possible Bother Scores ranged from 0 to 4).

Another way of recording the amount of bother was by Bother Categories. Individuals' Bother Scores of zero were placed in the category "None." Then scores from .001 to 4.0 were evenly divided into three categories: Slight Bother (.001-1.33); Moderate Bother (1.34-2.66); and Severe Bother (2.67-4.0). The amount of bother subjects experienced could thus be judged by the percent of subjects whose scores fell under each category.

Hypotheses Operationally Stated

H_1: The higher the Difference Score, the higher the Bother Score. Difference will be positively correlated with Bother.

H_2: The higher the Anticipatory Socialization Score, the lower the absolute value of the Difference Score. Anticipatory Socialization will be negatively correlated with the absolute value of Difference.

H_3: The higher the Anticipatory Socialization Score, the lower the Bother Score. Anticipatory Socialization will be negatively correlated with Bother.

Analysis Plan for the Hypotheses

The first step in analyzing the data was to determine the reliability of the predicted scales that comprised the Preconception, Experience, and Bother Indexes. The Predicted scales were Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care. An alpha

coefficient was calculated for each scale. When ten items were discarded, no scale had a reliability of less than .65 (see Appendix I).

In order to test H_1, the following procedures were carried out. For each scale, individual and mean Preconception Scores, Experience Scores, and Bother Scores were determined. Next, a Mean Difference Score for each scale was calculated by subtracting each Mean Preconception Score from the corresponding Mean Experience Score. Finally, individual Difference Scores for each scale were computed and correlated with the corresponding Bother Scores, using product-moment correlation.

In order to test H_2 and H_3, Individual and Mean Anticipatory Socialization scores were calculated. Anticipatory Socialization Scores were then correlated with Difference Scores (H_2) and Bother Scores (H_3), using product-moment correlation.

Sociodemographic Variables and Dependent Variables

Sociodemographic information was elicited from participants for the purpose of describing the study sample. Sociodemographic characteristics included the subjects' age, educational level and major field of study, employment status, occupation, and length of time married. Information was also obtained about the subjects' husbands' age, education, employment status, and social position.

Product-moment correlation was used to determine the correlations between continuous, ordinal variables, e.g.

age, and the dependent variables. Point-biserial correlation was used to correlate true dichotomous variables, e.g. whether or not the subject was employed, with the dependent variables. Chi-square was used to determine whether the frequency of mean scores differed significantly according to categories to which women belonged, e.g. occupation, or level of education.

Summary

In Chapter IV, the study hypotheses were reiterated and the variables were operationally defined. The study sample and settings were identified. The data collection procedures, including steps taken to ensure human rights protection, were explained. Instrument development, scoring techniques, and the data analysis plan were described.

In Chapter V, the data and the results of data analysis will be presented. Findings will be explained and interpreted in relation to the study hypotheses.

CHAPTER V

DATA PRESENTATION AND ANALYSIS

Overview

In Chapter V, data describing the study sample and the amount of anticipatory socialization the women have had for parenthood will be presented. The sample's preconceptions of the postpartum period, their actual postpartum experiences, and the amount of bother these experiences caused them will be described.

In addition, the data presented describe the relationship between the congruence of preconceptions of and experiences during the postpartum period, and the amount of bother the women reported as a result of their postpartum experiences. The data also compare the amount of anticipatory socialization for parenthood the women have had with the accuracy of their preconceptions and with the amount of reported bother.

Finally, data relating several of the women's sociodemographic characteristics to the dependent variables will be presented.

Description of the Study Sample

Sociodemographic Characteristics

A convenience sample of 44 women completed a Prenatal Questionnaire when they were about to give birth to their first child, and a Postpartum Questionnaire when their child was 6-8 weeks old. The women were healthy, married, and living with their husbands. They delivered single, normal,

healthy infants. Thirty-five women (79.5%) experienced vaginal births; nine women (20.5%) experienced Cesarean births. All women and infants were discharged from the hospital at 5 days or less postpartum; none of them returned to the hospital during the postpartum period.

The ages of the women ranged from 16 to 34 years old. The mean age was 24.3. The actual ages of the women are shown in Table 1.

The ages of the subjects' husbands ranged from 18 to 41 years old. The mean age was 26.7. Actual husbands' ages are shown in Table 1.

Table 1
Ages of Study Subjects and Their Husbands

	Subjects		Husbands	
	No.	%	No.	%
Age				
< 20	4	9	3	7
20-24	20	45.5	12	27
25-29	14	31.8	18	41
30-34	6	13.7	8	18
> 35	0	0	3	7
Total	44	100%	44	100%

The subjects' educational achievements ranged from some high school to an advanced degree. A large majority (75%) had had at least some college. Only 4 women (9.1%) had not completed high school. The data describing the sample's educational achievement are shown in Table 2.

The level of education attained by subjects' husbands ranged from some high school to an advanced degree. A large majority of husbands (70.5%) had finished at least some college. Only 5 husbands (11.4%) did not have a high school diploma. Table 2 shows complete data for husbands' education.

Table 2
Highest Level of Education Attained by Subjects and Their Husbands

	Subjects		Husbands	
	No.	%	No.	%
Level of Education				
Some High School	4	9.1	5	11.4
High School Diploma	7	15.9	7	15.9
Some College	20	45.5	16	36.4
Bachelor's Degree	10	22.7	8	18.2
Advanced Degree	3	6.8	7	15.9
Military Training	0	0	1	2.3
Total	44	100%	44	100%

A majority of the women (32 women, or 72.7%) had worked outside the home for money within the year preceding their completion of the Prenatal Questionnaire. Of these, 9 (28%) indicated they planned to return to work right away after their postpartum check-up; 23 (72%) indicated they did not plan to return to work right away. When asked at 6 weeks postpartum whether they intended to return to work right away, 11 (34%) said "yes," and 18 (56%) said "no."

Data were missing for 3 women (see Table 3). Two more women postpartally than prenatally planned to return to work right away; it is not known whether the women who planned prenatally to return to work at 6 weeks postpartum are the same ones who later planned to return to work right away.

Table 3
Working Women's Intention to Return to Work at 6 Weeks Postpartum (N=32)

	Intend to Return to Work		Did Not Intend to Return to Work		Missing Data	
	No.	%	No.	%	No.	%
Prenatal	9	28	23	72	0	0
Postpartum	11	34.4	18	56.2	3	9.4

Women who had worked outside the home within the previous year were asked to state their occupation. Their stated occupations were coded according to categories proposed by Hollingshead (1967). These categories, and the number and percent of women whose occupations are represented by each category, are presented in Table 4. Half of the employed women (16) worked in jobs rated "3" or higher; half worked in jobs rated "4" or lower. It is interesting to note that none of the women worked in a skilled manual position.

Forty of the subjects' husbands (90.9%) were employed; 4 (9.1%) were unemployed. Their occupations, by category, are presented in Table 4. By combining education and

occupation, a Social Position Score (Hollingshead, 1967) was calculated for 39 of the employed husbands (data were missing for one case). These scores were translated into one of five possible social classes, where Class I is the highest, and Class V the lowest. Over one quarter of the husbands (11) were in the highest social class. No employed husbands were in the lowest social class. The mean social class was 2.77, or somewhat above the middle class (Class III). Husbands' ratings by social class are listed in Table 5.

Table 4
Occupations, By Category
(Hollingshead, 1967)

		Subjects		Husbands	
Categories		No.	%	No.	%
1	Higher Executives, Proprietors of Large Concerns, Major Professionals	4	12.5	12	30
2	Business Managers, Proprietors of Medium-Sized Businesses, Lesser Professionals	6	18.7	3	7.5
3	Administrative Personnel, Small Independent Businesses, Minor Professionals	6	18.7	4	10
4	Clerical and Sales Workers, Owners of Little Businesses	12	37.5	5	12.5
5	Skilled Manual Employees	0	0	10	25
6	Machine Operators and Semi-Skilled Employees	2	6.3	5	12.5
7	Unskilled Employees	2	6.3	1	2.5
	Total	32	100%	40	100%

Table 5
Social Class of Subjects' Husbands
(Hollingshead, 1967)
(N=43)

	Social Class						
	I	II	III	IV	V	Unemployed	Total
No.	11	3	9	16	0	4	43
%	25.6	7	20.9	37.2	0	9.3	100

Respondents were asked how long they had been married. The range was from less than one year to nine years of marriage. Seven women (15.9%) had been married less than one year at the time they completed the Prenatal Questionnaire. A majority of the study sample (54.5%) had been married for two years or less. Data describing how long the women in the sample were married are shown in Table 6.

Table 6
Length of Time Subjects Had Been Married
(N=44)

	Years									
	<1	1	2	3	4	5	6	7	9	Total
No.	7	8	9	7	6	3	2	1	1	44
%	15.9	18.2	20.5	15.9	13.6	6.8	4.5	2.3	2.3	100

Anticipatory Socialization Experiences

Subjects were asked in the prenatal period whether they had had formal learning experiences preparing them for parenthood (see Appendix A, questions 81-84). Only three women (6.8%) had not taken prenatal classes; the remainder

(41 women, or 93.2%) had taken Lamaze preparation classes. Only 16 women (36.4%) indicated they had taken courses in parenting or marriage and the family. Three women (6.8%) had attended one La Leche League meeting each.

Subjects indicated that they had read between 0 and 50 books and articles about parenting or child care. Data are missing for two cases. Of the remaining 42 subjects, only 2 women (5%) had done no such reading. The average number of books and articles read was approximately 11.

Subjects were also asked about life experiences that exposed them to children and child care (see Appendix A, questions 85-87). Thirty-three women (77%) stated that at least one of their close friends or relatives who lives locally had had a baby within the past year. Ten women (23%) had no close friends or relatives in the area who had had a baby within the past year. (Data are missing for one case.) Four women (9.1%) had children living with or visiting them regularly.

The study subjects were asked to estimate the amount of experience they had had caring for infants. Thirty-five women (79.5%) estimated they had had "a lot" or "some" infant-care experience. Only 7 women (15.9%) had had "very little" experience, and 2 women (4.8%) admitted to having no previous experience caring for infants. Complete information about the amount of infant-care experience respondents had is displayed in Table 7.

Table 7
Amount of Infant-Care Experience
Subjects Stated They Had Had
N=44)

	A Lot	Some	Very Little	None	Total
No.	17	18	7	2	44
%	38.6	41.0	15.9	4.5	100

It is interesting to note that all four of the subjects who were later deleted from the final sample because they or their infant had experienced early postpartum health complications had indicated prenatally that they had had little (3 women) or no (1 woman) infant-care experience. Had these women been included in the final sample, the percentage of women reporting "very little" or no infant-care experience would have risen from 20.4% to 27.1%.

Women who indicated they had had "a lot" or "some" infant-care experience were asked to choose from a checklist the types of experiences they had had. Most of these women (94.3%) noted they had done babysitting as a teenager. Other responses are displayed in Table 8. (Because of the way the infant-care question was worded, it is not possible to determine what kinds of experiences were had by women who indicated having had "very little" infant-care experience).

Summary

The women in the study population were, on average, in their mid-twenties and educated beyond high school. They had been married for two years, and had been employed within

Table 8
Type of Experiences Cited by Respondents
Who Had "A Lot" or "Some"
Infant-Care Experience
(N=35)

	No.	% *
Babysitting as a teenager	33	94.3
Babysitting as an adult	23	65.7
Caring for siblings	16	45.7
Working in a day care center or nursery	6	17.1
Caring for nieces and nephews	5	14.3
Working in a health care setting	4	9.1
Other	2	5.7

* Subjects could mark more than one response.

the previous year. Between one quarter and one third of the employed women planned to return to work when their baby was 6 weeks old, depending on whether the women's prenatal or postnatal statement of intent indicated their true plans. On average, the women whose husbands were employed (90.9%) were middle to upper-middle class; none were in the lowest class.

Almost all the women had attended Lamaze classes, but only a little more than one third had participated in formal parenting or marriage and the family classes. A large majority of the women had read at least one book or article about child care or parenting, had close friends or relatives with new babies, and believed they had had at least some experience caring for infants.

Subjects' Index Scores

Scales

The Preconception, Experience, and Bother Indexes all consist of the same items: sample experiences women may have during the postpartum period. Some of the items represent similar experiences, and it was speculated that related items would measure a unitary concept, i.e., would comprise scales. Items seemed empirically to belong in the following categories of experiences: those resulting from the physical and emotional aftermath of childbirth; those related to the impact of a first infant on the woman's ability to manage her time; those reflecting the impact of a first infant on the woman's roles as wife, friend, relative,

employee; and those related to child care (see Appendixes J and K).

Alpha coefficients were computed for each predicted scale: Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care. All alpha coefficients were .65 or above for all three indexes (see Appendix I). Thus, the Preconception, Experience, and Bother Indexes are comprised of the same scales, all of which attain an acceptable level of reliability. Since correlations among the scales were low, it was assumed that the scales were not inter-related.

Preconception Scores

Subjects responded to each Preconception Index item by marking, on a 5-point Likert-type scale, the degree to which they agreed or disagreed they were likely to have the experience in the postpartum period: "Strongly Disagree" = 1; "Strongly Agree" = 5 (see Appendix A). Individual scores could range from 1 to 5. A low score indicated a relative degree of disagreement that the respondent would have the experiences. A high score indicated a relative degree of agreement that the respondent would have the experiences.

Individual scores for each scale were averaged, and a group mean reported for the Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care Scales. The group means for the Preconception Index Scales ranged from 2.94 to 3.79. A summary of the Preconception Scores is found in Appendix L.

Experience Scores

Subjects responded to each Experience Index item by marking, on a 5-point Likert-type scale, the degree to which they agreed or disagreed they had had the experience during the postpartum period: "Strongly Disagree" = 1; "Strongly Agree" = 5 (see Appendix B). Individual scores could range from 1 to 5. A low score indicated a relative degree of disagreement that the respondent had had the experiences. A high score indicated a relative degree of agreement that the respondent had had the experiences.

Individual scores for each scale were averaged, and a group mean reported for the Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care Scales. The group means for the Experience Index Scales ranged from 2.65 to 3.80. A summary of the Experience Scores is found in Appendix M.

Bother Scores

Subjects were instructed to report, on a 5-point Likert-type scale, an amount of bother for each item on the Experience Index to which they had agreed (see Appendix B). Individual scores could range from 0 to 4. A high score indicated high bother; a low score indicated low bother.

Individual scores for each scale were averaged, and a group mean reported for the Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care Scales. Mean Bother Scores ranged from 1.66 to 2.33. Complete data

on mean Bother Scores are displayed in Appendixes N and O.

Anticipatory Socialization Scores

Individual Anticipatory Socialization Scores represent the total number of preparation for parenthood experiences the subject reported having. One point was assigned for each affirmative response to an item on the Anticipatory Socialization Index (see Appendix G). The possible range of Anticipatory Socialization Scores was 0 to 7; the actual range was 2 to 6. The mean Anticipatory Socialization Score was 3.56; the standard deviation was 1.087. Anticipatory Socialization Score frequencies are shown in Appendix P.

Study Questions

Two study questions were posed. Because the data analysis answering these questions provides insight into the meaning of the Index Scores, the study questions will be considered before the hypotheses.

Accuracy of Preconceptions

The first study question was, "How accurate were first-time mothers in anticipating their postpartum experiences, or concerns?" This question was answered by searching for significant differences between mean Preconception Scores and mean Experience Scores.

Mean Preconception Scores and mean Experience Scores are presented in Table 9. There were no significant differences between these two scores for the Physical,

Emotional, or Career Scales. The interpretation given this finding was that women's expectations and their experiences were congruent for items comprising these scales.

Table 9
Comparison of Mean Preconception Scores and Mean Experience Scores

Scales	Mean Preconception Scores	Mean Experience Scores	Significance
Physical	3.80	3.80	NS
Emotional	3.12	3.02	NS
Time	3.57	3.78	$p < .03$
Wife	3.07	3.33	$p < .008$
Friend/ Relative	2.97	2.65	$p < .004$
Child	2.94	2.70	$p < .03$
Career	2.94	2.70	NS

Significant differences were found between Preconceptions and Experiences for the remainder of the scales. For the Time and Wife Role Scales, the mean Experience Score was significantly higher than the mean Preconception Score, t (42) = -2.17, $p < .03$; and t (42) = -2.76, $p < .008$, respectively. The difference was in the direction of agreeing more strongly, or agreeing more often, that the experiences had occurred, as compared with what was expected. This finding can be interpreted to mean that the preconceptions the women had concerning Time and Wife Role Scale items were inaccurate. It appears that they had

more "negative" experiences related to time management and their wife role than they had anticipated before their babies were born.

For the Friend/Relative Role and the Child Care Scales, the difference was in the opposite direction: the mean Preconception Score was significantly higher than the mean Experience Score, t (42) = 3.06, $p < .004$; and t (42) = 2.21, $p < .03$, respectively. The difference is in the direction of stronger agreement, or agreement more often, that the experiences had been expected, as compared with what actually happened. This finding can be interpreted to mean that expectations concerning Friend/Relative Role and Child Care Scale items were also inaccurate. However, it appears that the women had fewer "negative" postpartum experiences related to their role as friend and relative and to child-care responsibilities, than they had expected.

Other findings concerned which experiences women most and least expected, and which they most and least had. High scores were in the direction of agreeing with scale items. The highest mean score was found for the Physical Scale on both the Preconception Index ($\bar{X}$ = 3.80) and the Experience Scale ($\bar{X}$ = 3.80) (see Table 9). The interpretation is that women most often expected, and most often had, "negative" experiences related to physical recovery from childbirth and the physical effects of new parenthood.

Low scores were in the direction of disagreeing with scale items. The lowest mean Preconception Scores were

found for the Child Scale ($\bar{X}$ = 2.94), Career Scale ($\bar{X}$ = 2.94) and the Friend/Relative Role Scale ($\bar{X}$ = 2.97). The lowest mean Experience Scores were found for the Friend/Relative Role Scale ($\bar{X}$ = 2.65), the Child Care Scale ($\bar{X}$ = 2.70), and the Career Scale ($\bar{X}$ = 2.70). The interpretation is that women least expected and also least had "negative" experiences related to child care, their relationships with friends and relatives, and not returning to work right away.

It would seem, then, that the women's preconceptions of child care, friend and family relationships, and career changes, were accurate. This appearance is borne out for the Career Scale: there was no significant difference between Preconception Scores and Experience Scores for the Career Scale (see Table 9). However, significant differences were found between mean Preconception Scores and mean Experience Scores for Friend/Relative Role and Child Care Scales in a "positive" direction. That is, although mean Friend/Relative Role and mean Child Care Preconception Scores were low, mean Friend/Relative Role and mean Child Care Experience Scores were even lower. The interpretation is that women did not expect many "negative" experiences related to these aspects of parenthood, and in fact, they had even fewer "negative" experiences than expected.

Ease of Transition

The second study question was, "How difficult was transition into the parental role for these first-time

mothers, as measured by their bother scores?" As in previous transition to parenthood studies (e.g. Hobbs, 1965; Russell, 1974), this question was answered by examining both group mean Bother Scores and the frequency distribution of individual Bother Scores.

Mean Bother Scores are displayed in Appendix N. The difference between the highest mean Bother Score (Physical: $\bar{X}$ = 2.33) and the lowest mean Bother Score (Child: $\bar{X}$ = 1.61) is very small--only .72. The means are distributed nearly equidistant from 2, the scale mid-point.

The frequency distribution of individual Bother Scores is presented in Appendix O. Four Bother Categories were devised (see Scoring, Chapter IV): None, Slight, Moderate, and Severe. As it turned out, the entire range of mean Bother Scores (1.61-2.33) fell under the "Moderate" category (Range: 1.34-2.66--see Appendix O).

Another way of looking at these data is to determine under which category the mode fell. The mode fell under the "moderate" category for all scales except the Friend/Relative Role Scale (see Appendix O). A reasonable interpretation of these findings is that the women in this study sample experienced a moderate degree of bother in response to their postpartum experiences.

Hypotheses

Data analysis was undertaken to test the study hypotheses. Results of analysis will be reported in this section.

Hypothesis 1

The first hypothesis states that the more congruent a first-time mother's preconceptions of the parental role are with her actual postpartum experiences, the easier will be her transition into parenthood. Operationally stated, the hypothesis reads, "Difference Scores will be positively correlated with Bother Scores."

Product-moment correlation was used to compare Difference with Bother. Significant positive correlations were found for five of the seven scales (see Table 10). Difference was positively and significantly correlated with Bother for the Physical ($r = .42$, $p < .003$), Emotional ($r = .38$, $p < .005$), Time ($r = .36$, $p < .008$), Wife Role ($r = .38$, $p < .005$), and Child Care ($r = .37$, $p < .008$) Scales. No significant correlation was found between Difference and Bother for the Friend/Relative Role or Career Scales. Thus, analysis supported H_1 for five of the seven scales.

Hypothesis 2

The second hypothesis states that the more selected anticipatory socialization experiences a first-time mother has had for the parental role, the more congruent her preconceptions of the postpartum period will be with her subsequent experiences. Operationally stated, the hypothesis reads "Anticipatory Socialization Scores will be negatively correlated with the absolute value of Difference Scores."

Table 10
Hypothesis 1: Correlations Between Difference Scores and Bother Scores, by Scale

	Bother						
	Physical	Emotional	Time	Wife	Fr./Rel.	Child	Career
Difference							
Physical	.42[a]						
Emotional		.38[b]					
Time			.36[c]				
Wife				.38[b]			
Friend/Relative					.07		
Child						.37[c]	
Career							-.12

a: p = .003

b: p = .005

c: p = .008

When computing the correlation between Anticipatory Socialization and Difference, the absolute value of the Difference Score was used. The sign of the Difference Score was ignored for the following reason. Women who held accurate preconceptions of postpartum would have a Difference Score approaching zero, indicating little or no difference between their preconceptions and their experiences. Women who had inaccurate preconceptions would have a Difference Score with a high absolute value: a high positive score indicating an overly optimistic woman; and a high negative score indicating an overly pessimistic woman. Since anticipatory socialization should engender accurate preconceptions of postpartum, it was predicted that low Anticipatory Socialization Scores would be positively associated with high Difference Scores, with either a negative or a positive sign. Thus, the absolute value of the Difference Scores was used to test H_2.

Product-moment correlation was used to compare Anticipatory Socialization with Difference. Analysis failed to find the predicted relationships. No significant correlation was found between Anticipatory Socialization and Difference for six of the seven scales. A significant positive correlation was found between Anticipatory Socialization and Difference for the Friend/Relative Role Scale ($r = .26$, $p < .04$). Thus, analysis failed to support H_2.

Hypothesis 3

The third hypothesis states that the more selected anticipatory socialization experiences a first-time mother has had for the parental role, the easier will be her transition into that role. Operationally stated, the hypothesis reads "Anticipatory Socialization Scores will be negatively correlated with Bother Scores."

Product-moment correlation was used to compare Anticipatory Socialization with Bother. No significant correlations were found for any of the scales; analysis failed to support H_3.

Sociodemographic Variables

Several sociodemographic characteristics of the study sample were compared with the dependent variables, Difference and Bother.

Sociodemographic Variables and Difference

The Difference Score is a measure of the congruence of a woman's preconceptions of and her experiences during the postpartum period. It is computed by subtracting the Preconceptions Score from the Experience Score for each scale: Physical, Emotional, Time, Wife Role, Friend/Relative Role, Career, and Child Care.

Care needs to be taken in interpreting the Difference Scores. A Difference Score represented by a negative number indicates that the Preconception Score was higher than the corresponding Experience Score. A negative Difference Score thus means that the woman expected to have more

experiences than she actually had. As explained in the Instrumentation section, Chapter IV, the scale items were designed to describe "negative" postpartum experiences, or concerns. Thus, expecting more of these "negative" experiences than in fact occurred means that the woman's preconceptions were inaccurate, but that things were "better" than expected. Therefore, the interpretation given a negative Difference Score is that the situation was better than expected.

A Difference Score represented by a positive number indicates that the Preconception Score was lower than the Experience Score. This score means that the woman expected fewer "negative" experiences than she actually had. Thus, her preconceptions were inaccurate, and things were "worse" than expected. Therefore, a positive Difference Score is interpreted as meaning that the situation was worse than expected.

These concepts must be kept in mind when examining correlations between Difference Scores and sociodemographic variables. A low (negative) Difference Score indicates that things were better than expected. A high (positive) Difference Score means that things were worse than expected. A Difference Score approaching zero indicates that things were similar to what was expected.

Difference Scores for all seven scales were compared with ten sociodemographic characteristics--subject's age, husband's age, years married, highest level of education

achieved by the subject, her major field of study if she attended college, husband's highest level of education, subject's employment status, her occupation, husband's employment status, and husband's social position. The purpose of these comparisons was to determine whether there were any relationships between these variables and Difference Scores.

Only seven significant correlations were discovered. A subject's age was negatively correlated with her Difference Score on the Friend/Relative Role Scale ($r = -.29$, $p < .03$). This finding indicates that the older the woman, the lower her Difference Score on the Friend/Relative Role Scale. Recalling how Difference Scores are interpreted, it can be said that the older the woman, the better she found the situation than expected for aspects of postpartum measured by the Friend/Relative Role Scale (see Appendixes J and K).

Husbands' education was measured on a scale of 1 to 7, where 1 = less than 7th grade and 7 = advanced degree. Using these numbers, product-moment correlation was used to determine the relationship between husbands' education and Difference Scores. A significant, positive relationship was found only for the Wife Role Scale ($r = .33$, $p < .02$). Thus, the more uneducated the woman's husband, the better she found the situation than expected with respect to the wife role.

Using point-biserial correlation, significant negative relationships were found between a woman's employment status and her Difference Scores on the Emotion Scale ($r_{bis} = -.29$, $p < .03$) and on the Child Care Scale ($r_{bis} = -.28$, $p < .03$). Since Employed = 1, and Unemployed = 2, these correlations mean that unemployed women tended to have lower Difference Scores than employed women. Thus, employed women tended to find the situation worse, and unemployed women better, than expected for aspects of postpartum measured by the Emotion Scale and the Child Care Scale (see Appendixes J and K).

Point-biserial correlation was used to compare husbands' employment status with Difference Scores. A significant negative relationship was found between husbands' employment status and Difference Scores for the Wife Role Scale ($r_{bis} = -.30$, $p < .03$). A significant positive relationship was found between husbands' employment status and the Difference Score for the Career Scale ($r_{bis} = .45$, $p < .03$). These significant correlations must be interpreted with caution, as only four husbands were unemployed. However, the tentative interpretation is that women whose husbands were unemployed found the situation better than expected in terms of their wife role, but worse than expected when it came to quitting their jobs to stay home with their babies.

The final significant association found was that between husbands' social position and the Difference Score

on the Wife Scale (r = -.31, p < .02). On the scale measuring Social Position, 1 = the highest position and 7 = the lowest position. Thus, the lower the social position, the lower the Difference Score on the Wife Role Scale. The interpretation is that the higher the husband's social position, the worse the woman tended to find her situation than expected in terms of her wife role.

To summarize, Difference Scores on seven scales were compared with ten sociodemographic variables. Out of a total of 70 possible relationships, only seven were found to reach significant levels. A general conclusion is that the woman's sociodemographic characteristics exerted very little influence over the accuracy of their preconceptions of the postpartum period.

Sociodemographic Variables and Bother

Bother Scores for all seven scales were compared with the same ten sociodemographic variables described above. The only significant associations were between the wives' and the husbands' highest level of education and Bother Scores for some scales.

A significant positive relationship was found between the women's educational level and their Bother Scores on the Time Scale (r = .26, p < .04). Thus, women who were more highly educated tended to report more bother as a result of factors measured by the Time Scale (see Appendixes J and K) than less educated women.

Significant positive relationships were found between husbands' level of education and Bother Scores for the following scales: Career ($r = .43$, $p < .03$); Wife Role ($r = .33$, $p < .02$); Child Care ($r = .31$, $p < .02$); and Time ($r = .27$, $p < .04$). Thus, women whose husbands were more highly educated reported more bother relative to the aspects of postpartum measured by those four scales (see Appendixes J and K) than women whose husbands were less highly educated.

To summarize, out of 70 possible relationships between the sociodemographic characteristics and Bother, only five significant correlations were found. All were related to the subject's or to her husband's level of education. Thus it appears that the women's sociodemographic characteristics exerted very little influence over their Bother Scores except in the area of education.

Summary

Data analysis revealed that the subjects accurately anticipated the effect of parenthood on their physical and emotional selves, and on their careers. They were overly optimistic about the effect of the infant on their wife role and on their usual routines. They were overly pessimistic about the effect of the infant on their friend/relative role and about their ability to care for their infant. Sociodemographic variables exerted very little influence over the accuracy of subjects' expectations of postpartum.

Data analysis also revealed that, contrary to reports in recent studies that parenthood results in only slight bother, most of the women reported a moderate degree of bother as a result of their postpartum experiences. An unexpected finding was a significant relationship between education and Bother for some scales: the more educated the woman was, the more bother she reported as a result of Time Scale experiences; and the more educated her husband was, the more bother she reported as a result of Career, Wife Role, Child Care, and Time Scale experiences.

The data analysis used to test the study hypotheses found a significant correlation between Difference and Bother for five of the seven scales: Physical, Emotional, Time, Wife Role, and Child Care. Contrary to expectations, no significant negative relationships were found between Anticipatory Socialization Scores and either Difference Scores or Bother Scores.

In Chapter VI, an overview of the entire study will be presented. Following the overview, the findings will be interpreted and discussed. Conclusions will be drawn, and implications of the study findings for nursing research, practice, and education will be presented.

CHAPTER VI

SUMMARY AND IMPLICATIONS OF THE STUDY

Overview

Purpose

A longitudinal, correlational study was conducted to determine the relationships among first-time mothers' anticipatory socialization for parenthood, the accuracy of their preconceptions of the postpartum period, and their ease of transition into the parental role.

Study Questions

Insufficient documentation was found in the literature to permit formulation of a hypothesis regarding the accuracy of preconceptions of the postpartum period. In addition, because of conflicting existing evidence, no hypothesis was made regarding the difficulty experienced by first-time mothers during the transition into parenthood. However, study questions were formulated that asked: "How accurate were these first-time mothers in anticipating their postpartum experiences, or concerns?" and "How difficult was transition into the parental role for these first-time mothers, as measured by their Bother Scores?"

Hypotheses

Based on a role transition model proposed by Burr (1972), it was hypothesized that anticipatory socialization would be related to accurate preconceptions of the postpartum period and to ease of transition into the parental

role. It was further hypothesized that accuracy of preconceptions would be related to ease of role transition.

Method

A convenience sample of 44 first-time mothers completed two questionnaires. The first questionnaire (see Appendix A), administered during the third trimester of pregnancy, attempted to measure the women's preconceptions of the postpartum period in terms of their confidence in their child-care abilities; in terms of the effects of motherhood and the infant's presence on their physical and emotional selves, their ability to manage their time, and their ability to continue performing their wife and friend/relative roles; and in terms of their feelings about quitting a job to stay home with their baby. The first questionnaire also attempted to measure their anticipatory socialization, i.e. preparation for parenthood, experiences.

The second questionnaire (see Appendix B), administered between 6 and 8 weeks postpartum, attempted to measure the women's actual postpartum experiences, and the amount of bother their experiences caused them.

Study Sample

The women in this study sample were, on average, middle class or higher, educated beyond high school, and employed outside the home before the baby was born. Most of the employed women did not plan to return to work at 6 weeks postpartum. The majority of women were in their mid-twenties and had been married for two or fewer years. The

women's husbands were also in their mid-twenties, were employed, and were educated beyond high school.

A large majority of the women had attended Lamaze classes, had read at least one book or article about parenting, had close friends or relatives with new babies, and stated they had had at least some infant-care experience prior to their pregnancy. Only a little more than one third of the women had attended parenting or marriage and the family classes.

In terms of sociodemographic characteristics, the current study sample most closely resembles those of the two earliest transition into parenthood studies (Dyer, 1963; LeMasters, 1957). All three studies used convenience samples. The earlier study samples were comprised entirely of middle-class, college-educated couples wherein the wife was not employed after the child's birth. While the current study's sample was more varied, the majority of subjects fit this profile.

The characteristics of the study sample may have affected the study results. This possibility will be explored in the Interpretation and Discussion section of this chapter.

Findings

Study questions. Data analysis provided answers to the study questions. The first study question concerned the accuracy of first-time mothers' preconceptions of postpartum experiences. Using the t-test for paired means, no

difference was found between preconceptions and experiences for items comprising the Physical, Emotional, or Career Scales. Women agreed to having significantly more Time and Wife Scale experiences then they expected; they agreed to having significantly fewer Friend/Relative and Child Scale experiences than they expected.

The second study question concerned the amount of bother reported by first-time mothers as a result of their postpartum experiences. Mean Bother Scores for the seven scales clustered about the scale midpoint. When "Bother Categories" were devised, it was found that the mode response fell under the "Moderate" category for every scale except for Friend/Relative, for which the mode response was "Slight."

Hypotheses. Data analysis provided grounds for rejecting or failing to reject the study hypotheses. Product-moment correlation was used to test all three hypotheses. H_1 stated that the more congruent a first-time mother's preconceptions of the parental role are with her actual postpartum experiences, the easier will be her transition into parenthood. Operationally stated, "Difference will be positively correlated with Bother." Data analysis revealed a significant, positive relationship between Difference Scores and Bother Scores for every scale except for Friend/Relative and Career. Thus, it was decided not to reject H_1 for the Physical, Emotional, Time, Wife, and Child Scales (see Appendixes J and K).

H_2 stated that the more selected anticipatory socialization experiences a first-time mother has had for the parental role, the more congruent her preconceptions of the postpartum period will be with her subsequent experiences. Operationally stated, "Anticipatory Socialization Scores will be negatively correlated with the absolute value of Difference Scores." A significant correlation was found between Anticipatory Socialization Scores and Difference Scores for only the Friend/Relative Scale, and the relationship was in the opposite direction from the predicted one. That is, the more anticipatory socialization experiences the woman had for parenthood, the higher her Difference Score. Therefore, H_2 was rejected for all scales.

H_3 stated that the more selected anticipatory socialization experiences a first-time mother has had for the parental role, the easier will be her transition into that role. Operationally stated, "Anticipatory Socialization Scores will be negatively correlated with Bother Scores." No significant correlations were found between Anticipatory Socialization Scores and Bother Scores for any of the scales. Therefore, H_3 was rejected.

Sociodemographic variables. No hypotheses or study questions were formulated about the relationships among selected sociodemographic variables and the dependent variables, Difference and Bother, but these relationships were sought for descriptive purposes. Seven significant

relationships were found between sociodemographic variables and Difference.

1. The younger the woman, the worse she found the situation than expected for aspects of postpartum measured by the Friend/Relative Scale.

2. The lower the woman's husband's education, the better she found the situation than expected for aspects of postpartum measured by the Wife Scale.

3. Women who had been employed within the year previous to participation in this study found the situation worse than expected for aspects of postpartum measured by the Emotion Scale.

4. Women who had been employed within the year previous to participation in this study found the situation worse then expected for aspects of postpartum measured by the Wife Scale.

5. Women whose husbands were unemployed found the situation better than expected for aspects of postpartum measured by the Wife Scale.

6. Women who had been employed within the year previous to participation in this study, and who did not intend to return to work right away, and whose husbands were unemployed, found the situation worse than expected for aspects of postpartum measured by the Career Scale.

7. The lower the woman's husband's social class, the better she found the situation than expected for aspects of postpartum measured by the Wife Scale.

Five significant relationships were found between sociodemographic variables and Bother.

1. The higher the woman's educational level, the more bothered she was by aspects of postpartum measured by the Time Scale.

2. The more highly educated the woman's husband, the more bothered she was by aspects of postpartum measured by the Time Scale.

3. The more highly educated the woman's husband, the more bothered she was by aspects of postpartum measured by the Wife Scale.

4. The more highly educated the woman's husband, the more bothered she was by aspects of postpartum measured by the Child Scale.

5. The more highly educated the husband of a woman who had been employed within the year previous to participation in this study, and who did not plan to return to work right away, the more bothered the woman was by aspects of postpartum measured by the Career Scale.

Interpretation and Discussion

Study Questions

The first study question was whether first-time mothers' preconceptions of postpartum were accurate. It was found that preconceptions were accurate for experiences comprising the Physical, Emotional, and Career Scales; overly optimistic for experiences comprising the Time and Wife Scales; and overly pessimistic for experiences comprising

the Friend/Relative and Child Scales (see Appendix J for scale items). The accurate preconceptions will be discussed first.

A likely explanation for the accuracy of preconceptions found for Physical and Emotional Scale experiences is that these two aspects of childbirth and postpartum have traditionally been included as content in prenatal classes. Only 3 subjects did not attend prenatal classes; the remainder may have learned what to expect at the classes they attended. Also, the Physical and Emotional Scale experiences are more concrete than experiences related to changing relationships or altering lifelong habits and activities. Perhaps this type of information is more easily conveyed to and retained by pregnant women than information about more complex postpartum experiences.

The explanation for women's holding accurate expectations for Career Scale experiences may be found by looking at the nature of the scale items. Essentially, the Prenatal Career Scale asks working women to predict what it will be like not to work outside the home. Perhaps the respondents had grown up with their mothers at home, and thus were provided with a role model for being a non-working mother. Or the respondents may have been unemployed at some time in the past, and based their accurate predictions on their own experiences. Even if a respondent has always worked outside the home, it may be easier to predict the

effect of deleting a familiar role from one's life than the effect of adding an unfamiliar role.

The picture the women held about experiences comprising the Time and Wife Scales were overly optimistic. The Time Scale was designed to include experiences dealing with the respondents' ability to manage their time, and to cope with the baby's unpredictable schedule. Women may have failed to predict Time Scale concerns because of the possibility that no amount of caring for other people's children can prepare one for the readjustment of one's usual schedule necessitated by the presence of and the 24-hour-a-day responsibility for an infant in the home. Clinical experience suggests that many new mothers are unprepared for the amount of time needed to care for their infant. Some research findings support this observation. For example, Pellegrom and Swartz (1980) found that new mothers spent less time than expected doing household tasks, being by themselves, being with their husbands, and engaging in recreational activities.

The women were also overly optimistic about the potential effect of the baby on their wife role. As with Time Scale experiences, perhaps no amount of previous baby care experience can prepare one for the effect of an infant on the marital relationship. The introduction of a third person into an established dyad is a complex process. When the third person is a demanding infant whose needs may get met

at the expense of a spouse's needs, this process can be even more difficult.

Expectations regarding difficult postpartum experiences measured by the Friend/Relative and the Child Scales were low, but even so were overly pessimistic. It is difficult to explain why this should be so for the Friend/Relative Scale, which attempted to measure changes in these relationships. Perhaps 6 weeks postpartum is too soon for these changes to be noticed.

It is easier to explain the Child Scale findings. Respondents were initially confident in their child care abilities. By 6 weeks postpartum, they were having even fewer problems than predicted. It is probable that six weeks of intensive baby care experience increased the woman's confidence, resulting in a lower postnatal than prenatal score on the Child Scale.

The second study question focused on how bothered the mothers were by their "negative" postpartum experiences. Most of the women reported a moderate amount of bother. Not only did the mean Bother Score for all scales cluster about the scale midpoint, but when responses were categorized, the mode response fell into the "moderate" category for 6 of the 7 scales. This finding conflicts with those of the most recent transition into parenthood studies, in which the mode Bother Category was "slight" (Hobbs, 1965; Hobbs, 1968; Hobbs & Cole, 1976; Russell, 1974). Only in Dyer's study (1963) was the mode response also "moderate." The mode

response in LeMasters' study (1957) was "extensive or severe."

Caution must be used in comparing results of the current study with those of previous studies. Not only were Bother Scores calculated differently, but sampling, population, and instruments differed. Nevertheless, the results suggest that participants in the current study reported more bother as a result of their postpartum experiences than those in previous studies. An attempt will be made to account for this phenomenon.

The amount of bother reported may be a result of the characteristics of the study sample. For example, a large majority of both husbands and wives had had at least some college education and most belonged to the middle class. Highly-educated, middle-class parents may have high expectations for their ability to cope with a newborn. If these expectations are violated, parents may undergo a difficult role transition. Also, highly-educated individuals are likely to have life-goals in addition to parenthood. A newborn's interference with these life-goals may impede a smooth transition into parenthood (see Figure 1).

There has been some speculation in the literature that a high level of education is positively associated with difficulty in the postpartum period. LeMasters (1957) and Dyer (1963), whose subjects were all college-educated, both reported high crisis scores. Russell (1974) reported no correlation between education and bother, but did find a

negative correlation between education and gratification scores for both husbands and wives. In addition, wives' and husbands' education was positively associated with Bother Scores for some scales in the current study.

Some countervailing evidence does exist. In two studies (Hobbs, 1968; Hobbs & Cole, 1976), scores of a sub-sample of college graduates were no different from scores of non-college graduates. Dyer (1963) found that husband's education was negatively related to the couple's crisis score. The disagreement in the literature concerning the relationship between education and bother thus precludes concluding that the high level of education of this study sample accounts for their relatively high bother scores.

A second characteristic of the study sample may account for the degree of bother reported. A majority of women were employed prior to the birth of their baby; most of these employed women did not plan to return to work at 6 weeks postpartum. Working women who decide not to return to work once they become mothers experience both a drop in family income and a large degree of lifestyle change. Both drop in income and lifestyle changes may be expected to increase the amount of difficulty adjusting to parenthood.

A second explanation for the amount of bother reported is the narrow age range of the babies belonging to this study sample. Participants' babies were between 6 and 8 weeks old when the Postpartum Questionnaire was completed. Other studies included subjects whose first child was up

to 5 years old (LeMasters, 1957), up to 2 years old (Dyer, 1963), between 3 and 18 weeks old (Hobbs, 1965), between 6 and 52 weeks old (Hobbs, 1968), and between 6 and 56 weeks old (Russell, 1974). Perhaps parents report more bother during an initial period of readjustment than they report as the baby grows older. This supposition receives mixed support in the literature. While some researchers report no relationship between the baby's age and adjustment difficulty (Hobbs, 1968; Russell, 1974; Wente & Crockenberg, 1976), others report a positive relationship between the baby's age and difficulty (Hobbs, 1965). In only one study reviewed did parents of younger babies report more difficulty than parents of older babies (Dyer, 1963). Given these study results, no case can be made that the age of the babies in the current study accounted for the relatively high amount of bother reported by this sample.

A third explanation for the amount of bother reported is the method of data collection used. There is some support in the literature for concluding that subjects will report more bother during an interview than when completing a questionnaire. For example, LeMasters' (1957) interviewed subjects admitted to a great deal of difficulty. Hobbs' (1968) subjects reported higher crisis scores in response to interview questions than in reponse to a questionnaire, although this difference was not tested for statistical significance. Perhaps the opportunity to build rapport during

an interview creates an atmosphere conducive to admitting to difficulties with the parental role.

The same reasoning may be applied to explain the bother scores reported by the current study sample. While it is true that the instrument was a questionnaire, not an interview schedule, the circumstances surrounding data collection may have created sufficient rapport to increase the chances of obtaining honest responses. First, subjects were initially asked to participate in the study by their physician, or by an office nurse or medical assistant. Some of the trust the women placed in their health care provider may have been transferred to the researcher, whose study may have been perceived as approved by the physician. Second, the researcher, as a nurse, may have been perceived to be a trustworthy person in her own right because of her profession. Finally, at least one telephone contact was made with each participant. This brief interaction may have contributed to a willingness to be honest in answering the questionnaire items.

A final explanation for the finding of moderate bother is that 100% of the eligible women who agreed to participate returned both questionnaires. It is possible that the same trust-enhancing circumstances that may have promoted honest responses also resulted in the inclusion of more women experiencing high stress levels than were included in previous studies. Russell (1974) followed up non-respondents to her study, and found that they were more likely to have been

premaritally pregnant than respondents. Russell suggested that these couples may undergo more stress than postmaritally pregnant couples, so that if they had responded, the mean difficulty score would have been higher. While it is not known how many women in the current study were premaritally pregnant, nearly 16% had been married less than a year when they completed the first questionnaire. The 100% response rate may indicate that women experiencing all levels of difficulty were included in this study. Inclusion of all these women may account for the moderate levels of bother found.

To summarize, participants in the current study reported more bother as a result of their postpartum experiences than participants in the most recent transition into parenthood studies reported in the literature. Several factors may account for this phenomenon. The women's high education and their plans not to return to work right away may have led to disappointments, life-style changes, and loss of income. Also, the Postpartum Questionnaire was administered at 6-8 weeks postpartum, at which time adjustment difficulties may not yet have been resolved. These factors may account for the amount of bother experienced. Data collection techniques that enhanced rapport may account for the amount of bother reported.

Hypotheses

The three study hypotheses are statements regarding the relationships among anticipatory socialization, accuracy of

preconceptions of the parental role in the postpartum period, and ease of transition into the parental role (see Figure 2). The assumption underlying H_1 is that holding accurate expectations about postpartum should result in less bother when these expectations are fulfilled, i.e., a relatively easy transition into the role. The assumption underlying H_2 is that it is anticipatory socialization (AS) that is responsible for an individual's holding accurate preconceptions of what the postpartum period will be like. The assumption underlying H_3 is that AS also facilitates role transition through role mastery achieved as a result of the role encumbent's having learned in advance the skills, knowledge, and values needed to enact the parental role.

In fact, the results of this study support only one of the hypotheses--that there is a relationship between accuracy of preconceptions (Difference) and ease of role transition (Bother). The predicted relationships between AS and Difference, and AS and Bother, were not found. In this section, an attempt will be made to interpret these findings.

Hypothesis 1. Difference Scores correlated with Bother Scores for the Physical, Emotional, Time, Wife, and Child Scales. A high Difference Score indicated high discrepancy between preconceptions and experiences. Thus, failure to anticipate the postpartum experiences measured by the

above 5 scales was related to reports of increased bother as a result of those same experiences.

Difference was correlated with Bother, but it cannot be concluded that inaccurate preconceptions led to more difficult role transition. When two variables are correlated, it is known only that they are related. Either variable could have caused the other, or a third factor could be responsible for the findings related to both variables. Since the current study was prospective, it is known that the preconceptions held by respondents about postpartum occurred before transition into parenthood. Thus, Bother could not have caused Difference. But a third unknown factor could have caused both Difference and Bother.

A second reason why causation cannot be inferred from the correlations found between Difference and Bother is that the correlations were not perfect. A correlation coefficient of 1.0 would allow one precisely to predict a woman's Bother Score by knowing only her Difference Score. Perfect correlations are rarely found in behavioral studies, and indeed the correlations found between Difference and Bother were only between .36 and .42. These coefficients indicate that Difference Scores accounted for only between 13% and 18% of the variance on Bother Scores.

Other unknown factors must have accounted for the remaining 82% to 87% of the variance observed among the women's Bother Scores. Previous researchers have sought to describe variables associated with ease or difficulty of

transition to parenthood, or attainment of the maternal role. Some of the factors they have found are the quality of the marital relationship (Dyer, 1963; Hobbs, 1968; Russell, 1974); the infant's temperament (Mercer, 1981; Russell, 1974); whether the pregnancy was planned (Dyer, 1963; Russell, 1974); the woman's perception of her birth experience (Entwisle & Doering, 1980; Mercer, 1981); the health of the mother (Mercer, 1981; Russell, 1974) and the baby (Hobbs, 1965); and the amount of social support the mother perceives (Mercer, 1981). These or other variables not measured in the current study, must have accounted for the remaining variability of scores on the Bother Scale.

Although the study results do not allow one to conclude that accurate preconceptions of postpartum led to an easy transition into parenthood, the fact that a statistically significant relationship was found between Difference and Bother for most of the scales is meaningful. It indicates that the more unrealistic a first-time mother's preconceptions of the Physical, Emotional, Time, Wife, and Child Scale aspects of postpartum, the more likely she was to be bothered by these aspects of her postpartum experience. Seemingly, if a mother's preconceptions were later confirmed, "negative" postpartum experiences did not trouble her too much. Conversely, if a mother's preconceptions were later violated, she found these same experiences bothersome.

It may be that mothers who accurately anticipated their postpartum experiences had an opportunity mentally to

rehearse their responses to these experiences in advance. Having engaged in preparatory problem-solving, these mothers may have readily found solutions to their concerns. Mothers who did not realize in advance that having "negative" experiences was a possibility had no mentally-rehearsed solution to rely on.

Another explanation for the finding may be found in the concept of "secondary anxiety." A mentally-prepared mother may have experienced some concern as a result of postpartum events and feelings. But, having anticipated them, she was aware that they were normal, and so may have had confidence that she could cope with them. A surprised mother, on the other hand, may have experienced not only the concern itself, but secondary anxiety as well. This anxiety could have resulted from the mother's wondering if she was normal, or if she was alone in having her problems. She may even have wondered if experiencing difficulty meant she was not a good mother, or was lacking "maternal instinct." These additional worries could have led the unprepared women to experience and report a high degree of bother.

The finding of a relationship between accurate preconceptions and amount of difficulty assuming a new role supports previous research. Kramer (1974) found that student nurses who held realistic preconceptions of their professional role functioned more effectively in the work setting than student nurses whose expectations were unrealistic. Curley and Skerrett (1978) concluded that the amount of

stress newly married couples experienced in the first year of marriage was related, in part, to the congruence of their preconceptions of and experiences in marriage. Thompson (1958) found that accurate preconceptions of retirement facilitated adjustment to retirement.

In addition to supporting previous research findings, the study results provide limited support for the conceptual framework. According to Burr's (1972) model (see Figure 1), anticipatory socialization facilitates role transition. Thornton and Nardi (1975) make explicit that, in order to be functional in promoting role transition, AS must be accurate. AS is accurate to the extent that 1) it provides for acquisition of the skills, knowledge and values actually needed to master the role and 2) it leads one to hold a realistic picture of what the role will be like.

It is the second result of accurate AS--the accuracy of preconceptions of the parental role--that was the focus of H_1. The data supported H_1 for the Physical, Emotional, Time, Wife, and Child Scales, suggesting that one proposition of the conceptual framework is tenable. The support for the conceptual framework is diminished, however, by the data's failure to support the relationship between AS and accuracy of preconceptions of the parental role (H_2). The rejection of H_2 will be considered next.

Hypothesis 2. Burr's (1972) model (see Figure 1) depicts AS as a factor that facilitates role transition. Based on Thornton and Nardi's (1975) observation that only

accurate AS facilitates role transition, it was proposed for this study that AS promotes ease of role transitions indirectly through providing the future role occupant with an accurate idea of what the role will be like. Product-moment correlation revealed, however, no significant relationship between AS and the Difference, i.e. the measure of accurate preconceptions, for six of the seven scales. In addition, it revealed a relationship in the opposite direction from that predicted between AS and Difference for the remaining scale. Thus, AS did not lead to an accurate picture of the postpartum period for the participants in this study, and H_2 was rejected.

There are three possible explanations for the fact that H_2 was not supported. The first explanation is that the proposed relationship exists, but that the hypothesis could not lead to its discovery because it did not logically derive from the conceptual framework. The second explanation is that the relationship exists, but that the tools designed to measure the concepts were incapable of leading to its discovery. The third explanation is that the relationship does not, in fact, exist.

The study contains a conceptual flaw that may account for the failure to find a relationship between anticipatory socialization for parenthood and realistic preconceptions of the postpartum period. The model for this study (see Figure 2) shows a relationship between accurate anticipatory socialization and congruence of preconceptions/experiences.

The hypothesis, however, states that there will be a relationship between the number of selected anticipatory socialization experiences and congruence of preconceptions/experiences. Thus, the conceptual framework concept is quality of anticipatory socialization, and the hypothesis concept is quantity of anticipatory socialization experiences. These concepts are clearly not equivalent. The existence of one thing is proposed by the conceptual framework; the existence of another is sought by the hypothesis.

This inconsistency between the conceptual framework and the hypothesis constitutes a major obstacle to finding the proposed relationship. That no relationship between anticipatory socialization experiences, without reference to their accuracy, and accuracy of preconceptions was found is, in fact, not surprising: "accuracy" was added to the concept of AS in the study model to reflect a belief that AS alone was not a facilitating factor. Unfortunately, this flaw in the formulation of H_2 was discovered only upon reflection as to the possible explanations for its not being supported by the study data. Future research seeking the relationship between accurate anticipatory socialization and accurate preconceptions of the parental role should certainly be guided by a more precisely-worded hypothesis.

Flaws in the instruments used to measure the study concepts may also have accounted for the failure of the data to support H_2. If the concepts were not accurately measured, existing relationships between the variables may

have been missed. Defects in the instruments fall under three categories: reliability and validity problems; the possibility of a response set on the Preconceptions and Experience Indexes; and an inadequate method of scoring the Anticipatory Socialization Scale.

Reliability and validity were discussed in Chapter IV. The alpha coefficients for the scales comprising the Preconception, Experience and Bother Indexes were above .65, and were considered acceptable. However, it is clear that some scales were more reliable than others (see Appendix I). If a scale did not measure an entirely unitary concept, it might not have been reliable enough to measure the relationship sought by H_2. In addition, the reliability of the Anticipatory Socialization Scale is unknown.

A more serious concern is the lack of information about the validity of any of the study's instruments. An attempt was made to design the scales to measure appropriate aspects of postpartum and anticipatory socialization experiences, i.e., to ensure content validity. But there is no way of knowing whether the scales measure what they were intended to measure--i.e. to what degree they possess construct validity. If, instead of measuring the study variables, the instruments measured other, unknown variables, it would not be surprising that no relationship between the variables was found.

A second potential defect in the instruments is the possibility of response set. Because all scale items

comprising the Preconception and Experience Indexes were negatively worded, some respondents may have had a tendency to agree--or more likely, to disagree--with every item, regardless of content (Polit & Hungler, 1978). This problem could be overcome in the future by counterbalancing positively and negatively worded statements.

Lack of reliability and validity information about the Anticipatory Socialization Scale has been discussed. It is possible that the scale items are not experiences that prepare people for parenthood, or that other life experiences that do socialize people for parenthood are missing from the scale. In addition, a question exists as to whether the method of scoring the Anticipatory Socialization Scale (see Appendix G) was adequate. When scoring this scale, distinctions made among the women may not have been fine enough to find the sought-for relationship. For example, no differentiation was made between the following groups of women: those who had read several books on parenting and those who had read just one; those who had attended several marriage and family courses and those who had attended just one; those who judged they had had "a lot" and those who judged they had had "some" previous infant-care experience; or those who judged they had had "very little" and those who judged they had had no previous infant-care experiences. Nor was a distinction made between women who had had actual "hands on" baby-care experience and those whose learning had been through classes or books alone. By placing groups of

women with diverse experiences into one large group, important information about their levels of anticipatory socialization for parenthood was probably lost.

The final explanation for the failure of the data to support H_2 is that the proposed relationship between accurate anticipatory socialization and realistic preconceptions of a role does not, in fact, exist. However, by definition, accuracy of anticipatory socialization is the extent to which it results in an accurate picture of a role (Thornton & Nardi, 1975). Because of this fact, and because the relationship seems empirically sound, the first two explanations offered in this section are the most likely explanations for the failure to find the relationship.

To summarize, H_2 was not supported by the data. It is possible that the proposed relationship between accurate anticipatory socialization and accuracy of preconceptions does not exist. It is more likely that H_2 was not supported because the concept "accurate anticipatory socialization" was not adequately operationalized. An additional explanation is that the instruments used and the method of scoring them may not have adequately measured the critical variables.

Hypothesis 3. According to the conceptual framework, anticipatory socialization facilitates ease of role transition directly, as well as through promotion of realistic preconceptions about a role. This relationship was tested by H_3, which was not supported by the data. The failure to

breast-feeding. Finally, Shereshefsky and Yarrow (1973) concluded that previous experience with children was associated with good maternal adaptation.

A specific means of preparation, attendance at prenatal classes, had been examined in terms of its relationship to postpartum outcomes. Wente and Crockenberg (1976) reported no difference between Lamaze fathers and non-Lamaze fathers on a measure of ease of adjustment to their babies. Entwisle and Doering (1981), however, reported that fathers who participated in prenatal classes scored higher on a measure of good fathering than fathers who did not participate in such classes. Attendance at prenatal classes had a negative direct effect on lower-lass women's mothering scores, but a positive indirect effect on mothering scores for both middle- and lower-class women (Entwisle & Doering, 1981).

Results of experimental studies in which an attempt was made to enhance desirable postpartum outcomes by providing formal anticipatory socialization interventions are also mixed. Gordon and Gordon (1960) concluded that women who attended classes offering anticipatory guidance about what to expect in the postpartum period scored lower on a measure of postpartum emotional difficulties than members of a control group. However, Meleis and Swendsen (1977) found no difference between scores of role supplementation group members and members of two control groups for any of the outcome variables examined. Additionally, Shereshefsky and

Yarrow (1973) concluded that prenatal social work counseling did not enhance women's scores on a measure of maternal adaptation.

To summarize, the results of some studies support the proposition that anticipatory socialization experiences assist parents adjust to their new role. Others, including those of the current study, fail to find evidence for the existence of an association between AS and ease of role transition. It is therefore difficult to conclude whether a relationship does exist between AS and ease of transition into the parental role. However, it is worth noting that none of the non-experimental studies cited above measured the accuracy of the AS content, that is, whether the ideas the experiences engendered in the future parents' minds bore any resemblance to reality. A relationship between <u>accurate</u> AS and ease of transition into parenthood could exist, and it would not have been found because it was not sought in any of the studies reviewed.

The mixed results of experimental studies indicate that helping professionals may not know what kinds of prenatal interventions assist new parents adjust to their role. Before nurses advocate more preparation for parenthood education for new parents, much more experimental research needs to be conducted to determine what kinds of programs lead to the desired results.

Sociodemographic Variables

Relationships between sociodemographic variables and the dependent variables were examined for descriptive purposes only. While these relationships do have implications for nursing research and practice, to be discussed later, they are not central to the study and will be interpreted only briefly. Interpretation of these relationships is not necessarily guided by theory, and so the explanations offered for the findings are tentative.

Sociodemographic Variables and Difference. The first finding was that the younger the woman, the worse she found the situation than expected for Friend/Relative Scale experiences. Younger women apparently held more preconceptions that were found to be inaccurate about the effect of the baby's arrival on these relationships than older women. Perhaps their preconceptions were comparable to those of older women, but because of their youth, they had more of these experiences. For example, their peers may not have children yet, and may pressure them to continue recreational activities, while older mothers may not experience this pressure, as their friends are more likely to be mothers, too. Or perhaps, being younger, these women may not have yet emotionally separated from their families. If not, they may be more prone to experiencing interference from their families, or conflicts such as whose mother should come to help with the baby.

Women whose husbands had a low level of education and belonged to a low social class expected more negative experiences relative to their wife role than they actually had. Any interpretation of this finding would be purely speculative.

Employed women had more negative emotional experiences than they expected. There is no way of knowing why this occurred, but perhaps the stress of either knowing one has to return to work when staying home is preferable; or that one has to stay home when returning to work is preferable, increased emotional upsets to a higher level than expected.

Employed women whose husbands were unemployed, and who planned to stay home after the baby's birth, found the situation worse than expected for Career Scale experiences. The purpose of the Career Scale was to determine women's feelings about quitting work. It makes sense that women whose husbands were not working would have experiences related to missing their jobs. Perhaps all employed women expected a similar number of Career Scale experiences, but those whose husbands were out of work actually had more of them because of their financial situation.

Sociodemographic Variables and Bother. The only extraneous variable found to have a statistically significant association with Bother was level of education--either the respondent's, or her husband's. The wife's education was associated with Bother only for the Time Scale. An educated woman may be accustomed to planning and being in control of

her situation. The very nature of a baby's unpredictable schedule and the immediacy of its needs precludes the ability to "take charge" of the infant. If the woman's usual means of coping with stress is to exert control over the situation, she will be frustrated when this method fails with her baby. Thus, she may report more bother as a result of Time Scale experiences than a less educated woman.

The more highly educated the woman's husband, the more bothered she was by Time Scale, Wife Scale, and Child Scale experiences. Possibly a highly educated husband has high expectations for his wife in terms of her ability to maintain her usual schedule, continue her usual wife role tasks and her ability to meet his needs, and to do well at child care activities. The wives of these men may internalize these expectations for themselves, setting themselves up to do everything they did before in addition to being a parent. The stress they feel at their inability to meet these expectations may account for these women's higher Bother Scores.

The more highly educated the husband of an employed woman who did not plan to continue working, the more bothered she was by Career Scale experiences. Educated men may tend to marry women who can be intellectually stimulating companions. Both the husband and wife may have high expectations for her success in the work world. When the wife quits her job to stay home with a baby, her husband may

fear that she will become uninteresting. If this is the case, his anxieties may be transferred to her, and be reflected in a high Bother Score for the Career Scale.

The interpretations of the relationships between education and Bother are admittedly speculative. They represent a "best guess" as to the reason for a surprising phenomenon. No study reviewed found a correlation between wife's education and bother. Russell (1974) did find significant negative relationships between a measure of the gratifications of parenthood and both the husband's and the wife's educational level. Dyer (1963) found that the higher the husband's education, the lower the couple's crisis score. But no study reviewed found a relationship between the husband's education and the wife's bother score.

The findings were surprising not only because they were not supported by the literature review, but also because together, they comprise a unitary finding that one would not expect to find by chance. Of the 70 possible relationships between sociodemographic variables and Bother, only 5 were found, and they were all relationships between education and Bother. An explanation for this finding is not immediately apparent, but it appears that women whose husbands are highly educated are at a risk for a difficult transition into parenthood. Further research should attempt to replicate this finding as well as seek an explanation for it.

Conclusions

1. There was a positive relationship between the accuracy of first-time mothers' preconceptions of several aspects of postpartum and their ease of transition into the parental role. Therefore, women whose preconceptions of the postpartum period were overly optimistic were at risk for a difficult transition into the parental role.

2. The study design was incapable of testing the proposed relationship between accurate AS and the congruence between preconceptions of and experiences during the postpartum period. However, the hypothesized negative relationship between AS (without reference to accuracy) and Difference was not found. The validity of the AS Scale was not established prior to the study. Only by assuming the Anticipatory Socialization Scale was valid can it tentatively be concluded that the women's AS experiences did not lead to their holding an accurate picture of what the postpartum period would be like.

3. Again assuming the Anticipatory Socialization Scale was valid, it can tentatively be concluded that AS experiences did not lead to an easier transition into the parental role.

4. First-time mothers accurately predicted their postpartum experiences relating to physical problems, emotional upsets, and quitting work to stay home with the baby. They failed to anticipate some of the "negative" aspects of postpartum relating to organizing their time, and to the effect their baby's birth and presence in the home on their marital

relationship. They experienced less difficulty with relationships with friends and relatives than they expected, and they had more confidence in their child care abilities than they anticipated.

5. First-time mothers expressed a moderate amount of bother as a result of their "negative" postpartum experiences.

6. Highly educated women may be at risk for having difficulty coping with the rearrangement of their routines and with the maintenance of a flexible attitude toward their schedules necessitated by the presence of an infant in their home.

7. Women whose husbands are highly educated may be at risk for experiencing difficulty with transition into the parental role.

Nursing Implications

Research

Future nursing research should build on the current study's strengths and rectify its weaknesses. Three main categories of studies should be undertaken: replication and modification of the part of the current research that found a relationship between accurate preconceptions and ease of role transition; exploratory studies aimed at refining the Anticipatory Socialization Scale; and experimental studies designed to discover what types of prenatal nursing interventions will result in more realistic expectations of postpartum and an easier transition to the parental role.

Because a non-random sample was used for this study, the finding demonstrating a relationship between accurate preconceptions of postpartum and ease of transition into the parental role cannot be generalized beyond the study sample. Therefore, replication using random samples, and samples having different characteristics from those of the current study sample, would increase support for the finding.

Certain modifications of the current study might make replication more valuable. For example, the format for obtaining information about the amount of bother women experienced was not entirely satisfactory. Several women were confused by the questionnaire format, and interpreting their responses to the Bother Index was a difficult task. This section of the Postpartum Questionnaire should therefore be revised. Also, concepts should be re-operationalized to more accurately derive from the conceptual framework. In addition, the current study obtained information about careers only from women who intended to quit their jobs to stay home with their babies. As more and more new mothers return to the workplace at 6 weeks postpartum, it would be informative to prolong the study and ask these working mothers about their expected and actual experiences related to integrating their work and parental roles. A final suggestion for instrument revision before replication is to write half the Prenatal Questionnaire items to begin, "It is unlikely I will experience..." Re-wording items in this way will help avoid the potential problem of response

set. Similar revisions should be made of the wording of Postpartum Questionnaire items.

Another goal of future nursing research should be the exploration for possible reasons for the rejection of H_2 and H_3. Prenatal class instructors, marriage and family living course teachers, and perinatal nurses inform future parents about the parental role based on the assumption that such anticipatory socialization is helpful. It is therefore important to know why the data used to test H_2 and H_3 failed to support this assumption.

The first step in researching the usefulness of anticipatory socialization experiences would be an exploratory study to determine which life experiences new mothers found most helpful in adjusting to the parental role. New mothers could be asked open-ended questions concerning experiences they found helpful, experiences they had assumed would be helpful, but were not, and experiences they wish they had had in preparation for parenthood. The specific qualities of the experience that made it helpful should be elicited from mothers as well.

The results of such a preliminary study could then be used to devise a more inclusive Anticipatory Socialization Scale. An attempt should be made to design the scale so that the accuracy of the anticipatory socialization experiences can be evaluated. This would be the most problematic step in creating this scale. The possibility that what was taught differed from what was learned would confound any

find the proposed relationship may have resulted from the inadequate operationalization of the variables or the insufficient sensitivity of the instruments cited above. In addition, the difficulty encountered in scoring the Bother Index may be a factor in the failure to find the proposed relationships. This difficulty was explained in Chapter IV. Briefly, some respondents disagreed with an item on the Experience Index, yet marked a degree of bother the experience caused (usually "none") on the Bother Index. Interpretation of what the subjects meant by these responses was difficult, and may have been in error. Incorrect interpretation of the Bother Scores could account for the rejection of H_3.

Another interpretation of this result is that the proposed relationship does not exist. Results of previous studies exploring the relationship between preparation for parenthood and postpartum outcomes are mixed. Dyer (1963) found that either spouses' having taken a preparation for marriage course in school was related to lower courses on a measure of the amount of crisis resulting from the first birth. Russell (1974), however, found that having had preparation for parenthood experiences was not associated with either husbands' or wives' scores on a scale designed to measure bother resulting from the first birth. Entwisle and Doering (1981) concluded that previous baby-care experience was indirectly related to mothering behavior through the quality of the birth experience or through early

evaluation of the socialization's accuracy. Would "accuracy" be defined in terms of the "actual" message of the experience, or in terms of how the future parent had interpreted the message?

If the problem of evaluating the quality of anticipatory socialization experiences could not be overcome, the Anticipatory Socialization Scale could at least be improved by a revised method of scoring. The current scoring method probably did not discriminate finely enough among women who had had various levels of anticipatory socialization. In the future, care should be taken to design a scoring method that remedies this shortcoming.

Anticipatory socialization is only one variable proposed by Burr's (1972) model to facilitate ease of role transition (see Figure 1). An interesting study would be one designed to test the other facilitating factors in terms of their impact on transition into parenthood.

Perhaps the most pressing need is for experimental nursing research designed to test the efficacy of a formal anticipatory socialization program in promoting ease of transition into the parental role. The current Prenatal Questionnaire could be administered to randomly selected, randomly assigned control and experimental groups. Experimental group expectations of postpartum could then be compared with those of the current study sample, with research reports of postpartum concerns, and with the researcher's knowledge, based on clinical experience, of commonly

occurring postpartum experiences. A program could then be developed to narrow the gap between any overly optimistic preconceptions and the probable reality of postpartum. At the end of the program, the Prenatal Questionnaire could be re-administered to the experimental group to determine whether the intervention succeeded in changing preconceptions of postpartum. At six weeks postpartum, the Postpartum Questionnaire could be administered to both groups; group scores could be compared to determine whether the experimental group scored lower on Difference and/or on Bother than the control group.

Practice

In recommending incorporation of the study findings into nursing practice, it must be pointed out that the study results are not generalizable to other populations. Therefore, implications for nursing practice are tentative.

One study finding was that first-time mothers experienced a moderate amount of bother as a result of their postpartum experiences. This finding has implications for nursing practice. If mothers experience only slight difficulty adjusting to parenthood, as some research has reported, nursing intervention might not be needed to facilitate adjustment. However, the moderate amount of bother found in this study, if supported by further research, justifies devising nursing interventions to reduce the difficulty. Reduction of postpartum difficulty would

enhance mothers' ability to engage in both self-care and infant-care.

A second, major finding of the study was the relationship between accurate preconceptions of postpartum and ease of transition into the parental role. This finding suggests that a desirable nursing goal for new mothers is to diminish any discrepancies between overly optimistic preconceptions and probable postpartum experiences. Nurses can approach this goal either by attempting to assist the pregnant woman to adopt preconceptions more in line with commonly occurring experiences, or to assist the new mother to bring her experiences more in line with her preconceptions. Examples of each type of intervention will be given.

Before nurses can intervene to promote congruence between preconceptions and reality, they must know the pregnant woman's ideas about postpartum. The Prenatal Questionnaire could be used as an assessment tool for this purpose. Based on research and clinical experience, the nurse could evaluate whether the woman's preconceptions are accurate, overly pessimistic, or overly optimistic. This evaluation would certainly be general, since no one can know exactly what experiences an individual woman will have. But the nurse could point out aspects of postpartum that commonly concern new mothers, and could assist the mother to devise coping strategies in advance in the event she experiences these same concerns. Helping the mother engage in anticipatory problem-solving is aimed at the nursing goal of

promoting the mother's ability to engage in self-care in the postpartum period.

Nursing intervention should continue into the immediate postpartum period. The Postpartum Questionnaire could be used to assess the new mother's experiences after she has had the baby home for only one or two weeks, before minor difficulties have become complex problems. The nurse could determine what unexpected concerns the mother has by comparing her answers on the Prenatal Questionnaire with those on the Postpartum Questionnaire. Nursing interventions can then be directed at helping the mother cope with these unexpected concerns, since these are likely to bother her more than those she was prepared for.

One way to assist a mother in coping is to help her shape her experiences to more closely match her preconceptions. For example, a mother may have expected she would know how often to feed her baby, but finds she does not. By teaching the mother about breastfeeding, or formula requirements, and about interpreting the infant's hunger cues, the nurse could adjust the woman's "reality" to be more commensurate with her expectations. As another example, a mother may experience unexpected fatigue. By assisting the mother to enlist help with household chores, re-order her priorities, and see the need for napping at every opportunity, the nurse could help her reduce her fatigue. As the mother begins to feel more rested, her experience becomes more congruent with her preconceptions.

Mothers may need assistance in accepting and coping with experiences that differ from their preconceptions and that cannot be readily altered. For example, a mother may unexpectedly experience postpartum depression. While the nurse may be unable to alleviate this condition, it may be possible to support and comfort the mother by reassuring her that she is experiencing a common, normal, and self-limiting condition. The nurse can also teach family members about the mother's depression, and encourage them to be understanding and supportive.

A third study finding was that an accumulation of anticipatory socialization experiences did not lead either to accurate preconceptions of, or ease of transition into, the parental role. Conclusions made about this finding were tenuous. However, an implication for nursing practice is that nurses should not assume that women who have had a great deal of formal and informal child care experiences are immune from a difficult transition into parenthood. These women's expectations and experiences should be assessed just as thoroughly as those of women with less child care experiences.

A fourth finding was that first-time mothers accurately anticipated their physical and emotional postpartum concerns. However, they failed to anticipate postpartum concerns related to their wife role and to the changes in their routine necessitated by having an infant. Perhaps perinatal nurses could do more to prepare women for

possible changes in their marital relationship and the effect of a baby on their current lifestyle. Conversely, nurses may be able to reassure women about their ability to competently carry out child care activities, and about the effect of the baby on their relationships with friends and relatives. This reassurance would be based on the study finding that mothers were overly pessimistic about these aspects of postpartum.

A fifth, and surprising, finding was that women whose husbands were highly-educated seem to be at risk for experiencing a difficult transition to parenthood. It might be expected that a low educational level would be related to adjustment difficulties, due to the likelihood of fewer problem-solving skills and resources being available to poorly-educated families. However, the data suggest the opposite, and, if supported by further research, would indicate that nurses should not assume that wives of highly-educated husbands do not need nursing intervention in the postpartum period. On the contrary, it appears they may need intervention more frequently than wives of less-educated husbands.

Education

Nursing implications for education can be derived from the current research study for nurses both in learning and teaching roles. Student nurses and nurses in practice can learn nursing interventions based on the research findings. In turn, they can teach others what they have learned.

Traditionally, the nurses' role in postpartum nursing has been to promote the mother's physical and psychological comfort. Study results showed that new mothers were well informed about the physical and emotional effects of childbirth, but poorly informed about the effects of a first birth on their wife role and on their ability to revise their schedule to meet their own as well as the baby's needs. More emphasis should therefore be placed in nursing schools on the effect of the first birth on the marital relationship and on the parent's lifestyle.

Part of the reason for the emphasis in nursing programs on the biological and emotional aspects of childbirth, versus the role and family development aspects of first parenthood, may be the in-patient focus of traditional nursing education. The full impact of a first birth is not felt until a mother goes home with her baby and the couple attempts to integrate the newborn into their family. As nursing programs begin to focus more on nursing in non-hospital settings, nurses will have to be educated about family health needs exhibited outside health care facilities. Among these are the needs related to postpartum concerns demonstrated by the study sample.

In order to address the new family's health problems, nursing curricula must include content on new mothers' postpartum concerns. As was seen in Chapter III, these concerns go beyond medical problems. Mothers expressed concerns about their body image, their child-care ability,

and their ability to continue carrying out their usual activities, roles, and responsibilities. Nursing students need to understand these concerns so they can assist their clients to resolve them.

Study results showed a relationship between the degree to which postpartum concerns were unexpected and the amount of bother mothers experienced as a result of those concerns. Nurse educators should teach students to assess first-time mothers' expectations of postpartum as well as their postpartum experiences. Students should be taught that any discrepancies they assess could indicate a potential for increased difficulty in that area. Students should be taught to reduce these discrepancies by promoting realistic preconceptions of postpartum, based on a knowledge of common postpartum concerns; and by supporting the new mother in the early postpartum period to make her experience as pleasant as possible. To complete the nursing process, the student should be taught to evaluate the nursing intervention in terms of the amount of difficulty the mother expresses, and in terms of the mother's ability to provide self-care for herself, and care for her infant.

Practicing nurses can benefit from inservice or continuing education programs based on the study results. For example, nurses should be taught that women whose husbands are highly educated may be at risk for a difficult postpartum adjustment, and that women with previous child care experience may not be immune from a difficult role

transition. In addition, continuing education seminars could alert office nurses, public health nurses, and nurse practitioners that intervention may be needed in the early postpartum period, before difficulties reach the proportion reported by mothers at 6-8 weeks.

An inservice program could teach nurses on obstetrics units about the study findings. Such a program could be the impetus for implementing a telephone service to check up on new mothers a week or so after they go home. Continuity of care and ease of role transition would be the goals of such a service. Obstetric nurses could be taught to assess a mother's expectations about postpartum. When calling the mother at home, the nurse could then assess the mother's experiences, and compare them with her preconceptions. Support and teaching could focus on areas of discrepancy; referral to a public health nurse or to the woman's primary health care provider could be made if difficulties were detected.

Family physicians and obstetricians also should be taught that mothers have non-medical needs during postpartum. These needs may necessitate an office or home visit prior to the usual 4 or 6 weeks check up. Ideally, the physician's nurse colleague could arrange a family visit at 2 weeks postpartum. At this visit, the nurse could assess how the family's experiences differ from their expectations, and could intervene to enhance their adjustment to parenthood.

Nurses could be instrumental in devising learning experiences for the general public. School nurses should be involved in designing and teaching family life classes for high school students. These classes should provide realistic child-care experiences for these future parents. Realistic experiences could include having students work in a day-care center located on the school campus; assigning students a "marital partner," with whom they must solve problems of family life; or directing students to take responsibility for a fragile, inanimate object twenty-four hours a day to simulate parental responsibilities. Although evaluation of such programs would be difficult, the goal would be realistic preconceptions of parenthood and ease of transition into the parental role.

Nurses teaching prenatal classes could incorporate material designed to promote realistic preconceptions of the postpartum period into the course content. Nurses could also teach groups of new parents in the hospital, or in the community at 2-8 weeks postpartum. The groups could provide peer support as well as education. The content could be based on the study findings: promoting realistic preconceptions of postpartum, and coping with the effect of a newborn on the couple's marital relationship and on their lifestyle.

In summary, practicing nurses, student nurses, and other health care professionals could be taught to incorporate the study results into their practices. In turn,

they could teach the general public what to expect during the postpartum period and how to cope with common postpartum concerns. The goal of such education would be to promote ease of transition into parenthood by promoting realistic expectations of the parental role.

Summary

In Chapter VI, an overview of the research was presented. In addition, the findings were discussed and interpreted, and conclusions were drawn. The significance of the study results for nursing research, practice, and education was discussed.

APPENDICES

APPENDIX A

Begin Card 1

Pt. ID __ (1-2)	Return __ (3)	Form 1 (4)	
Site __ (5)	Dr. __ (6-7)	Card 1 (8)	

PRENATAL QUESTIONNAIRE
Instructions

On the following pages are some statements describing experiences some pregnant women expect may happen to them during the first 6 weeks after their baby is born. Please read each statement carefully, and decide whether you expect to have the experience during the first 6 weeks after your baby is born. Then put a circle around the number that best describes how much you agree or disagree that it is likely you will have the experience. (Use the key at the top of the column.)

Here are two sample items:

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. Having less time to chat with my neighbors than before.	1	2	3	(4)	5
2. Not knowing what to do when my baby cries.	(1)	2	3	4	5

The woman who answered the first item agrees that she will have less time to chat with her neighbors than before, so she put a circle around the number 4.

The woman who answered the second item strongly disagrees that she will not know what to do when her baby cries, so she put a circle around the number 1.

There are no right or wrong answers. Each woman will have different ideas about what the first 6 weeks of motherhood will be like. Please answer the items as honestly as you can.

When you have completed the questionnaire, place it in the accompanying envelope, seal it, and drop it in the mail.

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
1. Feeling overwhelmed by the responsibility of being a mother.	1	2	3	4	5	(9)
2. Not having enough time to do the things I want to do for myself.	1	2	3	4	5	(10)
3. Having the quality of relationships with childless friends and/or relatives change.	1	2	3	4	5	(11)
4. Having decreased contact with friends and/or relatives.	1	2	3	4	5	(12)
5. Being unable to go out on the spur of the moment.	1	2	3	4	5	(13)
6. Resenting my baby.	1	2	3	4	5	(14)
7. Having conflict with friends and/or relatives over who should stay at our house to help when I get home from the hospital.	1	2	3	4	5	(15)
8. Not knowing how to keep my baby safe.	1	2	3	4	5	(16)
9. Having the "baby blues" or postpartum depression.	1	2	3	4	5	(17)
10. Having decreased communication with my husband.	1	2	3	4	5	(18)
11. Feeling isolated from my friends.	1	2	3	4	5	(19)
12. Having the quality of my relationship with my husband change.	1	2	3	4	5	(20)
13. Having problems with meal preparation, e.g. grocery shopping, cooking.	1	2	3	4	5	(21)
14. Wondering how warmly to dress my baby.	1	2	3	4	5	(22)

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
15. Not knowing how often to feed my baby.	1	2	3	4	5	(23)
16. Being too tired to do the housework.	1	2	3	4	5	(24)
17. Being unable to go out with friends and/or relatives.	1	2	3	4	5	(25)
18. Getting angry at my baby.	1	2	3	4	5	(26)
19. Having difficulty keeping up with the laundry.	1	2	3	4	5	(27)
20. Feeling like I have less in common with childless friends and/or relatives.	1	2	3	4	5	(28)
21. Finding that child care by itself is almost a 24 hour job.	1	2	3	4	5	(29)
22. Needing to change my usual pattern of having sex with my husband.	1	2	3	4	5	(30)
23. Having decreased uninterrupted time alone with my husband.	1	2	3	4	5	(31)
24. Not being back to my pre-pregnant weight by 6 weeks after the baby is born.	1	2	3	4	5	(32)
25. Being unable to comfort my baby when he or she is crying.	1	2	3	4	5	(33)
26. Finding it hard to get up with the baby at night.	1	2	3	4	5	(34)
27. Being unable to just be by myself when I want.	1	2	3	4	5	(35)
28. Not being able to get enough sleep.	1	2	3	4	5	(36)
29. Being out of shape.	1	2	3	4	5	(37)
30. Wondering if having a baby was the right thing to do.	1	2	3	4	5	(38)

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
31. Needing less affection from my husband.	1	2	3	4	5	(39)
32. Wondering whether my baby is ill or not.	1	2	3	4	5	(40)
33. Having the quality of relationships with friends and/or relatives change.	1	2	3	4	5	(41)
34. Having soreness in my vaginal area.	1	2	3	4	5	(42)
35. Being unable to keep up my usual standard of housekeeping.	1	2	3	4	5	(43)
36. Finding that my childless friends and/or relatives act bored when I talk about my baby.	1	2	3	4	5	(44)
37. Not knowing when my baby has had the right amount to eat.	1	2	3	4	5	(45)
38. Getting upset with my husband over little things.	1	2	3	4	5	(46)
39. Wondering if I am less attractive to my husband.	1	2	3	4	5	(47)
40. Not enjoying sexual relations as much as before.	1	2	3	4	5	(48)
41. Wondering when it is OK to take my baby outside.	1	2	3	4	5	(49)
42. Finding it hard to get places on time.	1	2	3	4	5	(50)
43. Finding that my time is no longer my own.	1	2	3	4	5	(51)
44. Spending more time with friends and/or relatives who have children.	1	2	3	4	5	(52)
45. Wondering what to do when my baby spits up.	1	2	3	4	5	(53)

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
46. Having sex less spontaneously because of the baby.	1	2	3	4	5	(54)
47. Feeling awkward holding my baby.	1	2	3	4	5	(55)
48. Finding it hard to schedule everything that needs to be done, e.g., care for baby, home and husband.	1	2	3	4	5	(56)
49. Having problems arranging to take my baby along when I need to run errands.	1	2	3	4	5	(57)
50. Wondering what my baby wants when he or she is crying.	1	2	3	4	5	(58)
51. Having an overwhelming amount of work to do.	1	2	3	4	5	(59)
52. Having less love to give my husband after meeting my baby's need for love.	1	2	3	4	5	(60)
53. Having conflict with friends and/or relatives over visits to our home when the baby first arrives.	1	2	3	4	5	(61)
54. Feeling emotionally tense.	1	2	3	4	5	(62)
55. Neglecting my husband because of spending time with my baby.	1	2	3	4	5	(63)
56. Crying easily for no reason.	1	2	3	4	5	(64)
57. Having to balance my needs with those of my husband and baby.	1	2	3	4	5	(65)
58. Having conflict over how long a chosen friend or relative should stay in our home to help when I get home from the hospital.	1	2	3	4	5	(66)
59. Having interference from friends and/or relatives on how to care for my baby.	1	2	3	4	5	(67)

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
60. Wondering whether my baby's wet and dirty diapers are normal.	1	2	3	4	5	(68)
61. Being unable to fit into pre-pregnant clothes when I come home from the hospital.	1	2	3	4	5	(69)
62. Having less time for personal grooming.	1	2	3	4	5	(70)
63. Not having enough energy to want to have sex with my husband.	1	2	3	4	5	(71)
64. Feeling tied down to the house or apartment.	1	2	3	4	5	(72)
65. Worrying that I'm not a good enough mother.	1	2	3	4	5	(73)
66. Being unable to plan my day because the baby's schedule is so unpredictable.	1	2	3	4	5	(74)
67. Wondering if my baby's behavior is normal.	1	2	3	4	5	(75)
68. Feeling awkward bathing my baby.	1	2	3	4	5	(76)
69. Having problems arranging for a babysitter when I need to go out.	1	2	3	4	5	(77)
70. Spending less time with friends and/or relatives who are childless.	1	2	3	4	5	(78)
71. Being unable to do things with friends and/or relatives if they call at the last minute.	1	2	3	4	5	(79)

End of Card 1
Begin Card 2

Keypunch: Duplicate Columns 1-7

2 (8)

72. Within the past year, have you worked outside the home for money? (Check one)

___ 1. Yes ___ 2. No → Go to Question 73. (9)

WOMEN WHO HAVE WORKED OUTSIDE THE HOME WITHIN THE PAST YEAR

72a. Do you plan to return to work right away after your postpartum check-up? (Check one)

___ 1. Yes → Go to Question 73. ___ 2. No (10)

WOMEN NOT PLANNING TO RETURN TO WORK RIGHT AWAY

DURING THE FIRST 6 WEEKS AFTER MY BABY IS BORN, IT IS LIKELY THAT I WILL EXPERIENCE:	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	
72b. Missing people at work.	1	2	3	4	5	(11)
72c. Missing the satisfaction I get from working.	1	2	3	4	5	(12)
72d. Missing the money I made at my job.	1	2	3	4	5	(13)
72e. Missing getting out of the house.	1	2	3	4	5	(14)
72f. Missing a chance to talk with adults.	1	2	3	4	5	(15)
72g. Fearing being "left behind" in my career.	1	2	3	4	5	(16)
72h. Fearing losing out on job benefits, for example, seniority, retirement.	1	2	3	4	5	(17)
72i. Missing the mental stimulation of working.	1	2	3	4	5	(18)
72j. Fearing losing out on promotion opportunities.	1	2	3	4	5	(19)
72k. Fearing becoming rusty in my work skills.	1	2	3	4	5	(20)

Finally, a few questions about your background to help me better understand the study results.

73. What is your doctor's name (Write in name) _____.

74. What is your age? (Write in age) _____. (21-22)

75. What is your husband's age (Write in age) _____. (23-24)

76. How many years have you been married? (Write in number of years) _____. (25-26)

77. What is the highest level of education you have achieved? (Check one)

_____ 1. Less than 7th Grade
_____ 2. Some Junior High School
_____ 3. Some High School
_____ 4. High School Diploma

→ Go to Question 78

_____ 5. Some College
_____ 6. Bachelor's Degree
_____ 7. Advanced Degree
_____ 8. Other (Please Specify)_____ (27-28)

77a. Please specify major field of study _____ (29-30)

78. What is the highest level of education your husband has achieved? (Check one)

_____ 1. Less than 7th Grade
_____ 2. Some Junior High School
_____ 3. Some High School
_____ 4. High School Diploma
_____ 5. Some College
_____ 6. Bachelor's Degree
_____ 7. Advanced Degree
_____ 8. Other (Please Specify) _____ (31-32)

79. Within the past year, have you worked outside the home for money? (Check one)

_____ 1. Yes ↓

_____ 2. No → Go to Question 80 (33)

WOMEN WHO HAVE WORKED WITHIN THE PAST YEAR

79a. What is your occupation? _____

79b. What do/did you do? _____

79c. In what kind of business do/did you work? _____ (34-35)

80. Is your husband employed? (Check one)

_____ 1. Yes _____ 2. No → Go to Question 81 (36)

HUSBAND IS EMPLOYED

80a. What is his occupation? _____

80b. What does he do? _____

80c. In what kind of business does he work? _____ (37-38)

81. Have you taken any prenatal classes? (Check one)

_____ 1. Yes _____ 2. No → Go to Question 82 (39)

81a. Which prenatal classes have you taken? (Check one) (40)

_____ 1. Visiting Nurses' Association (VNA) Lamaze
_____ 2. Saginaw Valley Childbirth Education Association (SVCEA) Lamaze
_____ 3. Other (Please Specify) _____

81b. How many classes have you attended? (Write in number of classes) _____ (41-42)

81c. In how many classes, if any, was the first few weeks after birth discussed? (Write in number of classes) _____ (43-44)

82. Have you taken any classes related to child care, or marriage and the family? (Check one)

_____ 1. Yes _____ 2. No → Go to Question 83 (45)

82a. How many courses did you take? (Write in number of courses) _____ (46-47)

82b. When did you take it/them? (Check one)

___ 1. In High School ___ 2. In College ___ 3. As an adult (48-50)

83. Since you learned you were pregnant, how many, if any, books and/or articles about child care, parenting, or the first few weeks after birth have you read? (Write in number of books and/or articles) _____ (51-52)

84. Have you attended any LaLeche League meetings? (Check one)

_____ 1. Yes _____ 2. No → Go to Question 85 (53)

84a. How many meetings have you attended? (Write in number of meetings) _____ (54-55)

85. Do you have any children living with you or visiting you regularly, for example, foster children or stepchildren? (Check one)

_____ 1. Yes _____ 2. No (56)

86. How many of your close friends and relatives, if any, who live in this area have had babies within the past year? (Write in number of friends and relatives) _____ (57-58)

87. Some pregnant women have had a lot of experience caring for infants before they become pregnant. Others have had little or no chance to take care of infants before they become pregnant. Please check the response below that you feel most closely describes the amount of experience you have had caring for infants.

_____ 1. A lot
_____ 2. Some
_____ 3. Very little → Go to Question 88
_____ 4. None (59)

87a. What kinds of experience caring for infants have you had? (Check all that apply)

_____ 1. Working or volunteering in a day care center or nursery
_____ 2. Caring for infant brothers and/or sisters while growing up
_____ 3. Babysitting infants as a teenager
_____ 4. Babysitting infants as an adult
_____ 5. Working with infants in a health care setting, for example, hospital, clinic, or doctor's office
_____ 6. Other (Please Specify) _____ (60-65)

88. Please write in today's date. __/__/__ (Mo. Day Yr.)

Thank you for your participation. Please write any comments you might have below, or on the back of this page. Then place the questionnaire in the accompanying envelope, seal it, and drop it in the mail. Be sure to keep the page with my name and telephone number on it. (66-71)

POSTPARTUM QUESTIONNAIRE
Instructions

On the following pages are some statements describing experiences some new mothers have during the first six weeks after their baby is born. Some new mothers have a lot of these experiences; others have very few of them. Also, new mothers will disagree about the amount of bother any one experience caused them. I am interested in learning about the experiences you have had as a new mother, and about how much, if at all, these experiences bothered you.

INSTRUCTIONS:

1. Read each item carefully. Decide whether you have had the experience since your baby was born.
2. To the left of the statement, put a circle around the number that best describes how much you agree or disagree that you have had the experience. (Use the key at the top of the column).
3. If you have had the experience, decide how much the experience bothered you.
4. To the right of the statement, put a circle around the number that best describes how much the experience bothered you. (Use the key at the top of the column).
5. If you have not had the experience, put a circle around the "X" to the right of the statement.

Here are two sample items:

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:						IT HAS BOTHERED ME TO EXPERIENCE:					
Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ⟷				None	Did Not Have The Experience
1	2	3	(4)	5	1. Having less time to chat with my neighbors than before.	1	(2)	3	4	5	X
(1)	2	3	4	5	2. Not knowing what to do when my baby cries.	1	2	3	4	5	(X)

The woman who answered the first item agrees that she has less time to chat with her neighbors than before so she circled the number 4 to the left of the statement. She then circled the number 2 to the right of the statement to show how much it bothered her on a scale of 1 to 5.

The woman who answered the second item strongly disagrees that she does not know what to do when her baby cries, so she circled the number 1 to the left of the statement. She then circled the "X" to the right of the statement because she did not have the experience.

There are no right or wrong answers. Each new mother's experience will be different. Please answer the items as honestly as you can. When you have completed the questionnaire, place it in the accompanying envelope, seal it, and drop it in the mail.

Begin Card 3

Pt. ID (1-2)	Return (3)	Form 2 (4)
Site (5)	Dr. (6-7)	Card 3 8

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:						IT HAS BOTHERED ME TO EXPERIENCE:						
Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ←				→ None	Did Not Have The Experience	
1	2	3	4	5	1. Feeling overwhelmed by the responsibility of being a mother.	1	2	3	4	5	X	(9-10)
1	2	3	4	5	2. Not having enough time to do the things I want to do for myself.	1	2	3	4	5	X	(11-12)
1	2	3	4	5	3. Having the quality of relationships with childless friends and/or relatives change.	1	2	3	4	5	X	(13-14)
1	2	3	4	5	4. Having decreased contact with friends and/or relatives.	1	2	3	4	5	X	(15-16)
1	2	3	4	5	5. Being unable to go out on the spur of the moment.	1	2	3	4	5	X	(17-18)
1	2	3	4	5	6. Resenting my baby.	1	2	3	4	5	X	(19-20)
1	2	3	4	5	7. Having conflict with friends and/or relatives over who should stay at our house to help when I get home from the hospital.	1	2	3	4	5	X	(21-22)
1	2	3	4	5	8. Not knowing how to keep my baby safe.	1	2	3	4	5	X	(23-24)
1	2	3	4	5	9. Having the "baby blues" or postpartum depression.	1	2	3	4	5	X	(25-26)
1	2	3	4	5	10. Having decreased communication with my husband.	1	2	3	4	5	X	(27-28)
1	2	3	4	5	11. Feeling isolated from my friends.	1	2	3	4	5	X	(29-30)

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		IT HAS BOTHERED ME TO EXPERIENCE: A Great Deal ⟷ None					Did Not Have The Experience	
1	2	3	4	5	12. Having the quality of my relationship with my husband change.	1	2	3	4	5	X	(31-32)
1	2	3	4	5	13. Having problems with meal preparation, e.g. grocery shopping, cooking.	1	2	3	4	5	X	(33-34)
1	2	3	4	5	14. Wondering how warmly to dress my baby.	1	2	3	4	5	X	(35-36)
1	2	3	4	5	15. Not knowing how often to feed my baby.	1	2	3	4	5	X	(37-38)
1	2	3	4	5	16. Being too tired to do the housework.	1	2	3	4	5	X	(39-40)
1	2	3	4	5	17. Being unable to go out with friends and/or relatives.	1	2	3	4	5	X	(41-42)
1	2	3	4	5	18. Getting angry at my baby.	1	2	3	4	5	X	(43-44)
1	2	3	4	5	19. Having difficulty keeping up with the laundry.	1	2	3	4	5	X	(45-46)
1	2	3	4	5	20. Feeling like I have less in common with childless friends and/or relatives.	1	2	3	4	5	X	(47-48)
1	2	3	4	5	21. Finding that child care by itself is almost a 24 hour job.	1	2	3	4	5	X	(49-50)
1	2	3	4	5	22. Needing to change my usual pattern of having sex with my husband.	1	2	3	4	5	X	(51-52)
1	2	3	4	5	23. Having decreased uninterrupted time alone with my husband.	1	2	3	4	5	X	(53-54)
1	2	3	4	5	24. Not being back to my prepregnant weight by 6 weeks after the baby is born.	1	2	3	4	5	X	(55-56)

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:						IT HAS BOTHERED ME TO EXPERIENCE;						
Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ⟷				None	Did Not Have The Experience	
1	2	3	4	5	25. Being unable to comfort my baby when he or she is crying.	1	2	3	4	5	X	(57-58)
1	2	3	4	5	26. Finding it hard to get up with the baby at night.	1	2	3	4	5	X	(59-60)
1	2	3	4	5	27. Being unable to just be by myself when I want.	1	2	3	4	5	X	(61-62)
1	2	3	4	5	28. Not being able to get enough sleep.	1	2	3	4	5	X	(63-64)
1	2	3	4	5	29. Being out of shape.	1	2	3	4	5	X	(65-66)
1	2	3	4	5	30. Wondering if having a baby was the right thing to do.	1	2	3	4	5	X	(67-68)
1	2	3	4	5	31. Needing less affection from my husband.	1	2	3	4	5	X	(69-70)
1	2	3	4	5	32. Wondering whether my baby is ill or not.	1	2	3	4	5	X	(71-72)
1	2	3	4	5	33. Having the quality of relationships with friends and/or relatives change.	1	2	3	4	5	X	(73-74)
1	2	3	4	5	34. Having soreness in my vaginal area.	1	2	3	4	5	X	(75-76)
1	2	3	4	5	35. Being unable to keep up my usual standard of housekeeping.	1	2	3	4	5	X	(77-78)
1	2	3	4	5	36. Finding that my childless friends and/or relatives act bored when I talk about my baby.	1	2	3	4	5	X	(79-80)

End of Card 3
Begin Card 4

Keypunch:
Duplicate Col.1-7
4/8

SINCE MY BABY WAS BORN,
I HAVE EXPERIENCED:

IT HAS BOTHERED ME TO EXPERIENCE:

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		Great Deal				None	Did Not Have The Experience	
1	2	3	4	5	37. Not knowing when my baby has had the right amount to eat.	1	2	3	4	5	X	(9-10)
1	2	3	4	5	38. Getting upset with my husband over little things.	1	2	3	4	5	X	(11-12)
1	2	3	4	5	39. Wondering if I am less attractive to my husband.	1	2	3	4	5	X	(13-14)
1	2	3	4	5	40. Not enjoying sexual relations as much as before.	1	2	3	4	5	X	(15-16)
1	2	3	4	5	41. Wondering when it is OK to take my baby outside.	1	2	3	4	5	X	(17-18)
1	2	3	4	5	42. Finding it hard to get places on time.	1	2	3	4	5	X	(19-20)
1	2	3	4	5	43. Finding that my time is no longer my own.	1	2	3	4	5	X	(21-22)
1	2	3	4	5	44. Spending more time with friends and/or relatives who have children.	1	2	3	4	5	X	(23-24)
1	2	3	4	5	45. Wondering what to do when my baby spits up.	1	2	3	4	5	X	(25-26)
1	2	3	4	5	46. Having sex less spontaneously because of the baby.	1	2	3	4	5	X	(27-28)
1	2	3	4	5	47. Feeling awkward holding my baby.	1	2	3	4	5	X	(29-30)
1	2	3	4	5	48. Finding it hard to schedule everything that needs to be done, e.g., care for baby, home and husband.	1	2	3	4	5	X	(31-32)

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:						IT HAS BOTHERED ME TO EXPERIENCE:						
Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ⟷				None	Did Not Have The Experience:	
1	2	3	4	5	49. Having problems arranging to take my baby along when I need to run errands.	1	2	3	4	5	X	(33-34)
1	2	3	4	5	50. Wondering what my baby wants when he or she is crying.	1	2	3	4	5	X	(35-36)
1	2	3	4	5	51. Having an overwhelming amount of work to do.	1	2	3	4	5	X	(37-38)
1	2	3	4	5	52. Having less love to give my husband after meeting my baby's need for love.	1	2	3	4	5	X	(39-40)
1	2	3	4	5	53. Having conflict with friends and/or relatives over visits to our home when the baby first arrives.	1	2	3	4	5	X	(41-42)
1	2	3	4	5	54. Feeling emotionally tense.	1	2	3	4	5	X	(43-44)
1	2	3	4	5	55. Neglecting my husband because of spending time with my baby.	1	2	3	4	5	X	(45-46)
1	2	3	4	5	56. Crying easily for no reason.	1	2	3	4	5	X	(47-48)
1	2	3	4	5	57. Having to balance my needs with those of my husband and baby.	1	2	3	4	5	X	(49-50)
1	2	3	4	5	58. Having conflict over how long a chosen friend or relative should stay in our home to help when I get home from the hospital.	1	2	3	4	5	X	(51-52)
1	2	3	4	5	59. Having interference from friends and/or relatives on how to care for my baby.	1	2	3	4	5	X	(53-54)
1	2	3	4	5	60. Wondering whether my baby's wet and dirty diapers are normal.	1	2	3	4	5	X	(55-56)

SINCE MY BABY WAS BORN,
I HAVE EXPERIENCED:

IT HAS BOTHERED ME TO EXPERIENCE:

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ⟷ None					Did Not Have The Experience:	
1	2	3	4	5	61. Being unable to fit into prepregnant clothes when I come home from the hospital.	1	2	3	4	5	X	(57-58)
1	2	3	4	5	62. Having less time for personal grooming.	1	2	3	4	5	X	(59-60)
1	2	3	4	5	63. Not having enough energy to want to have sex with my husband.	1	2	3	4	5	X	(61-62)
1	2	3	4	5	64. Feeling tied down to the house or apartment.	1	2	3	4	5	X	(63-64)
1	2	3	4	5	65. Worrying that I'm not a good enough mother.	1	2	3	4	5	X	(65-66)
1	2	3	4	5	66. Being unable to plan my day because the baby's schedule is so unpredictable.	1	2	3	4	5	X	(67-68)
1	2	3	4	5	67. Wondering if my baby's behavior is normal.	1	2	3	4	5	X	(69-70)
1	2	3	4	5	68. Feeling awkward bathing my baby.	1	2	3	4	5	X	(71-72)
1	2	3	4	5	69. Having problems arranging for a babysitter when I need to go out.	1	2	3	4	5	X	(73-74)
1	2	3	4	5	70. Spending less time with friends and/or relatives who are childless.	1	2	3	4	5	X	(75-76)
1	2	3	4	5	71. Being unable to do things with friends and/or relatives if they call at the last minute.	1	2	3	4	5	X	(77-78)

End Card 4
Begin Card 5

Keypunch:
Duplicate Col.1-7

5
8

72. Within the past year, have you worked outside the home for money? (Check one)

___ 1. Yes ___ 2. No → Go to Question 73 (9)

WOMEN WHO HAVE WORKED OUTSIDE THE HOME WITHIN THE PAST YEAR

72a. Do you plan to return to work right away after your postpartum check-up? (Check one)

___ 1. Yes → Go to Question 73 ___ 2. No (10)

WOMEN NOT PLANNING TO RETURN TO WORK RIGHT AWAY

SINCE MY BABY WAS BORN, I HAVE EXPERIENCED:						IT HAS BOTHERED ME TO EXPERIENCE:						
Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree		A Great Deal ← →				None	Did Not Have The Experience:	
1	2	3	4	5	72b. Missing people at work.	1	2	3	4	5	X	(11-12)
1	2	3	4	5	72c. Missing the satisfaction I get from working.	1	2	3	4	5	X	(13-14)
1	2	3	4	5	72d. Missing the money I made at my job.	1	2	3	4	5	X	(15-16)
1	2	3	4	5	72e. Missing getting out of the house.	1	2	3	4	5	X	(17-18)
1	2	3	4	5	72f. Missing a chance to talk with adults.	1	2	3	4	5	X	(19-20)
1	2	3	4	5	72g. Fearing being "left behind" in my career.	1	2	3	4	5	X	(21-22)
1	2	3	4	5	72h. Fearing losing out on job benefits, for example, seniority, retirement.	1	2	3	4	5	X	(23-24)
1	2	3	4	5	72i. Missing the mental stimulation of working.	1	2	3	4	5	X	(25-26)
1	2	3	4	5	72j. Fearing losing out on promotion opportunities.	1	2	3	4	5	X	(27-28)
1	2	3	4	5	72k. Fearing becoming rusty in my work skills.	1	2	3	4	5	X	(29-30)

Finally, a few medical questions to help me better understand the study results.

73. What kind of delivery did you have? (Check one)

___ 1. Vaginal (through the birth canal) ___ 2. Cesarian Section (33)

74. When your doctor examined your baby in the hospital, did he or she find any major problems? (Check one)

___ 1. Yes (please specify) _____ ___ 2. No

_____

75. Did your baby come home from the hospital with you?

___ 1. Yes → Go to Question 76 ___ 2. No (34)

75a. How many total days was your baby in the hospital? (Write in number of days) ____ (35-36)

76. Have either you OR your baby had to go back to the hospital to stay overnight since you brought your baby home? (Check one)

___ 1. Yes ___ 2. No (37)

77. Please write today's date ___/___/___ (38-45)
Mo./Day/Year

Thank you for participating in my study. Please write any comments you may have below. If you would like to receive a summary of the study results, check this box. ☐ Then place the questionnaire in the enclosed envelope, seal it, and drop it in the mail.

Best of luck with your new role as a mother!

APPENDIX C

CRITERIA FORM

Pt.#_____

Chart

Prenatal:

1. Any previous pregnancies carried to the third trimester? NO___ YES___
2. Will be 36-39 weeks pregnant during data collection period? YES___ NO___
   EDC_____
3. Any of the following conditions?

   Health Hx Summary

   1. Diabetes NO___ YES___
   2. Cancer of the cervix or uterus NO___ YES___
   3. Hypertension NO___ YES___
   4. Heart disease NO___ YES___
   5. Hx rheumatic fever NO___ YES___
   6. Chronic respiratory disease NO___ YES___
   7. Chronic kidney disease NO___ YES___
   8. Major psychiatric disorder NO___ YES___
   9. Major endocrine disorder NO___ YES___

   Prenatal Flow Record

   10. Multiple fetuses NO___ YES___
   11. Pre-eclampsia/eclampsia--3+ proteinuria, edema of the face and hands, and diastolic BP greater than 90 NO___ YES___

   Initial Pregnancy Profile

   12. Viral infection first 12 weeks of this pregnancy NO___ YES___

Postpartum:

4. Vaginal delivery? YES___ NO___
5. Full-term, single infant? YES___ NO___
6. Mother & baby D/C from hospital 5th day or less postpartum? YES___ NO___
7. Any abnormalities of baby on newborn PE? NO___ YES___

Telephone Call

8. Married, not separated? YES___ NO___
9. Any hospitalizations this pregnancy? NO___ YES___

Questionnaire

10. Children living with or step-children visiting? NO___ YES___
11. Hospitalization of mom or baby since D/C? NO___ YES___

MHC
Hospital Center

July 6, 1981

Ms. Roxann Hamblin, R.N., B.S.N.
711 Kenny Court

Dear Ms. Hamblin:

This is to advise you that your proposed study with regard to pregnant patients through the Family Practice Center at the Hospital Center has been approved. However, the patients must have the consent of their physician to participate in the study.

Sincerely,

Robert S Brown

Robert S. Brown, M.D., Chairman
Research Committee

RSB/bw

APPENDIX E

Prenatal Expectations and Postpartum Experiences
Michigan State University
College of Nursing
Consent Form
June 24, 1981

Your doctor has agreed to assist me, a graduate student of nursing at Michigan State University, with my master's research. I am doing a study of pregnant women who will be mothers for the first time. I would like your permission to look at your maternal/newborn record to see if you are eligible to be a participant in my study. If you are eligible, I would also like your permission to contact you so I can describe my study to you and ask if you would like to participate in my study by filling out two questionnaires, one before, and one after your baby is born.

As a nurse and a researcher, I would of course keep all information about you strictly confidential. If you sign this consent form, you are agreeing only to allow me to see your maternal/newborn record, and to contact you. You may at any time choose not to answer my questionnaires.

If you do not want to give your permission, your care at this office will of course, not change. If you do want to give your permission, please sign the following statement.

Roxann Hamblin, R.N.
Family Nurse Clinician Student
College of Nursing
Michigan State University

I, _____, give Roxann Hamblin, R.N. permission to look at my maternal/newborn record to see whether I am eligible to participate in her study. I also give her permission to contact me to describe her study and ask if I want to fill out her questionnaires. I understand that she will keep all information about me strictly confidential, and that I may decide at any time not to participate in her study.
(Print name)

_____
Signature Date

_____
Witness Signature Date

_____
Researcher Signature

APPENDIX F

Prenatal Questionnaire
Michigan State University
College of Nursing
July 15, 1981

Thank you for agreeing to participate in my study. As we discussed on the phone, my study is designed to discover what experiences pregnant women expect to have as new mothers, and what experiences they actually have during the first six weeks at home with their new babies. While the study results will not benefit you personally, I hope that nurses can use the results to help women prepare for motherhood and adjust to their new babies.

The enclosed questionnaire asks you what experiences you expect to have as a new mother, and also asks some questions about your background. Six weeks after you have your baby, I will send you a second questionnaire, which will ask you about your experiences as a new mother.

Completing the questionnaire will take about 20 minutes of your time. It is important that you answer the questions as honestly as you can. You do not have to complete the questionnaire all at once, but I would like you to return it to me within a week. I am interested in <u>your</u> responses, so please do not ask anyone to help you with your answers. If you do not understand a part of the questionnaire, you may call me for help.

There is no physical risk to you in completing this questionnaire. However, as you respond to the questionnaire items, you may become aware of issues that you hadn't thought of before. If you discover that these new ideas trouble you, I hope you will discuss them with your husband, a friend, or your doctor or nurse after you have completed the questionnaire. If such discussion does not ease your mind, please feel free to call me, and I will try to answer your questions. Keep this page so you will have my name and telephone number.

You do not have to put your name on the questionnaire, and the information you give will remain strictly confidential. You may change your mind about completing the questionnaire at any time without affecting the care you receive at your doctor's office.

Roxann Hamblin, R.N.
Family Nurse Clinician Student
Michigan State University
College of Nursing
Telephone: 832-3692

Postpartum Questionnaire
Michigan State University
College of Nursing
September 16, 1981

Congratulations on having your new baby! I know how busy you must be now, but I would appreciate your taking a few minutes to fill out the enclosed questionnaire for the second part of my study. You do not have to complete it all at once, but I would like you to return it to me within a week. I am interested in your responses, so please do not ask anyone to help you with your answers. If you do not understand a part of the questionnaire, you may call me for help.

This questionnaire asks you about your experiences since your baby was born, and also how much, if at all, you have been bothered by these experiences. It is important that you answer the questions as honestly as you can.

There is no physical risk to you in completing this questionnaire. However, as you respond to the questionnaire items, you may become aware of issues that you hadn't thought of before. If you discover that these new ideas trouble you, I hope you will discuss them with your husband, a friend, or your doctor or nurse. If such discussion does not ease your mind, please feel free to call me, and I will try to answer your questions. Keep this page so you will have my name and telephone number.

You do not have to put your name on the questionnaire, and the information you give will remain strictly confidential. You may change your mind about completing the questionnaire at any time without affecting the care you receive at your doctor's office.

Roxann Hamblin, R.N.
Family Nurse Clinician Student
Michigan State University
College of Nursing
Telephone: 832-3692

APPENDIX G

Method of Scoring Items Comprising The Anticipatory Socialization Scale

Item #	Item	Scoring
81	Have you taken any prenatal classes?	Yes = 1 No = 0
82	Have you taken any classes related to child care, or marriage and the family?	Yes = 1 No = 0
83	Since you learned you were pregnant, how many, if any, books and/or articles about child care, parenting, or the first few weeks after birth have you read?	Any books and/or articles read = 1 No books and/or articles read = 0
84	Have you attended any LaLeche League meetings?	Yes = 1 No = 0
85	Do you have any children living with you or visiting regularly, e.g. foster children or stepchildren?	Yes = 1 No = 0
86	How many of your close friends and relatives, if any, who live in this area have had babies within the past year?	Any friends or relatives = 1 No friends or relatives = 0
87	Check the response that you feel most closely describes the amount of experience you have had caring for infants.	A lot or Some = 1 Very little or none = 0

APPENDIX H

Postpartum Concerns*

I. Self

A. Physical

1. Return of figure, personal appearance. 3,4,5,11,12,15,16,17
2. Fatigue/decreased energy. 2,3,4,5,7,10,11,13,16
3. Resuming sexual relations. 3,5,10,12,13,14,17
4. Loss of sleep. 2,10,12,15,17

B. Psychological

1. Emotional tension. 3,4,14,17
2. Depression. 11
3. Anger at baby. 12
4. Overwhelming feelings of responsibility. 10
5. Feelings of isolation, of being tied down. 2,3,5,8,10,16
6. Feelings of inadequacy as a parent. 2,5,8,10,11,13,16

C. Time Management

1. Finding time for self. 3
2. Regulating demands of husband, housework, child. 3,12
3. Unpredictable schedule. 5,6,9,10,12
4. Increased amount of work. 5,10,16
5. Amount of time needed for child care. 10,13,16
6. Decrease in mobility/getting places on time. 12

II. Roles

A. Wife

1. Sexual relations. 3,5,10,12,13
2. Changes in relationship with husband. 3,5,8,10,12,13
3. Decreased communication & uninterrupted time with each other. 7,10,13,15
4. Neglect of husband. 2
5. Decrease in doing housework. 2,4,5,10,12,16

B. Friendship/Kinship

1. Changes in relationship with neighbors. 4,5,7,9
2. Decreased contact with friends. 4,5,10
3. Decreased spontaneity with childless couples. 12
4. Shift in friendship pattern to more time with friends with kids. 12
5. Changes in relations with relatives. 4,5,7,9,10

D. Career

1. Missing career. 4,5,10,16

*Numbers refer to references

III. Child Care

A. Infant behavior & physical care. 3,5,9,12

1. Feeding. 1,6,7,9,10,11,12,13,14
2. Crying. 1,6,7,9,10,11,14
3. Elimination. 5,6,7,14
4. Safety. 3,7
5. Taking baby outdoors. 1,7
6. Communication with baby (picking up cues). 3,9

References--Appendix H

1. Adams, 1963

2. Dyer, 1963

3. Gruis, 1977

4. Hobbs, 1965

5. Hobbs & Cole, 1976

6. Humitz & Perrone, 1977

7. Stranik & Hogberg, 1979

8. Sweeny, et. al., 1979

9. Williams, 1977

10,11,12,13 Unstructured interviews with new mothers conducted by the researcher in 1981

14. Summer & Fritsch, 1977

15. Pellegrom & Swartz, 1980

16. LeMasters, 1957

17. Russell, 1974

APPENDIX I

Alpha Coefficients of Scales, By Index

	INDEXES		
	Preconception	Experience	Bother
SCALES			
Physical	.80	.65	.75
Emotional	.79	.85	.85
Time	.79	.80	.89
Wife	.76	.77	.77
Friend/Relative	.79	.83	.85
Child	.85	.89	.90
Career	.93	.86	.94

APPENDIX J

Questionnaire Items Comprising Scales of the Preconception, Experience, and Bother Indexes

Scale	Items
Physical	16, 24, 28, 29, 61
Emotional	1, 6, 9, 18, 30, 38, 54, 56, 64, 65
Time	2, 5, 27, 42, 43, 48, 49, 51, 57, 62, 66
Wife	10, 13, 19, 22, 23, 35, 40, 46, 52, 55
Friend/Relative	3, 4, 11, 20, 33, 36, 53, 58, 59, 70, 71
Child	8, 14, 15, 25, 32, 37, 41, 45, 47, 50, 60, 67, 68
Career	72b—72k
Discarded from Scales	63, 69, 12, 31, 17, 44, 21, 26, 34

APPENDIX K

Explanation of Scales

Physical — Experiences related to the physical after-effects of pregnancy, labor, and delivery, e.g. fatigue, body changes.

Emotional — feelings commonly associated with peurperium, new motherhood, and the impact of the presence of a first infant.

Time — experiences and feelings related to the amount of time needed for child care, and for the changes in routine brought about by an infant's unpredictable schedule.

Wife — experiences and feelings related to changes in the woman's marital relationship and her ability to continue carrying out her usual family roles and responsibilities.

Friend/Relative — experiences related to changes in relationships with friends and relatives due to the mother's new role.

Career — experiences and feelings associated with the decision to delay returning to work in order to stay home with the baby.

Child — experiences and feelings representing a lack of self-confidence in the woman's child care ability.

APPENDIX L

Summary of Preconception Scores, By Scale

Scale	Range	Mean	Standard Deviation
Physical	1.6-4.8	3.79	.694
Emotional	1.9-4.9	3.12	.612
Time	2.5-5	3.57	.521
Wife	1.7-4.5	3.07	.593
Friend/Relative	1.5-4.3	2.97	.631
Child	1.6-4.1	2.94	.630
Career	1.0-4.6	3.10	.969

APPENDIX M

Summary of Experience Scores, By Scale

Scale	Range	Mean	Standard Deviation
Physical	2.0-5.0	3.80	.832
Emotional	1.4-4.8	3.02	.804
Time	2.5-4.9	3.78	.605
Wife	1.7-4.7	3.33	.724
Friend/Relative	1.0-4.4	2.65	.766
Child	1.1-4.1	2.71	.826
Career	1.0-5.0	3.09	.913

APPENDIX N

Summary of Bother Scores,
in Rank Order By Mean

Scale	Range	Mean	Standard Deviation
Physical	.50-4.0	2.33	.977
Wife	0.00-3.6	2.19	.866
Emotional	.40-4.0	2.13	.945
Career	.38-4.0	2.07	1.138
Time	.18-3.9	1.98	.902
Friend/Relative	0.00-3.7	1.17	.896
Child	0.00-3.6	1.61	.976

APPENDIX O

Frequency Distribution of Bother Scores,
By Category

	Bother Scores									
	0 (None)		.001-1.33 (Slight)		1.32-2.66 (Moderate)		2.67-4 (Severe)		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Scales										
Physical	0	0	9	20.5	18	40.9	17	38.6	44	100
Emotional	0	0	12	27.3	17	38.6	15	34.1	44	100
Time	0	0	14	31.8	18	40.9	12	27.3	44	100
Wife	1	2.3	8	18.2	18	40.9	17	38.6	44	100
Friend/Relative*	1	2.4	18	43.9	14	34.2	8	19.5	41	100
Child	4	9.1	15	34.1	19	43.2	6	13.6	44	100
Career**	0	0	6	28.6	10	47.6	5	23.8	21	100

* Data missing for 3 cases

**N=21. Applicable only to women previously employed who do not plan to return to work at 6 weeks postpartum.

APPENDIX P

Anticipatory Socialization Score Frequencies

Score	Number	Percent
2	9	20.4
3	11	25.0
4	15	34.1
5	8	18.2
6	1	2.3
Total	44	100
Range Possible: 0-7		$\bar{X}$ = 3.56
Actual Range: 2-6		S.D. = 1.087

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