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THE RELATIONSHIP OF LIFE CHANGE HISTORY AND CONTROL OVER BIRTH TO POSTPARTUM BLUES

By

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ABSTRACT

THE RELATIONSHIP OF
LIFE CHANGE HISTORY
AND CONTROL OVER BIRTH
TO POSTPARTUM BLUES

By

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Postpartum blues occurs within the first few days postpartum and is characterized by sadness, episodic weeping, irritability, anxiety, and inablility to concentrate. In this culture the syndrome is a common and expected emotional reaction following childbirth. A review of the postpartum blues literature reveals studies with biological, psychosocial, and crosscultural perspectives.

This study explores the relationship of two variables to postpartum blues. These variables are: a woman's sense of control over her birthing experience; and a woman's life change history (both before and during the woman's pregnancy).

This study views postpartum blues as a type of grief response to the experience of loss related to physical, social and psychological changes engendered by childbirth. Although often unacknowledged and less intense, this experience parallels a grief process.

The study sample consists of 71 women who delivered normal infants in a community hospital setting which permitted a broad range of birthing plans and interventions. All deliveries were considered low risk including those done by cesarean section.

Women in the study completed checklists and questionnaires during the first four days postpartum and responded to telephone follow-ups ten days post hospitalization. Ten of the women were

interviewed.

Although the study's primary hypotheses were not statistically significant some important and unexpected findings emerged. The incidence of postpartum blues in this sample was lower than that reported in the literature. On the first and third day postpartum, the study population did not differ from a normal population on self-report measures of depressive affect. On the second and fourth day, depressive affect was significantly less than what might occur in a normal population.

Women in this sample were able to associate symptoms of the blues to particular concerns in their life situation, and to their childbirth and postpartum experiences.

These findings suggest that postpartum blues is potentially modifiable and that the current bias toward biological causation requires further evaluation. Clinical implications of the findings are discussed and suggestions regarding social work practice are outlined.

TO MY MOTHER
AND MY DAUGHTERS

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INTRODUCTION

In recent years there has been renewed interest in the childbirth experience and its significance in affecting maternal psychological health and early parent-child adjustment (Noble & Hamilton, 1981; Oakley, 1980a; Kitzinger & Davis, 1978; Bradley, 1983a). Women are encouraged to exercise more control over the manner of delivery; couples are invited to share childbirth education and experience; and attention has been given to the need to have mother and child available to each other immediately following birth to encourage bonding (Klaus & Kennell, 1982).

Birthing and its related problems for women in this society is still not well understood. The normal experience of chilbearing and the postpartum have rarely been seen as a legitimate research area (Bradley, 1983a; Leifer, 1977; Oakley, 1980b). Since the mild transient depression occurring within three to five days postpartum occurs with such frequency in this culture, it is often regarded as normal. Consequently, the phenomenon has been neglected as a subject of investigation (Stein, 1982). The syndrome, often called postpartum blues, maternity blues, or third day blues is characterized by episodic weeping, irritability, anxiety, confusion, sadness, and worry.

Yalom, Lunde, Moos, and Hamburg (1968) found this dysphoria perplexing, noting that it occurred after delivery at a time when one might expect a woman to feel joyous. However, this apparent paradox might be better understood if childbirth is seen as a time of profound change for a woman, both intrapersonally and interpersonally and that changes of such importance for an individual generally involve simultaneous gains and losses.

The birth of a child confronts the birthing mother with dramatic changes. Physically, the child previously within her body is now outside and has the capacity for survival separate from her. Psychologically, she needs to deal with this sudden separation and the symbolic meaning it may hold for other

separations in her life. Additionally, the birthing process and environment may precipitously convert her previous view of her body as healthy and intact to that of an "unwell", "mutilated" body.

Episiotomies, cesarean sections, and forceps deliveries have painful aftermaths. The hospital experience may have required a patient role of passivity and acceptance. For some women such a change is contrary to their usual coping style. Socially, there are all the role changes that becoming a mother implies in this culture. A mother is expected to move from independence to, at the least, an interdependent relationship with her infant; she is expected to be adult; to act in ways that would put her infant's needs before her own.

Oakley (1980a) discusses these losses and gains of childbirth and points to the work of Marris (1974) who suggested that since change may indeed stimulate feelings of loss, the response to that change may be much like mourning and can be understood in the same terms as any grief reaction. In this study I propose that postpartum blues may be an expression of grief related to loss.

Postpartum blues is a complicated phenomenon undoubtedly influenced by biological, psychological, social and cultural factors. There is agreement that it is common in this culture and, in most instances, naturally resolves itself in a few days to a few weeks. It is of interest and concern because knowing more about the variables that influence this phenomenon will increase our understanding of the childbirth experience for women. For example, if we accept that physical, psychological, and social changes related to childbirth may be experienced as loss, then we might expect that a woman's sense of control over the change experience (childbirth) might influence her reaction to that experience (postpartum blues). In addition, we might expect that previous traumatic life change events (such as death of parents, separations, job loss), to influence a mother's

coping (postpartum blues) with the life change event of childbirth. Since affective states during the early days and weeks of the postpartum appear to influence mother-infant attachment and interaction, (Sroufe & Waters, 1976; Cohn & Tronick, 1983; Kumar, 1982) increased understanding of the variables modifying postpartum blues would be of use.

The purpose of the proposed investigation is three fold; (1) to explore the nature and extent of the relationship between a woman's sense of control over her birthing experience and her postpartum affective state; (2) to explore the nature and extent of the relationship between life change history (both before and during a women's pregnancy) to the postpartum affective state; (3) to suggest ways for the helping professions to be more effective and supportive to birthing mothers.

CHAPTER I
LITERATURE REVIEW

Adjustment Reactions Associated With Childbirth

The postpartum emotional reactions most often reviewed in the obstetric or psychiatric literature include a range of psychiatric disorders with depressive symptoms as a component. Waletsky (1981) places these adjustment disorders on a continuum of depressive adjustment reactions associated with childbirth. Psychotic reactions are set apart as having a particular etiology. Of the others, neurotic depressions are at one end of the continuum and the mildest, postpartum blues, at the other.

Psychotic Reactions

Psychotic reactions associated with childbirth may include manic-depressive psychoses, manic psychoses, and schizophrenic psychoses. The symptoms are similar to the nonpuerperal psychoses (Herzog & Detre, 1976; Protheroe, 1969) and are marked by intensity over a long period of time. They may include symptoms of less serious illness such as crying, loss of energy, impaired concentration and irritability. Additional symptoms characteristic of the particular psychosis, however, such as grandiosity, thought disorder, depressive delusions, or frantic behavior, are also present.

The incidence of postpartum psychosis is reported as occurring in one or two of every thousand mothers (Pugh et al., 1963; Paffenbarger, 1964; Kendell, Rennie, Clarke & Dean, 1981; Brockington, Winokur & Dean, 1982). The symptoms often begin within a month of delivery.

Some investigators have attempted to separate psychotic from non-psychotic reactions to childbirth by proposing dynamic formulations arising out of clinical experience. Markham (1961)

compared psychotic and non-psychotic reactions to childbirth. He found that both groups of women experienced depressive reactions which represented an affective response to the reactivation of earlier conflicts under the impact of the stress of childbirth. The dynamic forces related to the psychotic response, however, involved conflicted symbiotic relationships to the maternal figure; a passive hostility to the maternal figure; and inner conflict around issues of castration. He suggests that in the course of normal development, separation anxiety, a sense of loss and some degree of oral deprivation are experienced as a part of the childbirth stress response. This implies that some depressive postpartum responses are normal or of different etiology than the psychotic response.

Postpartum Syndrome

Another adjustment reaction on this continuum described by Bieber and Bieber (1978) is called postpartum syndrome. These are disturbances in previously health men and women which are related to pregnancy, birth, or the postpartum. They may begin during pregnancy or any time during the first year postpartum. Acute anxiety, psychosomatic disorders, alcoholism and drug abuse, changes in relationship with spouse, and disturbances at work, present as symptoms. The incidence of this syndrome is hard to establish since it is as yet not well defined and symptoms as described may appear in either parent or within the marital relationship.

Neurotic Depression

Women with long standing emotional or personality disturbances antedating pregnancy which worsen in the postpartum period are often diagnosed as neurotically depressed. These symptoms which become apparent withing six weeks of delivery and

may remain for six months or more, generally respond favorably to a supportive environment (Waletsky, 1981). Pitt's (1968) criteria for puerperal neurotic depression included depressive disabling symptoms developing after delivery and persisting for more than two weeks. Oakley's (1980b) criteria included the persitence of the depressed state after hospital discharge to five months postpartum and the presence of two or more symptoms (for example, poor concentration, extreme fatigue, anxiety, irritability) for at least two weeks.

Kumar (1982), emphasizes the potential impact of social variables affecting depressive reactions. He cites Oakley (1980a) who describes the "medicalization" of childbirth as a process of depersonalization of the mother, turning her into an object with little opportunity to have any meaningful dialogue with her caregivers.

Arguments as to whether postpartum depression is an "illness" or a "reaction to events" continue in the literature, and an excellent summary of the issue is provided by Kumar (1982). In this research I assume that the normal range of responses to childbirth may be adversely affected by environmental events. Persons with a predisposition to neurotic depression may be particularly vulnerable to such stressful environmental events.

Incidence of neurotic postpartum depression averages 10% to 15%, (Kumar, 1982). Variations in the size of samples, composition of the sample and the methods used to detect and define postnatal depression has led to a reported incidence range of 2.9% (Tod, 1964) to 16% (Meares, Grimwade & Wood, 1976).

POSTPARTUM BLUES

The mildest adjustment reaction on the continuum is postpartum blues which is described as a common transient mild depression with the onset most likely within the first four days of delivery (Waletsky, 1981). The symptoms are benign and

self-limiting. Sporadic crying, possibly related to depressed feelings, anxiety or worry is described as the most prominent symptom. Irritability, fatigue, poor concentration, and mild confusion are also part of the syndrome.

In her discussion of possible etiology, Waletsky cites Affonso (1977) who found the impaired memory of the birth experience and a sense of detachment from the infant two or three days postpartum was related to long labors, rapid labor, high risk conditions, discrepancies between expectation of labor and the actual experience, and labors in which medications were administered. Klaus and Kennel (1982) suggest that mother-infant separation, concern about ability to care for the infant and the limiting of visitors to the mother may be factors in the occurence of postpartum blues.

Waletsky explains the symptoms as resulting from the large hormonal changes occurring in the postpartum period. She points to the work of Handley, Dunn, Cockshott & Gould (1977) who correlated falling cortisol levels with maximal blues symptoms. Also, she sees the work of Paschall and Newton (1976) as supportive of this conclusion. They demonstrated that test measures of neuroticism in women two to three days post delivery are the same as the national norms. They reasoned that the increased depressive symptomotology must therefore be related to biological rather than psychological factors.

Attempts to propose a single major cause of a complex phenomenon seem simplistic. To hypothesize the interaction of psychological, socio-cultural, and biological variables would seem more productive. A focused literature review of postpartum blues is presented, followed by a proposal for an integrated theory of its etiology.

Description

Investigators of postpartum blues describe it as a transient

mild postpartum depression occuring during the first week postpartum. It is characterized by sporadic short-lived tearfulness lasting a few minutes to a few hours often with no obvious precipitating factor. Other related symptoms include fatigue, irritability, distractability, feelings of depression, a mild confusional state and anxiety and worry, especially about personal health and that of the baby (Yalom, et al., 1968; Pitt, 1973, Hamilton, 1962; Davidson, 1972; Harris, 1981). In most women the symptoms may last for a day or two and in some instances for a week or more (Stein, 1982).

Stein (1982), in his comprehensive review states that since neither women nor their attendants consider postpartum blues as an illness, and since more than half the population at risk seems subject to symptoms, it cannot be regarded as an illness. He suggests instead that this common set of mental changes be regarded as a normal reaction, which if better understood, might provide new insights into more pathological reactions. Since Stein seems to favor a biological explanation of the blues, he may be implying that more pathological reactions may have biological causes. However, the same argument could be made for those supporting psychological or socio-cultural causations, or some combination of all these explanations.

Others who regard postpartum blues as a normal response suggest that prolonged postpartum blues might presage a more severe disorder in a subsequent postpartum period (Melges, 1968; Paffenbarger, 1966; Butts, 1969, Thuwe, 1974). The Merck Manual, (Berkow, Ed., 1982) a widely consulted medical handbook prized for its clinical utility, describes "blues" as a common depression usually appearing within 24 hours of delivery and ending after 72 hours. The handbook notes that if the depression lasts longer than 72 hours or is associated with lack of interest in the infant, suicidal or homicidal thousghts, hallucinations, or psychotic behavior, it is pathologic.

The duration of symptoms, their intensity and their range

distinguishes the normal response of postpartum blues from more pathological responses. The problem reserchers have had to confront lies in espablishing where one begins and the other ends. The possibility of neurotic or psychotic symptoms overlapping those of postpartum blues, especially in the early postpartum period, would also have to considered.

Incidence

Yalom and associates (1968) state that because of the lack of consensual definition of the syndrome, incidence rates vary widely, with estimates ranging from 5% to 80%. A common estimate is that postpartum blues occurs in 50-60% of mothers at some time during the first ten days postpartum. Davidson (1972) reports 60% among Jamaican women, and Macfalrane (1977) reports depressive symptoms in at least 60% of women delvering in hospitals. Kane, Harman, Keeler & Ewing 1968) report 64% of new mothers with minor emotional disturbance which do not require require psychiatric intervention. Butts (1969) reports that medical personnel expect periods of depression following childbirth in normal mothers.

Kruckman, Craig, Svendsen, Acsmann-Finch and Stewart (1980) using a broad definition of postpartum blues and depression suggest that 85% of women of western culture experience this reaction and note that women of non-western culture experience it rarely, if at all. The implication is that socio-cultural factors influencing pregnancy and the birthing system affect depressive responses to childbirth. It is not clear whether the studies they reviewed were careful about searching out what may be depressive equivalents in a non-western culture. For example, physical complaints or hyperactivity may be ways that depression is expressed.

In summary, although there is disagreement about incidence, there is agreement that in this culture postpartum blues is

commonplace and that it is expected to occur in more that 50% of all birthing women. Current childbirth preparation literature in this culture does not ignore this transient emotional disturbance occurring a few days postpartum. It is described as an expected mild depressive state which resolves without treatment.

Early Investigators

Speculation about mild postpartum dysphorias appeared in the medical literature in 1875 when Savage described "milk fever" and suggested that emphasis be placed on the relationship of the symptoms to lactation (Savage, 1875). He described women becoming excited, sleepless, and incoherent about two days after delivery and reported that the disturbance seemed to resolve about the fourth day postpartum. Hippocrates in the 4th century B.C. cautioned that a bleeding nipple of a woman recently delivered of a child was an ominous sign pointing to the onset of possible mania (as reported in Herzog & Detre, 1976). No attempt is made in these early observations to separate mild and the mroe intense pathological symptoms.

Hamilton (1962) in reviewing the early literature cites Manton (1892) and Siegenthaler (1898) who reported observations of a high incidence of mild and transitory confusion after childbirth. Moloney (1952) described the syndrome as including symptoms of fatigue, despondency, tearfulness, and inability to think clearly. He suggested more careful attention to physical comfort and emotional support of birthing women.

In an early effort to study the range of symptoms of the blues, Hamilton (1962) interviewed ten nurses specializing in the home care of newborn infants and their mothers and listed eight symptoms in order of frequency with which they were mentioned. This list is still utilized in current research. It includes: lack of energy and fatigability, episodes of crying, anxiety and fear, confusion, headaches, insomnia, worry about physical

symptoms and status, and engative attitudes especially towards husbands.

Hamilton concluded that these symptoms might be related to the early symptoms of serious psychiatric illness and invited consideration of psychobiological mechanisms that might be related to hormonal changes.

Research efforts continued to concentrate on creating chdcklists of symptoms. Such methodological problems as the timing of the data collection and the issue of whether the symptoms were present before childbirth, made comparability difficult (Stein, 1982).

Attempts to distinguish other postpartum reaction from the blues and to understand more about their relationship or nonrelationship with one another continues to be of interest to researchers. The intensity, range, and duration of symptoms, the time of onset in the postpartum, the possible differences in etiology, are all areas of ongoing research and discussion.

Researchers of postpartum blues have attempted to find correlates of the blues in three major areas: psychosocial, biological, and crosscultural.

Psychosocial Studies

Stein (1982) in his summary of the literature notes that although clinical correlates of the blues have been found (for example, first child, breast feeding difficulties, anxiety during first trimester), few of the findings have been reported in more than one study. An exception is the association between blues and mental symptoms in late preganacy (Davidson, 1972; Nott, 1976; Harris, 1980).

Yalom and associates (1968) and Nott (1976) found increased incidence of the blues among the primiparous subjects. Other studies did not confirm these findings (Pitt, 1973; Ballinger, Buckley, Naylor & Stansfield, 1979). Stein (1982) also reports

that no obstetric variable has been found to correlate with the blues. These variables, however, are typically physiological measures (fetal position, blood loss, lacerations sustained, length of each stage of labor, type of delivery). The experience of the birth is generally rated as easy, average, or difficult by the attending physician. Little attention is given to the mother's perception of obstetrical variables which might be of inportance. In this regard, Bradley (1983b) found that although type of birth did not affect postpartum affective state, satisfaction with the birth experience did seem to influence the degree of depression in the hospital.

The Yalom and associates study (1968) is one of the most extensive in the area of postpartum blues and its results are often cited. Of particular interest in the study were observations concerning postpartum crying. The most frequent constellation of factors centered around what the authors described as increased vulnerability or hypersensitivity to possible rejections. Examples included doctors paying little attention on rounds or leaving the woman alone too long in the labor room, and husbands arriving late to visit. Loneliness was poorly tolerated and several women wept at the departure of roommates, husbands, or visitors.

One subject wept of distress at the loss of control over her interpersonal environment and her sense of helplessness; another wept with relief that an anticipated painful labor and delivery were over. (Her first delivery involved spinal anaesthesia followed by a severe spinal headache). Other reasons given included doubts about the capacity to mother; difficult interaction with the obstetrician, and dissatisfaction with the baby.

Although many women were puzzled by what they felt to be an exaggerated response to these issues, there seems to reason to suspect that aspects of the birthing system might have been experienced as unsupportive and hence stimulated this sense of

sadness or anger. (There is evidence that women are socialized not to express anger and therefore crying may be a compensatory equivalent).

Macfarlane, et al. (1978) and Gordon (1978) suggest that home deliveries are associated with much less, if any, postpartum blues. Proximity to family and new infant were seen as contributing to increased self-confidence. The problem with comparing hospital and home birth populations is that choice of environment might select a very different sample the latter having more self-confidence as an aspect of their emotional style.

Biological Studies

Researchers viewing postpartum blues as a normal behavioral response to childbirth often support hormonal changes as a major determinant. In females, times of stress often coincide with endocrine fluctuation. Menarche, pregnancy, childbirth, and menopause are times in the life cycle when there are marked changes in the circulating steroid hormones. Following childbirth, estrogen, progesterone, and prolactin dramatically fall (Waletsky, 1981). Since the onset of depression seems to coincide with this drop, a hormonal cause is postulated (Dalton, 1971; Meares, Grimnade & Wood, 1976; Paykel, Emms, Fletcher & Rassaby, 1980).

Nott, Franklin, Armigage & Gelder (1976), in a study which attempted to correlate hormone findings and clinical findings in normal pregnant women, failed to produce evidence supporting hormone imbalance having relationship to postpartum affective disturbance. Yalom and associates (1968) took postpartum blood samples daily to test for changing hormone levels. Although the findings were not available at the time the report was written, the authors postulate a psychoendocrine profile suggesting that women with early menarche (in combination with other variables)

are likely to become depressed postpartum.

Stein (1982) offers an extensive review of research in the area of biological changes and their relationship to postpartum blues. Although he feels that the hypothesis has merit, he believes that the lack of definition of posptartum blues will make metabolic studies of the blues unlikely to generate results that can be meaningfully compared.

In addition, when a group of researchers found indication of a theoretical association between postpartum blues and lowered free tryptophan (Handley, et al. 1977; Paykel, et al, 1980; Stein, et al, 1976) it could not be verified. An attempt to confirm the result by providing prospective trial fo L-tryptophan for multiparous women after delivery did not reduce the blues (Harris, 1980).

Weissman and Klerman (1977) after extensive review of the literature note that the psychiatric reactions of the postpartum are almost all of a depressive nature and conclude that women are indeed at greater risk for depressive disorders in the postpartum period. They add, however, that if any specific endocrine abnormality is involved, the mechanism is not understood. Thus far, research has not demonstrated a significant relationship between postpartum blues and hormonal state (Gelder, 1978; Steiner, 1971).

Crosscultural Studies

Some researchers interested in supporting a biological determinant for the blues have theorized that if the symptoms also occur in radically different non-western populations, it might indicate that the symptoms are not likely to be culturally or socially determined (Harris, 1981).

Harris (1980,1981) studied Maternity Blues in an East African population of Tanzanian multiparous mothers. He selected a sample of fifty mothers excluding subjects with socioeconomic

problems, the unmarried or unhappily married, and persons who were ill or had previous abnormal pregnancies and abnormal deliveries. All subjects delivered their babies in a hospital setting. Those delivering at home were excluded from the sample.

Harris reported that 38 (76%) mothers in the sample experienced postpartum blues which, according to him, demonstrated that blues is indeed a crosscultural phenomenon. He concludes also that its expression may be culturally related. He explains that eight of the subjects with blues showed somatic symptoms without tearfulness and that somatization of stress in East Africa is characteristic.

Limitations cited by the author are issues of language and the difficulty implicit in asking questions which are relevant to another culture. What is not mentioned is a limitation but which is potentially quite important, is that the sample was drawn from a population using a western clinic and hospital facility. The traditional birthing in contrast to the western styled hospital system is not described and the impact of the birthing experience (although normal from a medical view), is not addressed.

Davidson's (1972) prospective study of 55 Jamaican women attempted to relate levels of anxiety and depression during pregnancy to attitude toward pregnancy, and to obstetrical, psychosexual and sociological factors. During the eleven days postpartum 60.4% were found to experience some emotional upset on days one to three). In this culture, Davidson saw the symptoms or "form" of the blues as similar to what was generally reported in western cultures.

He concluded, however, that the symptoms had special meaning for this population. The symptoms seemed related to higher parity and Davidson concluded that poor economic and social conditions led to intense emotional stress around having larger families. Hence, the birth of still another child to an already large family increased the potential for postpartum blues.

Kruckman and associates (1980) in their review of crosscultural studies note the rarity with which postpartum blues is discussed in the literature. They suggest that male domination in the discipline of anthropology prevented observation of childbirth and its traditions. Typically only females are given access. A lack of conscious awareness of the existence of a range of postpartum emotional reactions may have resulted. Also there has been a problem in defining symptoms of the postpartum period, making relevant literature hard to locate.

Kruckman and associates (1980) report that Stephenson (Stephenson, Huxel & Harui-Walsh, 1978), a female research, specifically addressed the issue of postpartum depressive reactions and did not find its existence crossculturally. Kruckman's group after a two year search of the literature concluded that postpartum blues and depression did not appear in the literature because it simply did not exist. The literature review, however, did reveal great differences in the social structures and support systems available to alleviate stress and anxiety in the birthing mother.

How can this be explained? These authors suggest that unlike western cultures, childbearing did not remove the woman and isolate her from her work and her community. New families are more likely to settle near families of origin. Powerful support systems which include extended family, ritual participation, and the practice of midwifery are available to the birthing mother and her infant. There is continuity of know support in a known environment. This contrasts with the high mobility of western culture which may weaken family ties and support groups. It constrasts also with a birthing system that depends on high technology and the services of person unknown to the birthing mother.

In a personal communication to the author, Jordan suggests still another reason why postpartum blues does not appear in crosscultural literature. She has observed that the first week

postpartum tends to be highly ritualized with strong prescriptors regarding the mother's seclusion and activities. She suggests that culturally appropriate behavior may mask occurrence of the blues. For example, her work in Yucatan, revealed that all women act depressed in the postpartum making it hard to distinguish who was indeed depressed and who was not.

Jordan (1983) in her study of birth in four cultures describes birth as a biosocial phenomenon involving a universal physiological process associated with socio-cultural practices which differ in each society. She indicates that birth is universally considered a significant life crisis event and that in order to deal with it, people create a set of internally consistent and interdependent practices and beliefs designed to cope with its problematic aspects. Jordan suggests that birth practices in a given society tend to become "packaged into relatively uniform, systematic, standardized, ritualized, and even morally required routine" (Jordan, 1983, p.2).

The most common childbirth system in the United States is physician attended and managed by a hospital trained staff. Having once entered the system a series of interventions take place. The hospital system rather than the patient controls the technical decisions made. The birthing woman is regarded as an ill person whose capacities to participate in decision making with competence is compromised and therefore devalued.

Viewing the birthing woman is ill (as opposed to well, which is a more common view in other cultures) has great impact. A set of culturally defined expectations of the sick person are in place which reciprocally allow the physician, nurse, and other health professions to fulfill their role. Parsons (1951) has contributed the classic description of the "sick role" in this culture. An individual who is sick is not responsible for the condition; is exempt from normal social role obligations; is obligated to get well; is obligated to look for and accept technically competent professional help. This model may best

relate to persons with acute illness. Expectations of "sick role" behavior, however, may complicate pregnancy and childbirth. The wish to participate actively in medical decisions, for instance, may be met with resentment and criticism. Similarly, the wish to have the birthing mother and family be the major managers of the condition, may lead to conflict.

Patients are expected to give highly personal information to strangers; the patient is expected to believe in the competence of strangers and regard them as potentially more helpful than a family member; they are expected to control emotion so that it does not interfere with professional care; they are expected to follow medical advise (Mumford, 1977). Dependency and compliance are rewarded.

Usual patterns of behavior are altered dramatically for the "ill person" in the hospital setting. Carlson (1978b) includes such areas as affiliation, (visitors are limited); achievement, (achievement goals are set aside due to lack of supplies or energy); aggression, (verbal and physical means of expression are often prohibited); dependency, (often increased because of illness and lack of information); elimination, (often have little privacy); ingestion, (usually eat alone and with minimal food choice); restoration, (rest is limited with many disruptions of hospital routine); sexual, (modified and curtailed). The area of personal control over environment might be added to this list.

All of these "requirements" potentially intensify the sense of change for the birthing woman; and, since change and feelings of loss are connected, it is of interest to know how patients manage the loss emotionally. Davidson (1972) notes that a blues reaction is also the sequel to other events in hospitals unrelated to birthing, such as surgery. He adds that the very act of admission to a hospital in itself could act as a stressor.

Summary

In summary, it may be stated that issues related to the birthing system in this culture affect the emotional response of women to childbirth. Issues identified include: the loss of independent status that being a patient implies; the presence of technologically rather than humanistically oriented environment; the deprivation of choice and control over one's situation; the lack of sufficient contact with important others, including the baby. These circumastance may stimulate or at least a psychologically vulnerable birthing mother.

Most problematic in this perspective is the lack of a theoretical framework that is broad enough to encompass what we have learned from the biological, psychosocial and cultural approaches. The theoretical framework of loss and grief proves a helpful integrating model. A discussion of its applicability follows.

POSTPARTUM BLUES: A GRIEF RESPONSE

Childbirth and Loss

The similarity of symptoms of postpartum and normal grief is striking. A sense of anxiety, mood variability, distractability, crying, fatigue, mild confusion, sadness and a sense of loneliness characterize both. In discussions of the grief process, Lindemann (1944), Parkes (1972), Marris (1974), and Schneider (1984) describe a phase of numbness with obsessive memories of the circumstance of the loss (usually death). A comparable situation often occurs immediately after birth: there is frequently a sense of numbness and disbelief followed by a need to review the circumstance of the birth in considerable detail (Affonso,1977).

Grief, in this discussion, is considered a complex

combination of numerous emotions experienced at the time of loss, (Zisook & DeVaul, 1983) and loss is defined as a state of being deprived of, or of being without something one has had. The most profound loss and its associated grief, is the loss of a significant relationship or loved person. Other loss, such as loss of possesions stimulate variable intensity of grief depending on the nature of symbolic emotional attachment. Loss may also involve a loss of some aspect of the self, physical or psychological.

Life changes have loss as an implicit component (Schneider, 1984). Change implies leaving one set of circumstances and embracing another set. This shift is an emotional process. Grieving the loss of the old is a part of that process. Schneider also suggests that loss is not easily recognized in this culture and that grieving is commonplace and may account for many puzzling emotional responses and somatic complaints. It is strking in this regard, that postpartum blues is also commonplace.

In this culture, childbirth is expected to be associated with gain, joy and achievement. The losses are rarely acknowledged. Yalom and associates (1968, p.16), in their paper on postpartum blues note, for example, that the "dysphoria curiously occurs after delivery at a time when one would expect to feel joyous." Women are not encouraged to reflect on their ambivalence or sense of loss regarding their changed situation.

If childbirth is regarded as signifying a life change, then the losses are multiple and obvious. There are, to begin with enormous rapid physical changes. The levels of female sexual hormones undergo rapid physical changes. There is also blood loss, trauma to the birth canal, and at times, the painful aftermath of episiotomy, spinal anaesthetic, or cesarean section. Most dramatic of course, is the change from having the fetus within the body to having an infant "in hand". capable of separate survival. The obvious life change of the infant

requires the mother to confront a life change for herself.

Psychologically, the mother may feel a loss of "apart of herself" when she loses the special attention she felt she received during her pregnancy. The state of pregnancy is evidence of a fertile female who has a growing fetus within her. This has special meaning both intrapsychically and socially. A major developmental change is begun in pregnancy and culminates in childbirth. In this culture it may be described as a developmental transition involving a move from an adolescent emancipation from her own mother to the realization that she must now face a role of nurturant mother herself. This change involves the negotiation of a series of developmental tasks which may need to be confronted immediately after childbirth.

Developmental change is often ushered in by a stressful event abruptly challenging homeostasis. Leifer (1977) noting the work of Deutch, Benedek, Bibring, Sander and Caplan, proposes that pregnancy is a period of developmental crisis in which psychological disequilibrium provides a maturational stimulus for new and more adaptive solutions to previous conflicts. Birth itself is a stressful event; it involves the management of dramatic change and within the formulation, loss. Earlier experiences with loss and change will probably influence the woman's coping style and adaptive capacity. Consequently, this model suggests that a history of life change events might be pertinent to a woman's postpartum course.

If we accord loss a central place in childbirth, then the commonly reported symptoms in the early postpartum seem more understandable. The symptoms are related to a sense of loss and a grief process. The symptoms may be more exaggerated in the early postpartum because the woman is certainly more physically vulnerable. We propose that she is also more psychologically stressed, not only by becoming a mother, but due to her previous experience with life stress and change, and because of issues related to the management of the birth and her care in the

hospital.

It is interesting to note that there are reports of depressive symptoms in new fathers (Ginath, 1974; Wainwritht, 1966; Waletsky, 1981) and in adoptive mothers (Einzig, 1980). These and other studies have identified social and psychological factors as major contributors to the stress of becoming a new parent. The new parent is immediately aware of a role change (and related losses) demanding a mastery of infant care skills and the redefinitaion of family relationships and obligations. These depressive symptoms may also signify a phase in the process of grieving.

The loss and grief framework suggests other variables which might affect the expression of grief in the postpartum. A woman's sense of control or mastery over the birth experience seems one such important variable. A discussion of this variable follows.

Mastery of Childbirth Experience

My clinical experience suggests that the more control a person has regarding changes in their lives, the less helpless, angry, and depressed they will feel. White (1959) alluded to this when he discussed perceived competence as an important determinant of self-esteem. He described competence in terms of feeling of efficacy, and expectation that one can successfully behave in such a way so as to affect outcomes. Competent human beings exerience the power of initiative and a sense of being the causal agent in their own lives. Losses experienced as a result of change are less intense when one can anticipate and remain involved in the change process.

There is support for this view in the childbirth literature. Humenick (1981) reports that women who take childbirth classes, for instance, report less postpartum depression and increases in self-esteem, changes she regards as indicating better mental

health and capacity to cope.

Notman and Nadelson (1978) challenge the current health care system's resistence to women having more control over their care. They see physicians as dominant and their established role as one of being helpful, authoritative and protective. They suggest that women, in response, tend to be compliant, accommodating and less well informed. Their passivity is heightened by the social requirements of the "sick role".

This traditional doctor-patient relationship is being challenged. Notman and Nadelson suggest that the patient may be better served if she is able to participate in her own medical care and if the physician can relinquish some aspects authority and power.

There has been considerable interest in studying ratings of satisfaction with the childbirth experience. Researchers have found no correlation between reported pain during childbirth and satisfaction with the experience. Entwistle and Blehar (1979) found that the amount of medicatiom was inversely related to positive rating of the birth experience. Participation in the birthing process seemed more important to women than the level of pain.

In a retrospective study Willmuth (1975) reviewed childbirth evaluations of 134 women reported that a major factor associated with a positive birth rating was the woman's perception of control during birth. She notes that control was defined by the woman as continuing to be able to influence the decisions made and to maintain a working alliance with the health care team.

Although measures of parent satisfaction are common in attempts to understand the realtionship of birth experience to other postpartum variables, Shearer (1983) cautions that there are no standardized or validated scales. Findings are unstable in that a woman rating a forceps delivery which she was told had saved her child's life, would not tend to be critical of the procedure, whereas another might. Similarly, as time goes on,

parents tend to develop a sense of loyalty to the birth experience. Shearer explains this phenomenon as the need to "put their lives back together with the new baby" (p.77). Dyanne Affonso's (1977) paper on "missing pieces" speaks to the tendency for parents to try to understand and remember the birth and to set events in order.

How do these observations relate to the grief framework? In such a framework, the wish to review traumas and the events around the change or loss is a part of the work that needs to take place before and adaptation to the change or loss can take place. In the case of childbirth, it is likely that the need to review and revise the birth event may be and expression of the same kind of process. I suggest that having an opportunity of simply tell the birth story enables a woman to have a sense of control over the trauma of delivery. The telling of the birth story lessens the sense of loss.

This study is not concerned with type of birth or with satisfaction ratings. More central is the woman's evaluation of her sense of control over the event or series of events leading up to and including the birth of her child.

Although "sense of control" may be a component of satisifaction it is also a variable which has independent influence on the immediate postpartum reaction. I hypothesize a relationship between the mother's sense of control over decisions made in the birthing environment and events in the birthing process itself, with postpartum blues. I propose that the woman who feels in control of decisions around these events will be less apt to feel low self-esteem, depression, helplessness, and other symptoms associated with the blues. Theoretically, a sense of control should lessen the sense of loss and change and hence the grief reaction within the first four days postpartum will be less intense.

Life Change

If managing loss is a component of the childbirth experience, how might previous experience in managing life stresses involving loss affect how well a woman copes with the stress of childbirth?

A death, divorce, marriage, abrupt change in location, illness, or imprisonment are among the situations defined as important life changes which are stressful (Homes and Rahe, 1967). There is now an extensive body of literature relating objective measures of life change to physical illnesses, Wyler, Masuda and Holmes, (1971). If we assume that the stress associated with life change is, at least in part, the need to confront losses and grieve, then we might assume that life changes close to the time of childbirth might add to the sense of loss normally experienced in childbirth.

Three studies utilizing the life change measures and pregnancy area of particular interest in this regard; Nuckolls, Cassel and Kaplan (1972), and Gorsuch and Key (1974), found a positive relationship between life change and physical obstetrical difficulties. They investigated the relationship between life stress and pregenancy and birth complications. No significant relationships were found when all subjects were considered. However, when mothers were divided into those displaying high and low levels of psychosocial assets (available support systems) significant relationships emerged. Those with high levels of such assets and high life change did not show increased complications while those with low levels of such assets did have increased frequency of such complications.

Gorsuch and Key (1974) also studied the relationship of obstetrical abnormalities, life change, and time-specific anxiety. Life events within a two year period were recorded by each woman during her pregnancy. Following the delivery, an update of such events was made. Findings indicated a higher magnitude of life change events was related to problem

pregnancies ONLY during the six month immediately prior to delivery. Analysis dividing the stressful events by trimesters of pregnancy indicated the second and third trimesters were most highly related to abnormal pregnancies.

The Jones (1978) study, on the other hand, produced an unexpected inverse relationship. The study assessed the utility of objective measures of life change, anxiety, and personality as predictors of labor complications. A moderate and reliable degree of predictive accuracy was found when life change history measures were taken for the two year period prior to delivery. It was, however, negatively associated with the occurrence of complications. The lower the scores on the schedule, the greater the likelihood of complications.

Jones suggests some mediating variables which may have altered the expected positive relationship. Individual differences in the perception of stressful events and the presence of varying levels of psychosocial supports are two such variables already identified in other studies (Nuckolls, et al., 1972); Yamamoto and Kinney, 1976). Individual differences in the level of preparedness of the individual for coping with stress is also suggested as a likely possiblity.

This last variable is of special interest in that the setting of the study placed special hardship on the mothers many of whom were young and separated from home and from important others for the first time. Jones hypothesized that those mothers who had experienced higher levels of life change in the past and had opportunity to make adaptation to change were less affected psychologically in the setting than mothers with lower levels of life change.

The loss and grief framework seems relevant in understanding these results. Prior experience with life change and the need to adapt to it might make the life change associated with childbirth of less magnitude. The death of a parent may have already made the birthing mother confront the necessity to be more adult. Also,

the stresses of the hospital situation may not add as significantly to the sense of loss. Early experience with stressful change might help such a person develop a more effective coping repertory.

Paykel, Fletcher and Rassaby, (1980) investigated the relationship of life events and social support with mild postpartum neurotic depression. Measurements of depression were made at around six weeks postpartum. A life events history was taken to correspond with the beginning of pregnancy. The report that "postpartum blues were only associated with neurotic depression in the absence of undesireable life events" (p.339) supporting a conclusion of the importance of hormonal variable. The postpartum blues measure was based on retrospective self-reporting.

There have been no attempts to relate life change specifically to postpartum blues. The literature seems to support an exploration in this area and therefore several hypotheses related to life change were proposed for this study.

HYPOTHESES

I have supported the idea that postpartum blues may be better understood if viewed in the context of a theoretical framework of loss and grief. This framework permits the testing of some psychosocial variables in the birth situation which might affect a grief response, (postpartum blues).

Since previous experience with loss and change (life events) affect the impact of present experience with loss and change, Revised Life Events Questionnaire (RLEQ) scores and measures of postpartum blues are used to test the following hypotheses:

1. WOMEN WHO SCORE HIGHER ON THE RLEQ PRIOR TO ONE YEAR BEFORE DELIVERY WILL HAVE POSTPARTUM BLUES OF LESS INTENSITY THAN WOMEN WHO SCORE HIGHER ON THE RLEQ WITHIN THE YEAR OF CHILDBIRTH.

2. WOMEN WHO SCORE HIGH ON THE RLEQ PRIOR TO ONE YEAR BEFORE DELIVERY AND WITHIN THE LAST YEAR OF CHILDBIRTH, WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO SCORE LOW ON THE RLEQ PRIOR TO ONE YEAR BEFORE CHILDBIRTH AND WITHIN THE LAST YEAR OF CHILDBIRTH.

Since perceived and actual control and mastery over a loss experience would theoretically result in a less intense grief response, we have identified some issues of perceived and actual control over the birthing experience to test whether this would affect intensity of the postpartum blues. Such issues as perceived and actual freedom to have access to the infant, perceived freedom to have/have not anaesthesia, to stay longer or leave the hospital sooner, are identified on the Control Over Birth (COB). We are using this instrument and measures of postpartum blues to test the following hypotheses:

3. WOMEN WHO PERCEIVE THAT THEY HAVE MORE CONTROL OVER DECISIONS RELATED TO ASPECTS OF THE BIRTHING EXPERIENCE WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO PERCEIVE THAT THEY HAVE LESS CONTROL.

4. WOMEN WHO ACTUALLY HAD MORE CONTROL OVER DECISIONS RELATED TO ASPECTS OF THE BIRTHING EXPERIENCE WILL HAVE LESS INTENSE POSTPARTUM BLUES THAT WOMEN WHO HAVE NOT HAD ACTUAL CONTROL.

5. WOMEN WHO PERCEIVE THAT THEY WERE AWAKE AND AWARE DURING THEIR BIRTHING EXPERIENCE AND HAD WISHED THIS KIND OF BIRTH EXPERIENCE WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHOSE PERCEPTIONS WERE NOT CONGRUENT WITH THEIR WISHES.

6. WOMEN WHO PERCEIVE THAT THEY HAD FREEDOM TO DECIDE HOW SOON TO SEE THEIR INFANT AFTER BIRTH WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO DID NOT PERCEIVE THAT FREEDOM.

7. WOMEN WHO PERCEIVE THAT THEY HAD FREEDOM TO DECIDE HOW MUCH CONTACT TO HAVE WITH THEIR INFANTS AFTER BIRTH WILL HAVE LESS INTENSE POSTPARTUM BLUES THAT WOMEN WHO DID NOT PERCEIVE THAT FREEDOM.

Since an opportunity to review the circumstance of a loss is important in then grieving process, we hypothesize:

8. WOMEN WHO ARE GIVEN OPPORTUNITY TO TELL A DETAILED STORY OF THEIR BIRTHING EXPERIENCE IN THEIR OWN WAY SOON AFTER BIRTH WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO DO NOT HAVE THIS OPPORTUNITY.

Since availability of support persons who are familiar and significant to the person who has experienced loss helps to modify the intensity of the grief process, we hypothesize:

9. WOMEN WHO WISHED SUPPORT PERSONS WITH THEM DURING THE LABOR, DELIVERY, AND IMMEDIATE POSTPARTUM AND PERCEIVED THAT THEY HAD THE OPPORTUNITY TO HAVE HAD THEM PRESENT, WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHOSE PERCEPTION AND WISHES WERE NOT CONGRUENT.

10. WOMEN WHO WISHED SUPPORT PERSONS WITH THEM DURING THE LABOR, DELIVERY, AND IMMEDIATE POSTPARTUM AND ACTUALLY HAD THEM AVAILABLE, WILL HAVE LESS POSTPARTUM BLUES THAN THOSE WHOSE WISHED AND ACTUAL EXPERIENCE WERE NOT CONGRUENT.

CHAPER II

METHOD

Overview

In this exploratory study, a population of normal low-risk women who have delivered healthy babies in a hospital setting were assessed on a variety of psychological and social self rating scales to test their relationship with a measure of postpartum blues. During a two and one half month time period data was gathered for four consective days on each subject, beginning within the first 24 hours after admission. Information collected by nurses making routine postpartum adjustment telephone calls then to twelve days following discharge was also made available to me.

A smaller group drawn from the original sample was interviewed to allow an opportunity for the woman to review her birthing experience (the birth story); to identify critical aspects (both good and bad) of her birthing and hospital experience; to check on the validity and reliability of the self-rating scores; and to get a better picture of the natural history of the early postpartum experience. These inverviews enabled me to clarify quantitative findings and to develop additional insights and hypotheses.

Setting

The study required an obstetrical service which offered a full range of birthing alternatives to women who are considered low risk for birthing complications. The setting utilized is a small general hospital in an urban community within a larger urban area. Historically, the hospital has had special interest in its obstetrical service. It served and continues to serve as

a facility for pregnant adolescents in need of residential care prior to delivery. Since the number of girls requiring such care has diminished, one floor of the residence has been remodeled into the Home-Like Birth Center. This unit is physically connected to the hospital by means of a specially constructed corridor. The birthing unit numbers an average of 27 admissions per month (1983). Birthing suites are available to birthing mothers, their husbands, and any additional family members selected by the couple. The birth attendants include a nurse midwife, other nurses and, at times a consulting obstetrician.

The basic maternity unit offers other alternative plans. It has available labor rooms, labor/birthing rooms, and a delivery room equipped for a range of medical interventions including cesarean section. This unit has 29 beds and averages 134 deliveries per month (1983). Rooms are two and four bed and a family room is available for family/infant visits. In an effort to maximize continuity and family focused care, the assigned nurse follows both the mother and baby as a pair. Admissions originating at the Home-Like Birth Center are transferred to the basic maternity unit if an intervention such as fetal monitoring, forceps delivery, or cesarean section is indicated.

Sample

The systematic sample includes 70 women admitted to the maternity service or Home-Like Birth Center for childbirth who met study criteria. A limit was set such that no more than three new admission daily become part of the study. This allowed sufficient time to follow each case over the required four day period.

Originally, subjects were to be selected by beginning with the first admission during the previous 24 hours on day one and accepting eligible subjects three and five. On day two, I was to begin with the second admission and accept eligible subjects four

and six. During the approximate ten week period of the study, admissions were unusually low. On some days there were no admissions or only two. Procedure was therefore modified. Although I continued to alternate beginning with the first or second admission, I would accept consecutive admissions if there were too few to utilize the original plan.

The sampling procedure prevented the possibility of ever including any birth that was the seventh or more on a given day. However, during the study period, more than six deliveries occurred only once or twice. On the other hand, the low floor census averaging two to five new patients daily, might have influenced the care and attention given each subject. This presented an unexpected variable in the setting.

Criteria for inclusion in the study were: the subject give written informed consent to become a subject in the study; that the subject read and write English; that the birth was of a live infant without congeintal anomaly or special medical problem, and that the infant was of 37 or more weeks gestation.

Babies of less than 37 weeks gestation are considered premature and were consequently excluded. They are usually of low birth weight and because of the immaturity of organ systems, there area often medical complications which put the infant at risk for survival. Mothers of premature infants have additional stresses which would introduce new variables to influence the findings. Similarly, the birth of an infant with a congenital anomaly or special medical problem would stimulate responses of shock and grief which are beyond what we are defining as postpartum blues. Mothers of such infants are also excluded.

I collected descriptive data on all women who participated in the study and on those who chose not to participate to see how they differed from the participants. A group of ten women was selected from the total sample for interviewing.

Procedure

A short document was prepared for the hospital research committee (see Appendix A) and presented to the hospital administrator for her suggestions prior to forwarding it to the committee for review. The committee's formal approval of the study gave me access to the hospital staff and patients. However, obstetricians and midwives admitting the majority of patients were contacted individually so that I could introduce myself and the study personally.

In order to recruit women for the study, I made a presentation to the obstetrical health care team regarding the general area of the study and the requirements for participation. The chief nurse of each maternity floor and her alternate were interviewed with regard to getting advice about when, where, and how to best make initial contact with newly admitted women.

Brief descriptions of the study, permission forms (Appendix B), demographic data questionnaires (Appendix C), and instrument packets were prepared for each maternity unit. On the regular maternity service, it was agreed that I was to introduce the study and invite prospective subjects to participate. The chief nurse in the Home-Like Birth Center chose to make the initial contact herself. Since most women remained on the unit for only 12 to 24 hours following delivery with access to a range of invited family and friends, the nurse felt the need to be the liason regarding all other requests.

During my first visit with the prospective subject, the project was described, signed permission obtained, questions were answered and the data packet for the first day explained. I advised the woman that I would be returning to collect the data schedules daily. In some instances, I remained at the bedside and did the initial mood form with the woman. Women who needed to remain flat after cesarean section welcomed the assistance.

Ten of the seventy subjects were selected for a semi-structured inverviews. In order to space them more evenly

over the data collection period, I arranged to choose one woman at random from new admissions every third day until the required ten interviewees were identified. Each subject designated for an interview was alerted to the need for this additional time with me and an appointment was made withing 24 hours of the birth (whenever possible). In the event that a woman left the hospital to return home before four days, she was asked to complete all the schedules except for the postpartum blues measures (which were designed to be collected daily) before leaving the hsopital. A packet containing the blues measures for each remaining day was given to her in a return stamped addressed envelope. I made a reminder call to the home and invited the woman to give me the data on the phone.

These calls took only five minutes and were required in only four cases. Most women completed the fourth day form before leaving the hospital. Others mailed them immediately. Women recruited from the Home-Like Birth Center had routine visits made to them by the mdiwife on the fourth day postpartum. Their completed packets were given to the midwife at that time.

As a token of appreciation for participating in the project, a bib or pair of booties was presented to each woman on her third day postpartum. Home-like Birth Center participants were given the gift along with the instrument packet on the day of delivery.

INSTRUMENTS

Postpartum Blues

Difficulties in measuring postpartum blues arise out of lack of agreement about definition; about timing of the measurement; and about self report scales versus observed behavior.

For purposes of this study, I define blues as a mild transient depression occurring within the first four days postpartum. To establish the presence of blues, I utilized a

measure of depressive affect, the Depression Adjective Check Lists, (Lubin, 1965), and a measure of the particular subset of symptoms identified in the literature as very early characteristics of the postpartum blues syndrome. These include crying, irritability, anxiety, and difficulty concentrating (Stein, 1983).

To avoid the limitations implicit in collecting retrospective data, I wanted a measure of blues that could be collected each day during the first four postpartum days. I assumed that some women who were (or would become) neurotically depressed might be difficult to differentiate with any blues measure during these early days. If there was overlap, namely that women with postpartum blues symptoms later developed symptoms of neurotic depression, I assumed that the same factors influencing the development of the blues in the early postpartum also affected the neurotically depressed. It was therefore acceptable to see them as having "blues" during the early postpartum and to include them in the sample.

Psychotic symptomatology is more easily differentiated. I assumed that the etiology was different from that of postpartum blues or from neurotic depression. If mothers presented these symptoms within the postpartum blues four-day time frame, they would have been deleted from the study. No such women in the study were identified. This was as anticipated since the expected incidence of psychosis is one or two per thousand birthing women.

To measure postpartum blues I chose a combination of self-report instruments used in two recent studies. Bradley (1983a) utilized the Depression Adjective Check Lists, DACL (Lubin, 1965) which were originally developed as part of an "investigation of mood changes during pregnancy and the postpartum period" (Lubin, 1965, p.7). The DACL has the advantage of being brief, (it takes an average of 2.5 minutes to administer) and has seven alternate forms for the purpose of

repeated measurement with only brief intervals between testings. (see Appendix D)

Reliability for the DACL was established at between .82 and .93 among the lists through split-half reliability tests. Intercorrelates between the forms used in this study (A.B.C.D) is .87. Validity of the checklists was tested by using normal persons and non-depressed and depressed patients of both sexes. The instrument was successful at discriminating between the two groupings at a 0.0005 level of significance adding to confidence in the overall validity of the instrument.

In addition to the DACL, a four question revised questionnaire related to blues and devised by Cutrona (1983) was used. Cutrona's data was collected three weeks postpartum and included an additional inquiry related to attibutional style. This study is designed to collect the data prospectively with interest in exploring events related to postpartum blues symptoms, hence the necessity for changes. For example, Cutrona's question, "Have you cried more easily or more frequently since the baby was born?" (followed by a series of choices as to who or what might be responsible), was changed to "Did you feel like crying at any time today?" "Do you have any idea about what made you want to cry?"

Similar changes were made for the questions regarding irritability, anxiety, and difficulty with concentration. These particular symptoms were chosed from lists of postpartum blues symptoms because they were identified has having a particularly high frequency during the first few postpartum days (Stein, 1982).

A weakness in this brief questionnaire was that it might prove suggestive, inviting the respondent to "feel blue." For this reason, three more questions were added focusing on positive affect: had the woman felt confident; had she felt happy and "like her old self"; had she felt rested and relaxed? These positive states are common in the early postpartum. Women

experiencing this sense of well being may or may not also experience the blues.

This instrument was not designed to be a scale hence no split-half reliability test was required. There was expectation that women could feel both positive and negative affect simultaneously: that one could feel entirely positive or negative; or experience as few as one symptom of either kind.

The last question added to the questionnaire was aimed at getting some sense of the woman's familiarity with her baby and her own estimate of her competence in caring for the baby. This was scored on a continuum of one to five. The questionnaire is reproduced in Appendix D.

The DACL was scored according to the instructions in the manual accompanying the instrument (Lubin, 1981). The questionnaire was scored by counting each claimed symptom of the blues.

Control Over Birth

Control over birth is defined as a sense of continuing to be free to accept or influence the decisions made regarding the series of events leading up to and including the birth, delivery, and postpartum days in the hospital. It is a sense of maintaining a working alliance with the health care team. This concept differs from measures of satisfaction in that it does not deal with likes and dislikes. Also, locus of control or attributional style is not a central issue because I am concerned here with whether the mother's cognitive style whatever it is, is sufficiently responded to by the system such that she feels that her need to control or have someone take control is met.

The Control Over Birth questionnaire (called Birth Experience on the instrument form) was adapted from a subset of questions created to measure this variable by Bradley (1983a). Here too one question was revised and other items added to more adequately

meet the requirements of the present study.

The original subset of seven questions appear almost exactly as in the original study. Only one item was changed because it appeared redundant as written. These items were maintained to preserve the possibility of eventually comparing findings from both studies and to test the reliability of new items created for the instrument. The original subset had an alpha reliability coefficient of .83. The revised subset designed for this study had a reliabilty coefficient of .76.

Ideas for additional items came from Fullerton (1982) who developed a scale measuring attitude toward control of the "situation specific content of childbirth experience" (p.20).

Locus of control is a possible influential variable although not central to control of birth as we define it. Locus of control is a construct developed by Rotter (1966). It involves a generalized expectancy that individuals have with regard to the extent that they have, or do not have, the power to control what happens to them. Persons with external locus of control defer to chance or the power of others while persons with internal locus of control look to power within themselves. This difference in orientation is bound to make a difference in the need to personally feel control over birth. The questionnaire as constructed, however, is designed to accomodate the response of both types. The issue is, did the woman feel that her needs with regard to control were responded to appropriately. As a check on the adequacy of the design, however, I included two items which ask specifically about locus of control (see items 15 and 16 Appendix E). This enabled me to make some judgement about whether those with internal or external locus of control responded in significantly different ways to the questionnaire items.

The Control Over Birth questionnaire (Appendix E) was collected on day two. Each question was scored within a five point scale beginning at +2 indicating strong control, to 0,

indicating neutrality, to -2 indicating strong lack of control. Ten points were added to each score so that negative scores would be avoided. A question was also asked regarding whether the decision to have a cesarean section was made before hospitalization or after labor was begun.

Life Change History

For purposes of this study, I required a quantitative measure of life change events over a person's lifetime in order to test the notion that the more experience a person had with life change, the less the sense of loss at the time of childbirth; the less the sense of loss, the less the need to express grief (postpartum blues). Also, a measure of more recent life change events would help explore the relationship of stresses immediately preceding and during pregnancy and postpartum blues.

An instrument based on the Holmes-Rahe (1967) Schedule of Recent Experience (SRE) was desirable because of the considerable experience with the use of such questionnaires in health and medical research. The original scale includes a variety of life events drawn from the areas of family constellation, marriage, residence, education, occupation, health, relationships, and religion. Some events may be seen as desirable (graduation) and some as upsetting (illness). Holmes assumed that change was more important than the positive or negative way a person viewed that change.

The original SRE instrument contained 43 items. A subject's life stress score was simply the number of events he or she reported over a recent time interval (usually six months to two years). Since it was recognized that some SRE items required considerable more adjustment than others (for example, a death versus a change of location), a subsequent instrument called Social Readjustment Rating Scale (SRRS) (Holmes and Rahe, 1967) was developed. Here life events were weighted according to the

amount of readjustment of "getting used to" each required. A cumulative weighted score was assumed to reflect the amount of change that took place in a person's life. The instrument has proved stable across subculture groups in the United States and cross-culturally (Miller, Bentz, Aponte & Brogan, 1974). Samples from different populations tend to give similar weights to life events despite the fact that the original sample was middle-class urban Americans.

The scale was designed assuming that adaptation to life events was stressful and that such stress might play a role in the etiology of various somatic and psychiatric disorders (Dohrenwend and Dohrenwend, 1974). Examination of the considerable research in this area confirms the existence of a significant relationship between the experience of stress as defined by life events scales and a host of adverse somatic and psychological conditions. Despite these findings, serious questions remain about methodology.

One of the problems with the original scale was that items were too general for use with specific populations such as adult female respondents of childbearing age. With this in mind, Norbeck (1984) revised the scales testing new items relevant to this specific population. Her Life Events Questionnaire (LEQ) was a modification of existing instruments. In particular, the format and instructions come from the work of Sarason, Johnson, and Siegel (1978). New items related to such issues as separations and reconciliations, parenting, job finding, housing, and being a victim of a violent sexual act.

Not only do given life events have different impact but they also have individual impact depending on whether an event was desirable or not for that individual. A miscarriage, for instance could represent an enormous loss, or a tremendous relief, or both, depending on how the woman felt about the pregnancy. Norbeck suggests solving this problem by utilizing self-weighted (both positive and negative) scores. This also

permitted her to include new items without needing to establish empirically derived weights.

This study utilized Norbeck's newly developed scale (LEQ) with some revisions. The LEQ test-retest reliability is reported by Norbeck for negative, postive, and total scores. For the entire LEQ, each score had a high degree of test-retest reliability (.78 to .83). A more complete discussion is found in Norbeck, 1984, p.66.

Validity of the instrument was tested by relating LEQ scores with psychological symptoms neasured by three instruments. Evidence of validity was strongest for the negative events scores for the entire questionnaire. The range using varied instruments was between .30 and .39. Pearson correlation coefficients between the LEQ negative events score and measures of Depression-Dejection was .34 or at the .01 level of significance using a two-tailed test. (Norbeck, 1984, p.67).

Revisions of the LEQ for this study included shortening the scale from 79 to 71 items. Some of the items did not apply to this group; for example, started menopause, retirement from work. Some were too general for my needs; for example, major changes in eating habits or sleeping habits. Still others were designed for male response should the scale be used for both males and females; for example, wife or girlfriends pregnancy. In addition to deleting these items, I also changed the questionnaire format slightly so that the respondent could indicate those events which occurred in her lifetime and those which occurred within the last year. The instrument as it is used in this study is called the Revised Life Events Questionnaire (RLEQ) and is reproduced in Appendix F.

Scoring for RLEQ involved adding the weighted scores. Positive and negative scores were totaled separately and together for each time period; totals were made of positive and negative scores across both time periods; and a grand total score was established for the entire schedule.

Time Period

The choice of time periods covered in the RLEQ include "within one year: and "over your lifetime". The first choice reflects previous research which indicates that stress during the last two trimesters of pregnancy increased the possibility of obstetrical complications (Gorsuch and Key, 1974). The one year time period is also of particular interest also because we suspect clinically that conception and pregnancy often follows loss.

The second time period "during your lifetime" is included because one of the hypotheses is that high life stress histories will relate to less postpartum blues. Again, the assumption is that a woman with this history will not experience the same degree of loss around the birth of a child. Hurst (1979) supports the use of longer time period in that he reported that the test-retest reliability of the original life event questionnaire is higher when there is a longer time period being considered. Also, Perkins (1982) comments that although three to six months is generally recommended as an optimal time interval to look for a relationship between a life event and a symptom, any cut-off point seems arbitrary short of a person's entire life time since we know so little about the temporal effect of such events.

INTERVIEW

Ten women were interviewed utilizing a semi-structured interview schedule. (Appendix G). The schedule was designed to allow an opportunity for the woman to review her birthing experience (the birth story): to identify critical aspects (both good and bad) of her birthing and hospital experience; to check on the reliability and validity of the other instruments by reviewing her responses to the questionnaires; and to allow other

issues to emerge which I had not considered.

The Birth Story

The beginning of the interview invites the woman to tell her birth story without interruption. Jordan (1983) suggested the potential usefulness of a story as representation of a cultural event and as such, a way of learning more directly about issues important to the participants.

Of interest also is the potential therapeutic value of telling a story related to trauma and loss. Schneider (1983) sees this as a key factor in facilitating grief. The environment must be permissive of the disclosure of a range of emotions and the telling and retelling of the story of the loss. Sullivan and Beernman (1981) discuss the pervasive need for women to reconstruct their birth experience, and in their sample, 80% mentioned that they had wanted to discuss the delivery soon after birth. I had the opportunity to observe this need in my limited sample. The question of whether "telling the story" has any connection to postpartum blues remains untested.

Critical Issues

Asking the subject to consider critical issues in her experience, both good and bad, is another way to allow new ideas to emerge about what is important to the participant. I was interested also in seeing if any critical issues related to control over birth. The rest of the interview was related to a review of the questionnaires and the woman's responses to the instruments.

The interview was planned to take place over two visits. The first was to include the birthing experience and occur within 24 hours of the delivery; the second was to take place just before discharge so that the woman had the opportunity to complete the

questionnaires. In the even that the subject was discharged within a 24 hour period, I planned to telephone or arrange a home visit. The latter did not prove necessary.

PILOT STUDY

A pilot study was arranged at a community University-run hospital under the supervision of a consulting psychiatrist who was a member of the obstetrical department and service. She arranged for me to meet several of the attending obstetricians, resident physicians, and nursing staff so that I could introduce myself and the study. I received permission to select and follow five newly birthed mothers.

Type of delivery included two cesarean sections and three vaginal births. All the women were receptive to participating in the study and all were able to complete the required instruments.

Revisions

Revisions made as a result of running the pilot included:

1. Names of the instruments were changed to neutralize their intent. Hence, the "Control Over Birth" questionnaire was renamed "Birth Experience" questionnaire. The "Blues" questionnaire title was revised to "How Did Your Day Go Today."
2. The pilot study alerted me to the need to take time to gain entry to the study setting. I allowed at least one week to be in the setting without collecting data to enable me to talk informally with staff and to accustom them to my presence on the obstetrical floors.
3. The value of wearing a name-tag became apparent in view of the number of staff members (and shift changes of personnel) in contact with new mothers.
4. The need to give special attention to rooms where there were two or more mothers. If both were in the sample, some

precautions had to be taken so that they would not share responses before completing the qeustionnaires. If one was not in the sample, an explanation needed to be given so that she would not feel left out.

5. Question #15 in the Birth Experience questionnaire related to whether or not a perineal shave and enema were procedures discussed with the birthing mother. I learned that at the University Hospital, these procedures were no longer done. I did not delete the time, however, because they were done on occasion at the setting for the study.

CHAPER III

ANALYSIS OF RESULTS

Introduction

This chapter reports the results of this investigation. It is divided into four sections. The first provides an overview of the data collected and analyzed. The second is a description of the sample. The third section consists of a restatement of the research hypotheses along with the results of statistical analyses. It also includes other quantitative findings which were not anticipated. The fourth section summarizes qualitative data derived from the blues questionnaire and interviews.

The collected data were analyzed to determine a) if a woman's history of stressful life events (RLEQ) is related to postpartum blues, b) if a woman's sense of control over her birth experience (COB) is related to postpartum blues and c) to learn more about her experience with mood changes over the first four days following delivery.

Postpartum blues is measured by four forms of the Depression Adjective Check Lists (DACL, forms A,B,C,D) and by a questionnaire regarding symptoms of the blues experienced by the mother. These measures were made for the first four days postpartum.

T-tests were utilized to determine if there are differences in blues experienced by mothers related to their experience with a sense of control over birth. T-tests were also utilized to determine if differences in intensity of the blues experienced were related to scores on stressful life-event histories within one year of delivery and/or prior to one year.

T-tests were also used to test whether there are significant differences in blues experienced by women who were asleep or awake during delivery; who felt they had "much" versus "little" contact with their newborn infant; who felt they had (versus had

not) freedom to decide how soon to see their infant after birth; who felt they had (versus not) their desired support persons with them during the birthing experience.

T-tests were again utilized to compare this sample of women to those of the larger population used by Lubin to establish norms for the Depression Adjective Check Lists (DACL). An alpha of .05 was set for rejection of all null hypotheses.

Demographic information obtained from the questionnaire and medical chart as well as from hospital statistical summaries is used to describe the sample. Additional information collected from questionnaires, the medical chart, and hospital follow-up discharge notes is also described and summarized.

Description of Sample

A total of 86 women was selected from total admissions for the study. Of these, 4 women were ineligible. One woman's father died during the second day postpartum; one woman's baby was sent to another hospital for further evaluation; and two were under 18 years of age and therefore could not legally give permission to participate.

Eleven women refused to participate in the study leaving a total of 71 subjects in the final sample. The age ranged from 19 to 38 years of age. The mean age is 27 years. For 29 women (40.8%) this was the birth of their first child; for 22 (31%) a second child; for 10 (14.1%) a third child and for the remaining 10 (14.1%) their fourth or more child. Of the 71 subjects, 11 (15.5%) were single, 56 (78.9%) were married, and 4 (5.65) were living with the father of the baby.

Table I summarizes age and marital status.

TABLE I

AGE AND MARITAL STATUS

AGE	SINGLE		MARRIED		LIVING WITH		
	Fr	%	Fr	%	Fr	%	
UNDER 21	1	2.8	2	2.8	1	1.4	
21-24	5	7.0	18	25.4	3	4.2	
26-29	2	2.8	16	22.5	0	0.0	
30-33	1	1.4	11	15.5	0	0.0	
34 PLUS	1	1.4	9	12.7	0	0.0	
COLUMN	10		57		4		71
TOTAL		15.5		78.9		5.6	100%

The racial distribution of the sample is 48 (67.7%) white, 22 (31%) black, and 1(1.4%) others. Median income for the group was between #20,000 and $30,000 per year.

Table II Sumarized educational level.

TABLE II

EDUCATIONAL LEVEL OF WOMEN

LEVEL OF EDUCATION	FREQ	RELATIVE FREQ%
GRADE 10 TO 12	30	42.3
JR. COLLEGE	17	23.9
COLLEGE	20	28.2
GRADUATE	4	5.6
TOTAL	71	100.0

Table III describes occupations of mothers.

TABLE III
OCCUPATION OF WOMEN

OCCUPATION CATEGORY	FREQ	RELATIVE FREQ%
PROF EXEC	1	1.4
BUS MANAGER	9	12.7
SEMI-PROF	22	31.0
CLER AND SALES TECH	17	23.9
SKILLED MANUAL	3	4.2
SEMI-SKILLED	4	5.6
UNSKILLED	2	2.8
HOUSEWIFE/MOTHER	9	12.7
UNEMPLOYED	2	2.8
MISSING	2	2.8
TOTAL	71	100.0

The sample population had considerable familiarity with the community in that 50% of the women had lived in the area for longer than 16 years. If women who had been in the community for six years or longer are included, the number rises to 75%. Potential support was also high. Mothers of 67% of the women lived nearby. The fathers of 44% were in the community and 56% of the women indicated that their inlaws lived in the area.

The study sample was compared with the total persons discharged from the hospital maternity services over the same period. The mean age of the larger sample was slightly younger, 26.4 years of age as compared with 27 for the study group. This is understandable since all women under 18 were excluded from the study. In the study sample, 63.4% of women were delivered vaginally and 36.6% were delivered by cesarean section. The larger sample indicated that vaginal deliveries accounted for 73%

of the sample and cesarean sections for 27%. This difference might have been less if women 18 and under had been represented in the study.

Table IV compares both samples.

TABLE IV

COMPARISON OF TOTAL DISCHARGED AND STUDY SAMPLE

TOTAL DISCHARGED N=243		STUDY SAMPLE N=71
Mean age	26.4	27.03
RACE		
White	70%	67.6%
Black	29%	31.0%
Others	1%	1.4%
TYPE OF DELIVERY		
Vaginal	73%	63.4%
C/Section	27%	36.6%

The 11 persons who refused to participate in the study had a mean age of 24.5. There were 2 black mothers and 9 white mothers in the group. Eight of the 11 were married. 72% had vaginal deliveries and 27.2% had cesarean sections. Place of birth included 8 from the maternity floor, 2 from Home-Like Birth Center and 1 was a transfer from this unit. Reasons given included; my husband would rather I did not participate (2); I don't have enough time to complete the instruments (4); would prefer not to participate (5).

Except for the younger mean age, this group does not seem to differ in any special way from the research sample. The two refusals invoking husband disapproval came early in the study. I subsequently was more careful to involve husbands in the decision

process by explaining the study and asking for permission in his presence. Once this plan was adopted. no other refusals occurred for this reason.

Results of Hypothesis Tests

Ten hypotheses were developed to test empirically the relationship between identified psychosocial variables (independent variables) and postpartum blues (dependent variable). Only one of these original hypotheses yielded findings significant at the alpha (p=.05) level set. However, other evidence of relationships between variables tested and postpartum blues did emerge. These will be discussed in the context of reviewing the original hypotheses.

H-1
WOMEN WHO SCORE HIGHER ON THE RLEQ PRIOR TO ONE YEAR BEFORE DELIVERY WILL HAVE POSTPARTUM BLUES OF LESS INTENSITY THAN WOMEN WHO SCORE HIGHER ON THE RLEQ WITHIN THE YEAR OF CHILDBIRTH.

H-2
WOMEN WHO SCORE HIGH ON THE RLEQ PRIOR TO ONE YEAR BEFORE DELIVERY AND WITHIN THE LAST YEAR OF CHILDBIRTH, WILL HAVE POSTPARTUM BLUES OF LESS INTENSITY THAN WOMEN WHO SCORE LOW ON THE RLEQ PRIOR TO ONE YEAR BEFORE CHILDBIRTH AND WITHIN THE LAST YEAR OF CHILDBIRTH.

T-tests run to test for differences in postpartum blues scores between the groups described in H-1 and H-2 did not yield results significant at the .05 level.

H-3

WOMEN WHO PERCEIVE THAT THEY HAVE MORE CONTROL OVER DECISIONS RELATED TO ASPECTS OF THE BIRTHING EXPERIENCE WILL HAVE LESS INTENSE POSTPARTUM BLUES THAT WOMEN WHO PERCEIVE THAT THEY HAVE LESS CONTROL.

Utilizing Pearson product-moment correlation, no significant relationship between perceived control over decisions regarding birthing (COB scores) and postpartum blues was found. Similarly significant findings were not obtained using a t-test to see if there were differences between extremely-high and extremely-low blues scoring groups and COB scores.

H-4

WOMEN WHO ACTUALLY HAD MORE CONTROL OVER DECISIONS RELATED TO ASPECTS OF THE BIRTHING EXPERIENCE WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO HAVE NOT HAD ACTUAL CONTROL.

This hypothesis was not testable since there was no objective way to compare a woman's perception of her control and her actual control over decisions related to her birthing experience. For example, an attempt was made to compare the "actual" and "perceived" duration of and difficulty with labor. The hospital chart generally indicated the time of labor onset once the woman arrived at the hospital. Some women arrived at the hospital almost fully dilated; others entered when the waters broke but when labor was barely begun; some were induced and experienced an intense active labor; others had a longer but less intense experience. The information in the chart does not clarify these issues and different obstetricians do not report information in the same way.

H-5

WOMEN WHO PERCEIVE THAT THEY WERE AWAKE AND AWARE DURING THEIR BIRTHING EXPERIENCE AND WISHED THIS KIND OF BIRTH EXPERIENCE, WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHOSE PERCEPTIONS WERE NOT CONGRUENT WITH THEIR WISHES.

This hypothesis was not testable because the sample groups were too small. There was only one case where the woman was awake and aware and did not wish to be. Of the five women who reported being "half asleep", three wished that they had been more awake; of the only three who were asleep during the delivery, only one did not wish it to be that way. Clearly the great majority of women in this sample were awake and this was congruent with their wishes.

H-6

WOMEN WHO PERCEIVE THAT THEY HAD FREEDOM TO DECIDE HOW SOON TO SEE THEIR INFANT AFTER BIRTH WILL HAVE LESS POSPTARTUM BLUES THAN WOMEN WHO DID NOT PERCEIVE THIS FREEDOM.

The number of women who reported that they had the opportunity to see their baby soon after birth as they wished were in the great majority. Sixty-one of 85.9% saw the baby within minutes of its birth; 9, or 12.7% saw the infant within a few hours and one person could not remember. Sixty-three or 88.7% felt that they saw the child as soon as they wished.

A total of eight persons had experiences which were not congruent with their wishes. Two persons saw their baby within the first hour and one wished she could have seen the child earlier; 7 saw the baby within a few hours and of these 6 wished they could have seen the child earlier; one person could not remember.

T-tests comparing the means on postpartum blues of those who saw their babies as soon as they wished and those who did not,

did not differ significantly at the .05 standard set.

H-7

WOMEN WHO PERCEIVE THAT THEY HAD FREEDOM TO DECIDE HOW MUCH CONTACT TO HAVE WITH THEIR INFANTS AFTER BIRTH WILL HAVE LESS INTENSE POSPTARTUM BLUES THAN WOMEN WHO DID NOT PERCEIVE THAT FREEDOM.

A t-test comparing the means on postpartum blues for womem who felt they had freedom to decided about infant contact (N=66) and those who felt they did not (N=5) yielded a t value of -3.23 with p=.05.

Unexpectedly, the five women who felt that they had less freedom to decide about contact with their infant had a lower postpartum blues mean score than those who felt they had more freedom. Three of these women had infants that needed to be placed under lights because of high bilirubin levels. Although this is not a serious problem with infants, it did deny the mother access to the baby in her own room. A third woman was not able to manage her baby for about eight hours following a cesarean section. The last was a mother who learned that her baby was restless during the night following circumcision. She indicated that she would have preferred that she had been wakened to care for him.

H-8

WOMEN WHO ARE GIVEN OPPORTUNITY TO TELL A DETAILED STORY OF THEIR BIRTHING EXPERIENCE IN THEIR OWN WAY SOON AFTER BIRTH WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHO DID NOT HAVE THIS OPPORTUNITY.

A t-test comparing the means of postpartum blues scores of women who told me their birthing stories and all others in the sample did not yield significant differences.

Only ten women formally told me their story as a part of the study plan. I soon learned, however, that women were telling birthing stories to visitors, to each other, and to friends calling on the telephone. Subjects who were not in the selected interview sample would often tell me at least some part of their story although I did not invite them to do so. Telling the story did seem to be a need for women and so it was a variable that could not be controlled.

H-9

WOMEN WHO WISHED SUPPORT PERSONS WITH THEM DURING THE LABOR, AND DELIVERY, AND IMMEDIATE POSTPARTUM AND PERCEIVED THAT THEY HAD THE OPPORTUNITY TO HAVE THEM PRESENT, WILL HAVE LESS INTENSE POSTPARTUM BLUES THAN WOMEN WHOSE PERCEPTION AND WISHES WERE NOT CONGRUENT.

This hypothesis is not testable because only three persons in the entire sample felt that they did not have the support persons they wished to have there.

H-10

WOMEN WHO WISHED SUPPORT PERSONS WITH THEM DURING THE LABOR, DELIVERY, AND IMMEDIATE POSTPARTUM AND ACTUALLY HAD THEM AVAILABLE WILL HAVE LESS POSTPARTUM BLUES THAN THOSE WHOSE WISHES AND ACTUAL EXPERIENCE WERE NOT CONGRUENT.

This hypothesis is not testable. Again, 68 or 95.8% of the women felt that support was adequate; that all the persons they wanted with them were there when they wanted them.

It is possible that the birth plans around support were made carefully and well. It is also possible that postpartum women tend to say that they wanted the persons who actually attended them during birthing. It may be a way of coming to terms with the reality of what happened. To prevent this kind of bias, it

would have been better to have collected data regarding choice of support persons during the last months of pregnancy.

Comparison of DACL Norms and Sample DACL Means

There were indications that the incidence of postpartum blues in this sample was less than the 50%-60% or more than might be expected from my review of the literature. To verify this in a general way, the group with high postpartum scores was plotted over the four days postpartum. Every subject who had at least one postpartum blues score that was one standard deviation above the mean established as a DACL norm (Lubin, 1981,p.7) with 2 blues symptoms was included in this group. Forty-three women or 60.6% did not have any such scores. Twenty-eight or 39.4% did have blues by this definition. Of these, 19 had only one such score; 6 had 2 scores; and 3 had such scores for 3 days. These unexpectedly low findings prompted the investigation of whether the depressive mood in the sample of birthign women was within the range of what migh be expected among populations of "normal" women.

Measures for depressed mood in the study utilized four forms of the depression adjective check lists, (DACL), designed by Lubin. One of four different forms was given each day over a period of four days. Mean scores and standard deviations on each form were compared with the Means and standard deviations for female non-psychiatric patient samples utilized by Lubin to establish norms for the instrument (Lubin, 1981,p.7). Persons in his sample seem to be comparable to those in my sample. A specific description of the Lubin sample is not available. The Lubin subjects numbered 591. The number of subjects in this study is 71.

Table V compares the DACL Means of both groups.

TABLE V

COMPARING SAMPLE DACL MEANS AND LUBIN MEANS

	THIS STUDY	LUBIN
FORM A (Day 1)		
MEAN	8.19	7.78
S.D.	4.95	5.39
FORM B (Day 2)		
MEAN	5.93	7.32
S.D.	4.16	5.48
FORM C (Day 3)		
MEAN	7.40	7.87
S.D.	4.30	5.33
FORM D (Day 4)		
MEAN	6.71	7.82
S.D.	3.32	4.96

The following hypothesis was then tested;

THE LEVEL OF DEPRESSIVE MOOD IN THE SAMPLE POSPARTUM POPULATION WILL BE GREATER THAN DEPRESSIVE MOOD IN A NORMAL POPULATION.

Table VI show results of t-tests comparing the sample DACL Means and the DACL Means established for normal populations (Lubin).

TABLE IV

T-TEST RESULTS FOR SAMPLE DACL MEANS AND LUBIN MEANS

DACL FORM	t	p
Form A (Day 1)	0.816	-
Form B (Day 2)	-2.70	*
Form C (Day 3)	-0.92	-
Form D (Day 4)	-2.82	*

*p=.05

The t values for Day 1 and Day 3 are not significant. We may therefore assume that there is no difference between this postpartum sample and a population of normal women regarding level of depressive mood on these two days.

On Day 2 and Day 4, however, there are differences at the .05 level of significance. These are in a negative direction indicting that the postpartum groups are significantly less depressed than the norm Lubin established.

This is understandable for Day 4. It is homegoing day for the majority of women and affect must be colored by this expectation. Day 2 is more of a puzzle. It may be that it is a more comfortable day for the mother. She has the opportunity to see her infant and significant others in a more leisurely way.

The above findings challenge the notion that the first four days postpartum are likely to marked by unusually depressed affect.

Follow-up Data

Ten days after discharge from the hospital each woman was telephoned by one of the head nurses to learn how the postpartum

home adjustment was going. In the context of asking about the health of both mother and baby (nutrition, sleep) and the adjustment of spouse and siblings, the subject was asked about her emotional state. Data is complete for 58 subjects in the sample. (10 subjects could not be reached after three telephone attempts and three were from the HLBC and were routinely contacted on the 4th rather than the 10th day).

Of the 58 responding, 48 or 79.3% reported feeling emotionally stable and happy. Eleven or 19% reported having some ups and downs mostly related to fatigue. Only 1 (1.7%) reported feeling depressed and blue for the past three days.

This indicates that in the group that responded, complaints of blues and depression were present in about 21% of cases after 10 days at home. The majority of women did not report such episodes.

Additional Findings

Three additional analyses were carried out to answer the following questions:

1. Is locus of control related to control over birth scores or measures of postpartum blues?

T-tests did not indicate significant differences related to internal or external locus of control.

2. Does type of delivery affect postpartum blues scores?

A t-test did not indicate significant differences between cesarean sections and all other types of delivery and measures of postpartum blues.

3. Are primiparas more prone to postpartum blues?

A t-test did not indicate significant differences for primiparas as compared to multiparas on measures of postpartum blues.

QUALITATIVE DATA

Blues Questionnaire

In addition to scoring a DACL form daily, each respondent was also asked to complete an attached questionnaire regarding symptoms of postpartum blues. This questionnaire was called HOW DID YOUR DAY GO TODAY (Appendix D). Four questions were designed to explore the woman's understanding of why she might feel like crying; why she might have cried; why she might have felt irritable, anxious, or why she might have had a hard time concentrating.

Similarly, questions were asked about positive states, namely, feeling confident; happy and like one's old self; rested and relaxed.

Most women made brief comments about what made them feel the way they indicated they were feeling. A content analysis of these statements is beyond the scope of the present study. However, some illustrations of the kinds of events or situations that stimulated a feeling response are presented. Common ones relating to positive affect are reported below.

On the day of childbirth, many women reported feeling excited and happy that the baby was born or finally born, that the child was healthy; that it was the sex it was. Feelings of self-confidence were related to support from spouse; feeling able to care for baby; having someone (baby) "depend on me". During the second and third day, several women linked feeling confident with being up and around; feeling less pain; feeling stronger and able to nurse baby better. A great number of women linked feelings of confidence with having the opportunity to take a shower. On the third and fourth day, happiness, excitement, and self-confidence were linked to the expectation of going home. Several women who had gone home on day 2 or 3 indicated that being at home was connected with feeling happy and "like my old

self."

Responses to what made the woman feel like crying or what made her cry, feel irritable, anxious, or unable to concentrate were very varied. Many "one of a kind" statements occurred. Illustrations of the more common responses, however, may be grouped under such themes as recollections of the birth; present physical discomfort; concern over older children; loneliness; ability to care for infant; comments of nurses; and lack of sleep. Some examples are given with the postpartum day on which they were reported indicated in parenthesis.

RECOLLECTIONS OF BIRTH:

(1) the spinal numbed me up to my chest and I had fears about being able to breath... felt tied down in delivery... it all came back and made me feel like crying.
(1) felt angry that the epidural they gave me was not enough manage the pain and thinking about it made me cry
(1) cried when I saw the baby, felt so relieved that the birth was over
(1) keep thinking about the birth and what might have happened (crying)
(1) am crying from relief: now that the birth is over, I don't have to worry about it anymore

PRESENT PHYSICAL DISCOMFORT:

(1) hurting too much to nurse the baby (felt like crying)... too uncomfortable to hold him...no family here, they all live away
(1) my butt hurts and my nose is stopped up.. I think it is from drugs (feel like crying)
(2) worried that my bowels haven't moved and that something bad will happen (anxious)
(2) have head and abdominal pain and I worry that I'll never get

to go home (anxious and crying)
(2) the pain medications make me groggy (concentration)
(3) crying because they had trouble with the IV and the kept fussing over it.. I think I have a bad infection

CONCERN OVER OLDER CHILDREN:

(1) worried about the two kids at home; I cried when I talked to them on the phone
(1) all of a sudden I'm the mother of two kids and it makes me anxious; I know the older one is having a hard time with all of this
(2) I have never been away from my little girl and she cried when she had to leave me today and I cried too
(2) this is the first time my son is living away for home and I'm worried about him
(3) I worry how the older children will adapt to the baby and I thought about that all day today
(3) my husband has to go back to work today and I know the baby (two-year old) will be scared

LONELINESS:

(1) I thought how I missed my husband and little girl at home (crying)
(2) this is the first time I've ever slept in a room alone; I cried when my roommate left
(2) I wanted my husband to keep me company because I'm lonely and I got angry when he left

ABILITY TO CARE FOR INFANT:

(1) scared to hold the baby; afraid it would choke (anxious)
(1) (anxious) worried that I don't have enough things for the

baby
(2) anxious because the baby sleeps too much; doesn't feed well
(2) baby wouldn't quiet down and I didn't know what to do (felt like crying)
(3) my breast was engorged and the baby wouldn't grasp and they left me all alone with her until noon (felt like crying; had not confidence)

NURSING RESPONSE:

(1) nurse told me that I was holding the baby wrong and I felt dumb (cried)
(2) I didn't want to feed the baby at 6AM because I felt too unwell and I think the nurse was angry and thought I was a bad mother (crying and irritable)
(3) I felt irritated because the nurses weren't giving me any attention and the baby kept crying and I wanted help to quiet him
(3) I told the nurse that I didn't want to breast feed and I know she was angry (anxious and irritable)

LACK OF SLEEP:

(2) just couldn't sleep last night or today; feel exhausted (irritable)
(3) they left me with the baby all night and I couldn't get any sleep (crying)
(2) I just feel so tired that it scares me (anxious and irritable)

Illustrations of the still other kinds of responses are as follows:
(2) the father didn't come to the birth and he's not here now and this pregnancy was unplanned and I just feel disappointed (crying)

(2) the baby was circumcized and the nurse said he was up all night and I felt sad and angry that they didn't bring him to me (irritable) and I feel upset that it was done at all (crying)
(3) (crying) when my parents came and held the baby it just felt so overwhelming like a miracle but it was sad too
(1)(crying) just so many unexpected things keep happening that I worry if I'll ever get through it all (unplanned C section)

Of interest is that all respondents gave explanations for some of the blues symptoms they experienced although they did not necessarily comment on each instance. Only two women noted on the questionnaire that they didn't know what might be responsible for their negative feelings.

In my conversations with women, it was common to hear "I don't know why I'm feelin blue" as an initial response. However, when I pursued the inquiry, asking if they and any hunches about why, they always reconsidered and gave an explanation.

Interviews

Ten interviews were completed. Each interview began by making a recording of the birthing story. Each woman was told to begin wherever she liked and to indicate to me when she was finished with her story; that I would not interrupt. In two instances, the husband was present at the interview and participated in telling the story. All participants knew that the information would be kept confidential; the data would be kept under code numbers; and that they would receive a copy of the recording on the following day.

All of the women or couples interviewed reported that they enjoyed the opportunity of telling the story. Eight of them spontaneously said that the process made them feel better.

Following the story, each woman was asked to tell the three best and worst times for them during the birthing experience. The remaining questions related to their experience in completing

the study instruments. I was open to also hearing about any other comment they wished to make about birthing and their observations about any variations in mood since the delivery.

Most of the interviews took place at the bedside with the infant present. In five cases, the father was also present. The low maternity-unit census permitted privacy in that most women roomed alone. At the HLBC, one interview took place at the bedside and the other in a sitting room.

The scope of this study did not permit analysis of the birthing stories. The focus for purposes of this research was to give the new mother an opportunity to review the birth in the presence of another person. Illustrations of the interview summaries appear in Appendix H.

A review of themes identified when women discussed best and worst times of their birthing experience, revealed some commonalities. Positive themes were associated with beginning labor and getting to the hospital or birthing center; seeing the baby born and being able to confirm for oneself that the baby was OK: that the baby was the desired sex; that support was present, particularly the fathers.

Negative commonalities are connected with severe pain, especially just prior to delivery; post-delivery pain and discomfort; and disppointment about the type of delivery or the way the delivery went. Even after having one or more childbirth experiences, the amount of pain and discomfort experienced seemed unexpected. Unexpected amount of pain; unexpected changes in the delivery plan; unexpected response a given mother had to the pain, and changed circumstance all were related to "worst times." Post-delivery pain often made women angry. They were being asked to be joyous and to look after the baby and yet felt that they were too uncomfortable to do either.

Postpartum blues symptoms in this small sub-sample, when they occurred, lasted for only one day. In each instance, symptoms were associated with physical discomfort.

Reactions to the research instruments indicated confusion with the RLEQ. Women had difficulty recollecting positive and negative events over their lifetime. They explained that what was once important to them did not seem so any longer. One said "having a baby makes everything else seem like nothing by comparison."

Reactions to the COB instrument were that although choices were available, it was not always possible to have the choice you most wanted. Namely, there really wasn't much choice about have a cesarean section. "It had to be done." Similarly, there were compelling reason to agree to have a fetal monitor or to remain in the hospital for a required number of days.

CHAPTER IV

SUMMARY AND DISCUSSION

This study proposed to identify psychosocial factors related to postpartum blues. Review of the literature indicated that postpartum blues is, in this culture, an indentifiable entity characterized by sporadic crying related to depressed feelings during the first three to five days following childbirth. Because of the high incidence of this syndrome (50% to 85% in this culture), it has been considered by many as a normal reaction to childbirth.

Suggested explanations for the blues have included its relationship with "milk fever", (Savage, 1875); the trauma of birth such as long labors, medication, disappointment in the labor experience, (Affonso, 1977); mother-infant separation and the absence of significant support persons (Klaus and Kennel, 1982). Research efforts have reflected biological, psychosocial, and crosscultural perspectives.

This study proposed that postpartum blues is a type of grief response to the experience of loss related to physical, social, and psychological changes engendered by the childbirth. Although often unacknowledged and less intense, this experience parallels a grief process. The birthing environment and system were considered important variables in affecting the intensity of grief. Also of importance was a woman's sense of control over the birth and her previous experience with life changes. To test the utility of this framework for understanding blues, I hypothesized that postpartum blues would vary with measures of control over birth and reports of life change history, (life events). No previous attempts had been made to relate these specific variables to postpartum blues.

A sample of 71 women who delivered babies in a setting which permitted a broad range of birthing plans and interventions was

studied. All deliveries were considered low risk. All infants were delivered near or at term and were considered to be normal. Women in the study were asked to fill out checklists and questionnaires and ten of the sample were interviewed. Although none of the study's primary hypotheses tested yielded significant findings, some important unexpected findings did emerge.

Most important was the discovery that the incidence of postpartum blues in this sample (as measured by daily combined scores of depressed mood and postpartum blues symptoms), was much lower than expected. Over a four-day period, less than 40% of women experienced blues and of these, only 12.6% experienced them for more than one day.

A comparison of scores on the Depressed Adjective Check Lists (DACL) of this sample and the norms established for the instrument indicated that this group of women did not differ from the normal population on days one and three of the four-day measurement period. On days two and four, depressed mood was significantly less than what might be expected in a normal population. Follow-up data collected for 58 subjects 10 days post-hospitalization indicated that 19% experienced minor mood variations attributed by the women to fatigue. Only one person had more pervasive and enduring depressive symptoms.

Variables expected to relate to the intensity of blues were unexpectedly homogeneous. Most women in the sample were awake and wanted to be; saw their infant soon after delivery and wanted to; had as much contact with their infants as they wished; and had wished-for support persons available to them. I was unable to adequately test for differences in intensity of blues because the subsample of mothers who were negative regarding these factors was too small.

In addition, other characteristics of the sample population may have also affected the blues scores. Three quarters of the women had lived in the community for more than six years and had available family support in the immediate area. Most had

reasonable financial resources and were essentially healthy persons with no chronic diseases.

Ten of the 71 women were given the opportunity to tell their birth story within 24 hours of delivery with the assumption that this experience might modify the intensity of the blues. Again, this variable, when tested, was not significant. The setting, however, seemed to permit and even invite most women to tell their stories. Each woman had a private telephone; each woman had permission to have at least two support persons with her constantly and other family and friends were permitted access for two hours daily. Also, since the floor census was low, many of the women may have had more than usual access to the staff. The implication is that "telling the story" as a variable could not be controlled.

Responses to the blues symptoms questionnaire and interview material indicated that women were able to relate depressed mood or blues symptoms to particular events or circumstances in their present situation. This was contrary to Yalom's conclusions (1968) that women were puzzled by their symptoms and could not explain them. In the present research, women attributed their blues symptoms to recollections of the birth; to postpartum physical discomfort; to concern over older children left at home; to loneliness; to concerns about ability to care for the infant; to nursing comments experienced as being critical; and to lack of sleep.

In my view, the above set of factors relate to grief. Childbirth is experienced as trauma and is connected with physical and emotional loss. When invited to describe their birth experience, the ten women welcomed the opportunity. They appeared to find significant emotional relief in detailing the events, suggesting that the telling of the birth story significantly aided coping with the disruptive and frightening aspects of the experience. Having physical discomfort at a time when one expects to enjoy a new status and to invest energy in

the new baby is experienced as disappointing. Worry about older children and a sense of loneliness is a function of feeling the loss of important others in their lives as well as the loss of the home environment.

Concerns about the ability to care for the infant, response to nursing comments and lack of sleep may also be related to a grief response. They reflect worry about the need to learn the mothering role (and coping with the losses implicit in that change). Worries are compounded by feeling physically uncomfortable and/or tired. Some mothers comment on how they worry that they will never have enough rest again. New mothers in this situation are often vulnerable to what they interpret as critical comments of nurses. Sadness, anxiety, and anger become common and understandable affective responses.

During interviews, women commenting on the negative aspects of their birthing experience identified severe pain during the post-delivery as a central factor. No amount of preparation was effective in helping them cope with this. Unexpected character of the pain, unexpected changes in their delivery plan and unexpected sex of the baby were also connected with negative aspects of their birthing experience. These events seem to reflect times of less control. By contrast, positive aspects of the birthing experience were related to high control and less sense of loss. Such concrete events as finally going into labor and getting to the hospital are examples. Others include seeing the baby born, seeing that the baby was of the desired sex, and having wished-for support available.

Although the original hypotheses were not supported, these findings encourage continued exploration of the relationship of loss and grief to postpartum blues.

Incidence of Postpartum Blues

In this study the incidence of postpartum blues was less than expected. If the birthing setting exerts an effect on the incidence of postpartum blues we may conclude that the syndrome is potentially modifiable. An important consequence of such a conclusion is that research into the proportional contribution of biological, psychological and social factors will continue to be studied and that the current bias toward biological causation will be modulated.

It is important to realize that this study was conceptualized during a period of reevaluation of the birthing system in this culture. Increased awareness of the medicalization and technicalization of birth and its possible consequence to the emotional response of birthing women has become more common. Hospitals and obstetrical practice began to reflect the demand for change. This study set about testing ideas about an old model in an already developing new model of care.

This time gap created a serious problem for the researcher. It was anticipated, for example, that choice for the birthing woman would be limited and that if it was limited in certain critical areas, this would affect postpartum blues. Instead, most women felt they had choice regarding type of birth, presence of support, access to the infant, etc. The hospital setting of the study had already created a more flexible system such that birthing plans could be more individualized to meet the needs of the woman and her family.

Jordan, (1983), suggests that such flexibility in the system is more likely to reflect the current changing social context for women and their new perceptions of themselves and their power to affect their lives. She implies that this may be more beneficial in improving birth experience and outcome than fixing on one specific model of care. Indeed, such flexibility may also be affecting the incidence of postpartum blues.

Limitations of the Study

A limitation of this study is its reliance upon the self report method for gathering information about the subject's experiences, history, and present state. Subjective biases are introduced suggesting cautious interpretation of the scores on the adjective check lists and questionnaires.

For example, asking subjects to respond to these instruments soon after delivery did seem to interfere with the capacity for some to recall events for the RLEQ. Women reported that they were so fixed on the childbirth experience, they found it hard to recall or appropriately weigh the effect of other events in their lives. Also, feeling unwell seemed to inspire recollection of more negative events. Feeling happy and relieved inspired a more positive set. Similarly satisfaction or disappointment with the baby's father's attentiveness colored RLEQ reporting of their history as a couple and the changes in their relationship.

Another, more general limitation of the RLEQ instrument is that it involves retrospective self-reporting and as such is open to memory error. This is a particular problem when the respondent is asked to recall a lifetime of events. Recollection may also depend upon the trauma associated with the event and/or timing of the inquiry. For example, an illness which felt traumatic one month ago is forgotten six month later. Also, the order of the items may influence associations in ways that alter what is remembered and what is forgotten. These remain limitations for this instrument as well as for most life event schedules.

For future studies I would suggest that the RLEQ be given within the last trimester of pregnancy and that the time frame of "events in your complete lifetime" be modified to "within the last ten years". Early childhood experience could be more effectively gathered by a straightforward inquiry regarding

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personal history. Deaths, divorce of parents, major relocation and the like could be learned in this way. An objective check of the subject's recollection of events would strengthen the findings. A spouse or significant friend or relative might be recruited to provide such a check.

In this regard, there were no objective observations of actual behaviors related to the blues symptoms made in this study. The study depended upon the subject's perception of all these factors. Such observations would have helped to validate measures of the blues.

Responses to the Control Over Birth questionnaire may have also been biased by the respondent's loyalty to the birth and by her gratitude that the pregnancy had a "good outcome".

The Control Over Birth questionnaire may need further modification if it is to be used in further studies. The instrument must reflect not only the feeling that there was choice, but on whether the subject felt that she was given true options. For example, some women complained that choosing to have a cesarean section was the only possible choice in view of what they were told were complicating circumstances. They were concerned that other options remained unexplored. Such situations led to reporting high control over birth despite the feeling that there was little control.

Suggestions for Further Research

Measuring the incidence of postpartum blues in a setting which is based on an earlier model of obstetrical care would help to verify that the setting and system within that setting might affect postpartum blues.

The continued exploration of the relationship between grief and postpartum blues seems to be a promising area of research. There is sufficient clinical evidence to encourage more studies in this area. Comparisons of the behaviors of postpartum women

and persons undergoing other major life change is one possibility. Carefully tracking and providing women with an opportunity to tell and retell their birth story as an aid to grieving and measuring its effect on blues is still another possible project.

Discussions with seasoned nursing staff on the obstetrical service supported the notion that more mature women had less postpartum blues than women who were less experienced in the world. Nurses felt that there were fewer women having blues nowadays and saw this as related to the birthing women being more mature. Perhaps continued refinement of the RLEQ would help demonstrate this clinical impression.

Nurses also felt that I was giving too little attention to the issue of drugs. They explained that women were given codeine, demerol, restoril, and dalmane to help them cope with discomfort. These drugs often make women feel more disabled, interfering with their capacity to concentrate. Many women never had drugs of this kind before and became frightened and depressed in response to them. Certainly it would be important to include drugs as still another variable affecting blues.

Most important is to continue the exploration of blues symptoms as having meaning. We may be calling a set of understandable, normal, coping behaviors the postpartum blues. By so doing, we imply that these behaviors and feelings are a form of illness. This assumption can seriously prevent new understanding and has often done a disservice to women. For example, women who complained about being tied down during delivery were once thought to be neurotically disturbed. It is now seen as an understandable and appropriate reaction

Implications for Social Work

In their recent comprehensive review article on improving pregnancy outcome Royer and Barth (1984) suggest the need for interventive strategies for social workers to use at the policy, program and case levels to effect this change.

They note that thus far the profession's focus has been almost exclusively on the study and treatment of complicated pregnancies and premature births. This severely limits social work's potential role in promoting maternal and infant health in more normal populations. It could be argued that the more normative population of pregnant and postpartum women should be a central concern to social work in order for the profession to be effective in preventive efforts.

Social workers have a range of interventive opportunities available in a comprehensive system of maternal and infant health care (Watkins, 1979). Such opportunities begin with the mother's preconceptual health, the infant's intrauterine development, and includes the mother's and infant's postnatal course.

It has been previously demonstrated that isolated women with high life-change scores during pregnancy have increased complications around birthing (Nucholls, Cassel, and Kaplan, 1972). Women who have the continuous company of a lay person during labor and delivery tended to have shorter labors, fewer instances of cesarean sections, forceps deliveries and stillbirths (Sosa et al., 1980). Such studies point to the importance of assessing psychosocial variables and their impact on the birthing woman.

A major focus of this study has been to discover the effects of the birthing environment on the new mother's postnatal adaptation. By suggesting that the postpartum blues experience varies in response to social and psychological issues, the possibility is reopened for designing birthing environments and systems of care which will diminish the incidence, intensity and

duration of the blues. Through research, the social work profession can participate in facilitating institutional responsivity to the changes birthing women require.

My discussions with nurses on the obstetrical floor reinforced for me the need for adding a social work perspective. Although care was compassionate and thoughtful, there was insufficient attention paid to the particular social and psychological needs of the individual patient. Caretakers need to be alerted to the double messages given their patients. On the one hand, postpartum women are told that they are ill enough to need IV's and medication. On the other hand, they are told they are well enough to show intense interest in their infant. They also are urged to care for the infant no matter how badly they feel physically or psychologically. Similarly, the nurse who reports: "Mrs. X is irritable; I told her it was probably the blues; She was relieved to know that this was the trouble;" may be helped to respond to such patients with greater capacity to understand what factors are behind the blues in that particular woman.

Clinically, it would be important to remain alert to the losses involved in normal childbirth and to develop programs to keep both women and caretakers mindful of this issue. Educational groups such as the ones developed by Dooley and associates (1983) are excellent models.

Perinatal programs developed by social workers must maintain a comprehensive approach. Support programs as outlined by Gray (1982) for parents at risk for child abuse might ideally be made available to all mothers. Such programs include opportunity for prenatal education, prenatal family and peer support, presence of helper during hospitalization, early contact between parents and infant, easy access of infant (rooming-in), ongoing contact postnatally (including supportive telephoning, home visits, availability of support groups), concrete economic and health care services, and professional referral. In addition, I would

assure parents choice of birthing environment most congruent with their needs. Provision of such choice lends professional confirmation to the knowledge that childbirth is a significant change event for the mother, father, and significant others. Childbirth in this highly technological and socially isolating culture deserves this kind of planning and attention.

APPENDICES

APPENDIX A

SUMMARY OF RESEARCH FOR HOSPITAL COMMITTEE

THE RELATIONSHIP OF LIFE CHANGE HISTORY AND CONTROL OVER BIRTH TO POSTPARTUM BLUES

APPENDIX A

SUMMARY OF RESEARCH STUDY FOR HOSPITAL COMMITTEE

THE RELATIONSHIP OF LIFE CHANGE HISTORY AND CONTROL OVER BIRTH TO POSTPARTUM BLUES

This study explores the relationship between some psychosocial variables (life change history and control over birth) and the common mild transient depression occurring within three to five days of delivery. The incidence of postpartum blues remains high. The estimate is about 60% in normal populations. Although biological factors probably contribute to the timing and intensity of the "blues", the literature and clinical experience indicate that other variables might also be influential.

The study requires a sample of 70 postpartum women. Type of delivery is not an issue as long as mother and full term newborn have no unusual complications. The study will be explained to each prospective subject and a signed letter of consent will be obtained before her participation begins.

Each woman who agrees to participate will be asked to fill out a total of two brief questionnaires on each of the first four postpartum days. The Depression Adjective Check List designed by Lubin (1969) to measure mild depression in postpartum populations will be collected daily. In addition, each woman will be asked to complete a Schedule of Life Changes patterned after the instrument designed by Holmes and Rahe (1967), and a short questionnaire regarding her role in the birthing experience patterned after one developed by Bradley (1983). Dr. Bradley, a research associate at the School of Nursing at the University of British Columbia has corresponded with me about the possibility of comparing findings.

A random sample of 10 women will be selected from the original group of 70 for interviewing. These women will be asked about their birth experience and will also be asked to elaborate

on their responses to the questionnaire.

Booth Memorial Hospital was chosen as the proposed setting for the study on the recommendation of Marshall Klaus, M.D. who advised me of its excellent reputation and special interest in birthing research. He also suggested that the philosophy and caring ways of the maternity service would probably result in a lower blues incidence in the population served by the hospital.

This research project has been reviewed by my doctoral committee at Michigan State University which includes senior faculty in the fields of social work, clinical psychology, and anthropology.

They agree that this study will have no negative effects and might indeed be a positive and interesting experience for the participants.

I am prepared to do all the interviewing and data collection personally and to complete these aspects of the project in a 30 day period. Confidentiality will be maintained and great care will be taken to minimize interruption of the usual floor routine.

My qualifications to do this project are enhanced by my being an experienced practicing social worker with long term interest in new mothers and their infants.

about

Lubin, B.L. Adjective check list for measurement of depression. Archives of General Psychiatry, 1965, 12, 57-70.

Bradley, C. The antecedents and consequences of maternal adaptation in the postpartum period.University of British Columbia and the Vancouver Health Department.March, 1983.

APPENDIX B

CHILDBIRTH RESEARCH STUDY

Informed Consent Form

APPENDIX B

CHILDBIRTH RESEARCH STUDY

Informed Consent Form

We are trying to learn more about childbirth so that we may increase our understanding and sensitivity to the needs of women at this important time. This study asks participants to respond to some questionnaires about their present birth experience and life history.

Participation is voluntary. The permission statement which follows provides more detail:

I understand:

1. that this is a research project, the nature of which has been explained to me.

2. that my voluntary participation involves completing a series of brief questionnaires during the first four days after delivery and perhaps an interview with the researcher, Marsha Worby.

3. that I am free to discontinue my participation in the study at any time without penalty.

4. that all information that I give will be treated in the strictest confidence and that at no time will my name or the name of my infant be used in the report of the study.

5. that participation in the study does not guarantee any beneficial results to me (although it may be of eventual benefit to birthing women).

6. that the proposed research in no way interferes with standard medical treatment or my rights as a patient.

7. that at my request, I can receive additional explanation and results of the study after my participation is completed.

8. I give my permission to Marsha Worby to have access to the medical records of myself and my infant.

Date:

Signed_____ Witness_____

This study is conducted by Marsha Worby ACSW under the supervision of Gerald Bostwick, Ph.D., School of Social Work Michigan State University. Permission and approval has been received from the appropriate administrators and research consultants at Booth Memorial Hospital.

APPENDIX C

DEMOGRAPHIC DATA

APPENDIX C

DEMOGRAPHIC DATA

ID#_____ TEL#_____ DATE:_____

Age:_____

Marital Status: Please Check:

Single____ Married (how long)_____ Living/with (how long)____

Ever divorced (how long ago)_____

Pregnancy: First___ Second____ Third____ Fourth or more____

New Baby's Sex: Girl____ Boy_____

Other Children? Please give sex and age: Age__ Sex__

Age__ Sex__

Age__ Sex__

Education: Check last completed:

Grade 9 or less ____ Jr. College____

Grade 10-12___ College____ Postgraduate____

Occupation:

Your occupation before (or during) pregnancy_____

Your husband/partner's occupation_____

Family income: Check one:

10,000 and under_____

10,001 - 20,000 _____

20,001 - 30,000 _____

Over 30,000 _____

Did you attend prenatal classes in childbirth education? Yes___

NO____

How long have you lived in this area?____

Do other family members live in this area? Please check:

mother father

sister brother

inlaws others

APPENDIX D

MEASURES OF POSTPARTUM BLUES

1. Depression Adjective Checklists
Forms A,B,C.D.

2. (Blues Questionnaire)

HOW DID YOUR DAY GO TODAY?

CHECK LIST

DACL FORM A

By Bernard Lubin

Name_____ Age_____ Sex_____

Date_____ Highest grade completed in school_____

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

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

APPENDIX D

CHECK LIST

DACL FORM D

By Bernard Lubin

Name_____ Age_____ Sex_____

Date_____ Highest grade completed in school_____

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

1. ☐	Depressed	17. ☐	Fit
2. ☐	Elated	18. ☐	Lonesome
3. ☐	Awful	19. ☐	Unloved
4. ☐	Lifeless	20. ☐	Glad
5. ☐	Griefstricken	21. ☐	Grave
6. ☐	Inspired	22. ☐	Sunk
7. ☐	Woeful	23. ☐	Shot
8. ☐	Lonely	24. ☐	Merry
9. ☐	Suffering	25. ☐	Wasted
10. ☐	Mellow	26. ☐	Washed Out
11. ☐	Drooping	27. ☐	Clear
12. ☐	Rejected	28. ☐	Gruesome
13. ☐	Fortunate	29. ☐	Tired
14. ☐	Dreary	30. ☐	High
15. ☐	Lousy	31. ☐	Worse
16. ☐	Good	32. ☐	Drained

APPENDIX D

(Blues Questionnaire)

HOW DID YOUR DAY GO TODAY?

DAY#____ID#____

THIS QUESTIONNAIRE ASKS FOR INFORMATION ABOUT YOUR MOOD TODAY. SINCE YOUR MOODS WILL VARY EACH DAY YOU ARE IN THE HOSPITAL, WE ASK THAT YOU FILL ONE OUT FOR EACH DAY FOLLOWING DELIVERY. (FOUR TIMES). PLEASE DO IT AFTER YOU HAVE HAD YOUR SUPPER.

1. Did you feel like crying today? Yes___ No____
   Did you actually cry? Yes___ No____
   Do you have any idea about what made you want to cry?
   (If yes, please answer in a few sentences)

2. Have you felt self-confident today? Yes___ No____
   Do you have any idea about what made you feel self-confident?
   (If yes, please answer in a few words or sentences)

3. Have you felt anxious or worried today? Yes___ No____
   Do you have any idea about what made you feel that way?
   (If yes, please answer in a few words or sentences)

4. Have you felt irritable today? Yes____ No____
   Do you have any idea about what made you feel that way?
   (If yes, please answer in a few words or sentences)

5. Have you found it hard to concentrate today?Yes____ No____

6. Have you felt excited, happy, and "pretty much your old self" today? Yes____ No____

   Any idea of what was making you feel so happy?

   (If yes, please answer in a few sentences or words)

7. Have you felt relaxed and well rested today?Yes____No____

8. PLEASE CHECK ONE OR MORE:

   Today I felt as if:

   I didn't know how to respond to my baby at all___

   I began to get the idea of how to respond ___

   I felt I knew how to respond pretty well___

   I felt I knew how to respond very well ___

   I felt I knew how to respond to my baby better ___ than any of the nurses

THANK YOU

APPENDIX E

(CONTROL OVER BIRTH)

BIRTH EXPERIENCE

APPENDIX E

(CONTROL OVER BIRTH)

BIRTH EXPERIENCE

ID#_____ DATE OF DELIVERY_____

TODAY'S DATE _____

This questionnaire is designed to learn about some aspects of your total birthing experience, particularly labor and delivery.

There are no right or wrong answers. We are interested in your honest feeling about how things went for you.

1. My labor experience was what I expected it to be.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly

Agree Disagree

2. My delivery experience was as I expected it to be.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly

Agree Disagree

3. How would you rate your labor and delivery?

--*----------*----------*----------*----------*----

Very long Very Short

4. How would you rate labor and delivery?

--*----------*----------*----------*----------*----

Easy Difficult

5. I felt that I had control over my birthing experience.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly

Agree Disagree

6. My birth experience has made me afraid to go through it again.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

7. I was able to have the baby whenever I wanted to and return him/her to the nursery whenever I wished.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

8. My husband/partner was free to participate in caring for our baby whenever he wished.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

9. I was able to see my baby as soon after the delivery as I wanted to.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

10. The amount of pain medicine that I had during labor was just what I needed.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

11. I was permitted to decide whether or not I wanted a relative or friend with me during labor and delivery.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

12. During labor I was free to do whatever I felt would make me most comfortable.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

13. I was invited to help decide how long I needed to be in the hospital.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

14. I was free to decide whether I wanted to be asleep or awake during delivery.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

15. The decision about whether or not to have a perineal shave and enema was discussed with me.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

16. I helped make the decision about whether to have a fetal monitor during labor.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

FOR CESAREAN SECTION MOTHERS

A. I felt that I participated in make the decision to have a C Section before I came to the hospital.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

B. I participated in the decision to have a C Section after I was in labor.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

FOR ALL MOTHERS

17. In general I would prefer that decisions with regard to labor and childbirth to made by professionals.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

18. In general, I would prefer to understand and participate in all decisions concerning labor and childbirth.

--*----------*----------*----------*----------*----

Strongly Agree Neutral Disagree Strongly
Agree Disagree

19. PLEASE CHECK ONE:

---I was awake during delivery

---I was half asleep during delivery

---I was asleep during delivery

This was how I wanted it: Yes___ No____

20. THE FOLLOWING PERSONS WERE OF SUPPORT TO ME DURING MY BIRTHING EXPERIENCE.(Please check all that apply)

My husband or partner____ My woman friend____

My mother___ Doctor___ Midwife___

My father____ The nurse_____

My sister____ My mother in law_____

My brother_____ Others...(Please List)

_____

I wanted more support___

Support was adequate____

I wanted less support___

21. Please check one:

I got to see my baby within minutes after delivery__

within an hour after delivery__

within a few hours after delivery__

a day or more after delivery __

This was how I wanted it: Yes__ No___

ANY COMMENTS:

APPENDIX F

REVISED LIFE EVENTS QUESTIONNAIRE

LIFE EVENTS

APPENDIX F

REVISED LIFE EVENTS QUESTIONNAIRE

LIFE EVENTS

I.D.#____ DATE:_____

THIS QUESTIONNAIRE IS A REVIEW OF LIFE EXPERIENCES AND THE DEGREE OF IMPACT THEY HAVE HAD ON YOUR LIFE. IT TAKES ABOUT 10-15 MINUTES TO COMPLETE.

FOR EACH EVENT LISTED BELOW, PLEASE CHECK

A. IF THE EVENT HAS EVER HAPPENED IN YOUR LIFETIME

B. CHECK IT AGAIN IF THE EVENT HAPPENED DURING THIS PAST YEAR.

C. INDICATE IF THE EVENT WAS "GOOD" OR "BAD" FOR YOU.
(IF THE EVENT HAPPENED MORE THAN ONCE, RATE THE ONE THAT WAS MOST SIGNFICANT FOR YOU).

D. CHECK THE EFFECT THE EVENT HAD ON YOU USING A SCALE OF
0=no effect
1=little effect
2=some effect
3=great effect

THERE ARE NO RIGHT OR WRONG ANSWERS. PLEASE TRY TO REMEMBER THE EVENTS AS BEST YOU CAN AND ESTIMATE THEIR IMPACT ON YOUR LIFE.

EVENT	DURING LIFETIME	DURING LAST YEAR	EVENT WAS	EFFECT ON ME
	YES.NO	YES.NO	GOOD.BAD	0,1,2,3
Example:				
Major trip	_x_.___	___._x_	___._x_	_2_

A. HEALTH

1. Major personal illness or injury	___.___	___.___	___.___	___
2. Major dental work	___.___	___.___	___.___	___
3. Pregnancy	___.___	___.___	___.___	___
4. Miscarriage	___.___	___.___	___.___	___
5. Abortion	___.___	___.___	___.___	___
6. Major difficulties with birth control pills or devices	___.___	___.___	___.___	___

B. WORK

7. Difficulty finding a job	___.___	___.___	___.___	___
8. Beginning work outside the home	___.___	___.___	___.___	___
9. Changing to a new type of work	___.___	___.___	___.___	___
10. Changing work hours or conditions	___.___	___.___	___.___	___
11. Change in responsibilities at work	___.___	___.___	___.___	___
12. Troubles at work with your employer or co-workers	___.___	___.___	___.___	___
13. Major business readjustment	___.___	___.___	___.___	___
14. Being fired or laid off from work	___.___	___.___	___.___	___
15. Taking courses by mail or studying at home to help you in your work	___.___	___.___	___.___	___
	___.___	___.___	___.___	___

C.SCHOOL

16.Beginning or ceasing college, or training program ___.___ ___.___ ___.___ ___

17.Change of school,college, or training program ___.___ ___.___ ___.___ ___

18.Change in career goal or academic major ___.___ ___.___ ___.___ ___

19.Problems in school, college or training program ___.___ ___.___ ___.___ ___

D.RESIDENCE

20.Difficulty finding housing ___.___ ___.___ ___.___ ___

21.Changing residence within the same town or city ___.___ ___.___ ___.___ ___

22.Moving to a different town,city,state,country ___.___ ___.___ ___.___ ___

22A.Moving away from your parents to a different town,etc. ___.___ ___.___ ___.___ ___

23.Major change in your living conditions(home improvements or a decline in home or neighborhood) ___.___ ___.___ ___.___ ___

E.LOVE AND MARRIAGE

24.Began a new, close, personal relationship ___.___ ___.___ ___.___ ___

25.Became engaged ___.___ ___.___ ___.___ ___

26.Girlfriend or boyfriend problems ___.___ ___.___ ___.___ ___

27.Breaking up with a ___.___ ___.___ ___.___ ___

boyfriend or girlfrend

28.Getting married (or beginning to live with someone) ___.___ ___.___ ___.___ ___

29.A change in closeness with your spouse or partner ___.___ ___.___ ___.___ ___

30.Unfaithfulness ___.___ ___.___ ___.___ ___

31.Trouble with in-laws ___.___ ___.___ ___.___ ___

32.Separation from spouse or partner due to conflict ___.___ ___.___ ___.___ ___

33.Separation from spouse or partner due to travel, (etc.) ___.___ ___.___ ___.___ ___

34.Reconciliation with spouse or partner ___.___ ___.___ ___.___ ___

35.Divorce ___.___ ___.___ ___.___ ___

36.Change in your spouse or partner's work outside the home (begin work, change jobs,laid off,etc.) ___.___ ___.___ ___.___ ___

F.FAMILY AND CLOSE FRIENDS

37.Gain of a new family member through birth, adoption, relative move-in ___.___ ___.___ ___.___ ___

38.Family member leaving home due to marriage, college, or other reasons ___.___ ___.___ ___.___ ___

39.Major change in health of family member or close friend (illness,accident,drugs,etc.)	___.___	___.___	___.___	___
40.Death of spouse or partner	___.___	___.___	___.___	___
41.Death of family member or close friend	___.___	___.___	___.___	___
42.Birth of grandchild	___.___	___.___	___.___	___
43.Change in marital status of your parents, (divorce, separation,remarriage, death of one)	___.___	___.___	___.___	___

G. PARENTING

44.Change in (your) child care arrangements	___.___	___.___	___.___	___
45.Conflict with spouse or partner about parenting	___.___	___.___	___.___	___
46.Conflicts with child's grandparents(or other important person) about parenting	___.___	___.___	___.___	___
47.Taking on full responsibility for parenting(as single parent)	___.___	___.___	___.___	___
48.Custody battles with former spouse or partner	___.___	___.___	___.___	___

H.PERSONAL AND SOCIAL

49.Major personal achievement	___.___	___.___	___.___	___
50.Major decision regarding immediate future	___.___	___.___	___.___	___
51.Change in your religious beliefs	___.___	___.___	___.___	___
52.Change in your political beliefs	___.___	___.___	___.___	___
53.Loss or damage of personal property	___.___	___.___	___.___	___
54.Took a vacation	___.___	___.___	___.___	___
55.Took a trip other than vacation	___.___	___.___	___.___	___
56.Change in family get-to-gethers	___.___	___.___	___.___	___
57.Change in your social activities (clubs,movies,visits)	___.___	___.___	___.___	___
58.Made new friends	___.___	___.___	___.___	___
59.Broke up with a friend	___.___	___.___	___.___	___
60.Acquired or lost a pet	___.___	___.___	___.___	___

I.FINANCIAL

61.Major change in finances (increase or decrease)	___.___	___.___	___.___	___

62.Made moderate purchase(TV,car, freezer,etc).	___.___	___.___	___.___	___
63.Made major purchase or mortgage loan (house,business,etc)	___.___	___.___	___.___	___
64.Experienced a foreclosure on loan	___.___	___.___	___.___	___
65.Credit rating difficulties	___.___	___.___	___.___	___

J.CRIME AND LEGAL

66.Being robbed	___.___	___.___	___.___	___
67.Being a victim of a violent act(rape,assault)	___.___	___.___	___.___	___
68.Being involved in an accident	___.___	___.___	___.___	___
69.Involved in a law suit	___.___	___.___	___.___	___
70.Involved in a minor violation of the law (like traffic tickets, disturbing the peace)	___.___	___.___	___.___	___
71.Legal troubles like being arrested or held in jail	___.___	___.___	___.___	___

K.OTHER

Other experience you have had which have had an impact on your life

LIST AND RATE

72..... ___.___ ___.___ ___.___ ___

73..... ___.___ ___.___ ___.___ ___

74..... ___.___ ___.___ ___.___ ___

THANK YOU FOR COMPLETING THIS FORM.
PLEASE PLACE IT IN THE ATTACHED ENVELOPE FOR COLLECTION.

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*Modified and reprinted by permission of Jane S. Norbeck, author of the Life Events Questionnaire.

** The RLEQ utilized in the study was reduced in print size so it required only two pages.

APPENDIX G

SEMI-STRUCTURED INTERVIEW SCHEDULE

APPENDIX G

SEMI-STRUCTURED INTERVIEW SCHEDULE

INTRODUCTION TO SUBJECT:

Talking with women like yourself about your birthing experience helps us learn more directly about what birthing is really like for individual women. This will enable us to meet women's needs more effectively.

I would like you to tell me your birth story and permit me to record it so that I can review it later. Please begin wherever you like. We will have about 20 minutes for the story. I won't interrupt until you are finished.

AFTER THE STORY IS RECORDED:

Is there anyting you left out? that you would like to add? Is there any part that deserves special emphasis? that you would like to say more about?

CRITICAL INCIDENTS:

Please tell me about three moments (times) in your experience which you feel were the best. What about the experience made you feel good?

Please tell me about three moments (times) in your experience which you feel were the worst. What about the experience made you feel bad?

LIFE CHANGE EVENTS:

Interviewer will review questionnaire with mother and ask about the impact of individual life change events. Interviewer will also ask about whether a particular loss has special meaning or feels related to the present delivery. How has she coped with past life changes; how does she feel she is coping now?

CONTROL OVER THE BIRTH EXPERIENCE:

Interviewer will review questionnaire with mother and ask what the impact of either having/not having a sense of control over events had for her. Interviewer will ask if critical incidents previously identified have anyting to do with the issue of control.

POSTPARTUM AFFECTIVE RESPONSE;

Interviewer will ask about mother's feeling state since delivery; how had it varied; any ideas about the context in which the affective change took place.

CLOSURE:

Interviewer will ask mother how it felt to talk together; if she felt that she was able to tell me about things that she felt were important that I know; if she had any questions she would like to ask of me.

APPENDIX H

ILLUSTRATIONS OF INTERVIEW SUMMARIES

APPENDIX H

ILLUSTRATIONS OF INTERVIEW SUMMARIES

Interview #1

Mrs. A is 21 years old and has been married for 2 1/2 years. She had a vaginal delivery (in the delivery room) of a third child, and first boy. She has a high school education and has not been employed outside the home since her marriage. She is black and has lived in this area for only one year. Relatives all live in another city in this state.

She began her story at the time she began to feel labor pains at home. She remembered her reluctance to go to the hsopital. She worried about leaving her 3 and 1 year old. She was also apprehensive about the pain of delivery.

Her husband and sister-in-law remained with her through labor and delivery. She ended her story by saying that she gave three or four big pushes and out he came.

The most positive times were when the baby was born; when "I saw for myself it was a boy"; the look on my husbands face when he saw the baby. The most negative time was related to having labor pains just before she delivered. There was no other.

Mrs. A explained that this delivery was just what she wanted. At previous deliveries she was cut and had a spinal. She didn't want that again and had explained that to her doctor. She felt that the presence of her husband at the delivery allowed her to concentrate on her work. She didn't have to worry about anything else. He would look out for that.

She is bottle feeding her baby. She indicates an internal locus of control.

A year ago her grandmother died and she recalls being upset for months afterwards. She wishes her grandmother could have seen this new baby. RLEQ scores are balanced between negative and positive events. She reports that thinking back over her whole life was difficult to do. She was not sure she remembered all events.

Blues scores were low. When asked, however, she did say that the time she feels most sad is when she does not have a visitor. She feels lonely and wishes she could be at home. Remembered feeling blue after her first child and thought it was because she felt so lousy, "hurt all over for a long time."

Follow-up call indicated that she was feeling fine. Her husband was a good support. She was having some trouble with her one-year old who was more babyish since she came home.

Interview #2

Mrs. B is white, 27 years old and has been married for 2 years. She had a vaginal delivery in the birthing room. She was transferred from the HLBC when labor did not progress and fetal monitoring was suggested. This is the couple's first child and it is a girl. The couple has lived in the area for 5 years. It is their original home, however, and both their parents and several siblings also live here. Mrs. B has had 3 years of college and is employed as an occupational therapist.

She began her story two days before the delivery when she was

asked to come in to do a stress test. She reflected that this was a time when she wondered if things were going to go as she had planned. Delivery in the HLBC did not work out and she felt upset that she had to be transferred. She described in detail how everyone encouraged her not to give up. This, she felt, enabled her to avoid a C section. She cried as she described seeing the baby and feeling relief that it was over and that the baby was OK. Her husband and friend attended the birth.

The most positive times were seeing that the baby was there and that it was normal; when everyone was helping and telling her to push, it meant a lot; when she got to the birth center and she knew that "this was it." The worst times were the last few contractions; pain from the episiotomy; feeling so uncomfortable the next day.

Mrs. B explains that she is religious and that she felt that God would see her through whatever had to happen. She knows she has a special relationship with Jesus. When things did not go as she had anticipated, she felt she lost faith. Her husband was frightened too but remained helpful to her.

She is breast feeding her baby. She indicates an external locus of control. RLEQ scores indicate only positive events during the last year. Other RLEQ scores are around the group average. COB score was more than one standard deviation below the mean.

Blues score was high on day one. She told me that telling the birth story helped her feel better. She said she felt bad because her vagina and abdomen hurt. She also felt upset and scared when she realized that so many unexpected things had happened.

Follow-up indicated that she was happy; that things were going well and that her husband and mother were helping.

Interview #3

Mrs. C is a 30 year old woman who had divorced 1 1/2 years ago and remarried eight months ago. She has a 5 year old child from the first marriage. She completed high school and worked as a waitress until her second marriage. She had a vaginal delivery of a baby boy in the HLBC. She has lived in this area for over 15 years and her family all lives here as well.

Her story began when she discovered that she was pregnant. She and her boyfriend were very happy about this and decided to marry. She ended her story by telling how exciting it was to see the baby born and to see the faces of family members who all were so dear to her. Her mother, husband, father and daughter attended the birth.

Best times for her included watching her father and daughter talk about what the birth was going to be like (father was to be the support person at the birth for his granddaughter); seeing the baby born; and having her husband with her. Worst times were related to having labor pains that were worse than she expected, and when she felt that because of the pain she was irritable with her husband.

Mrs. C said that she believed that a gentle entry into the world shapes a person. She herself was adopted at nine months. She believes that she came into the world well because she is usually feeling content and loving. Her first daughter had this kind of birth and she was pleased that her son did too. It felt important to her to have her daughter there with her father to see the birth.

Mrs. C is breast feeding her baby. She indicates an internal locus of control. Blues scores are very low. COB score is average; RLEQ scores are average except that the negative score for "years ago" is more than one standard deviation above the mean. Most of the items scored related to her negative experience in her first marriage.

Interview #4

Ms D. is a 20 year old white unmarried woman who gave birth to her first child by cesarean section. She has a high school education and worked as a vending machine attendant until the week she delivered her baby. She has lived in this area for twenty years and all of her family still reside here.

She began her story by telling about another pregnancy she had three years earlier. This pregnancy ended with an abortion at three months because the fetus wasn't growing and tests indicated that the baby was anencephalic. The father of that baby left as soon as he learned she was pregnant. The current pregnancy was welcome because she has always wanted a baby. She was also scared that something might be wrong with the baby. Her story ended with her remembering how great it was to see the baby born.

The best moments for her included being reassured when she was eight months pregnant that her baby would be fine; beginning labor; and seeing the baby born. The worst time was hearing that she would be having a cesarean section. They told her that the baby could not take the stress of delivery. She worried that something was wrong with the baby. The other hard time was the first day after the delivery when she felt so sick.

Ms D is bottle feeding her baby. At the end of 48 hours she had

not yet named him saying that it was hard to make a choice. The father of the child was present during the delivery and visited daily. Since he was not yet divorced, they were not planning to live together.

Blues scores were low except for the third day where her score was made high because she responded to so few items on the DACL. She indicates that she was told that her blood pressure was high and that she had had a headache all day long. The COB score was average and an internal locus of control was noted.

RLEQ scores are all average except for the negative score within the past year. This is above one standard deviation from the mean. She indicates that a close friend died in an accident within the past year.

At follow-up, she stated that she was feeling fine and happy. Her boyfriend and mother were being very supportive.

Interview #5

Mrs. E is a 35 year old black married woman who delivered her second son via cesarean section. She was disappointed that the child was a son. She had wished for a daughter.

She attended junior college and was employed as a machine operator until the last three months of her pregnancy. She has lived in this area for 11 years. Both families of origin have always lived here.

Her story was brief. It began with feeling labor pains at night and coming in to the hospital. She labored for about 7 hours before they decided to do a cesarean section. She was annoyed that the decision got postponed for so long. She felt that it

was delayed because her own doctor was not available. Her husband remained with her through the labor and delivery. She ended her story with saying that she was put to sleep during the delivery which is just how she wanted it to be.

Mrs. E. told me that the first time she delivered, she felt too alone so this time she had told her husband that if he wanted to name the baby, he had better be there. He thought he would faint and was pleased to see that he did OK and that it felt important to see the baby delivered as well as how much "pain and suffering" his wife endured.

The best part of the birthing experience for Mrs. E. was when they finally decided to do the section and when they put her out. She was also glad that her husband decided to stay with her. The worst times were when she was in hard labor and when she first came to the hospital and learned that her own doctor wasn't going to be there.

The baby is to be bottle fed. COB score was below two standard deviations from the mean. She indicated an external locus of control. She said that not having much control over the birth might have been acceptable except for her disappointment about the absence of her physician.

RLEQ scores are all average. The within-the-last-year negative events score, however, indicated considerable marital difficulty which was verfied in the interview.

Her postpartum blues score was high on day one. She indicated that the anaesthesia had made her feel sick and irritable. She was also disappointed when she learned about the sex of the child. She guessed that she would get over it in a day or two.

Follow-up indicated that Mrs. E was feeling pretty good. She felt that her down times were related to feeling tired. Her mother was spending time with her and would look after the baby when she returned to work in a few weeks.

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and

GENERAL REFERENCES

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