



Social support of primiparas after early hospital discharge
by Barbara Kaye Swehla

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

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Abstract:

This study was conducted for the purpose of describing the phenomenon of perceived social support among low-risk first-time mothers following early hospital discharge. Perceived levels of social support experienced by military and nonmilitary primiparas were contrasted. The study was conducted during a four-month period in 1988.

Study subjects included 36 low-risk primiparas, 19 nonmilitary and 17 military, residing within a 40-mile radius of a Montana community. Subjects were accessed within 24 hours of delivery through a community hospital which averages 116 deliveries monthly. Low-risk determination was made prior to contact by hospital chart review and use of a Risk Assessment Tool. Forty-three primiparas met the criteria for the study, six of whom chose not to participate (84% participation rate). Subjects were interviewed in their homes within one week of delivery.

In addition to demographic questions, data was obtained by utilization of the PRQ-85, and additional questions pertaining to the new motherhood experience.

Demographics, the PRQ-85 Part I, and the additional questions were descriptively analyzed for the entire sample and for military and nonmilitary subgroups. Mean scores on the PRQ-85 Part II were calculated. Cronbach's alpha was utilized to determine if there were relationships between the perceived level of social support (PRQ-85 Part II scores) and various demographic characteristics.

The sample was homogenous. All subjects reported increased need for social support for general new motherhood concerns, psychological concerns, physiologic changes, and baby care. However, the satisfaction with available support for all new motherhood concerns is less than that in the other life situations addressed in the PRQ-85 Part I.

Scores obtained by the PRQ-85 Part II were similar between military and nonmilitary subjects. No relationship was identified between the perceived level of social support and the demographic variables of age, length of residence, education, and additional help in the home. Most of the primiparas in the study sample had neither professional nor extended family support in the home at the time of interview.

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DISCHARGE

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

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This thesis has been read by each member of the thesis committee and been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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VITA

Barbara Kaye Swehla was born on November 8, 1953 to Carl John Mattson, Jr. and Marilyn Lou Mattson. She was raised in rural farming communities in North Dakota, graduated from Lakota Public Schools in 1971, and from the University of North Dakota College of Nursing, Grand Forks, in December, 1974, with a Bachelor of Science in Nursing.

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ABSTRACT

This study was conducted for the purpose of describing the phenomenon of perceived social support among low-risk first-time mothers following early hospital discharge. Perceived levels of social support experienced by military and nonmilitary primiparas were contrasted. The study was conducted during a four-month period in 1988.

Study subjects included 36 low-risk primiparas, 19 nonmilitary and 17 military, residing within a 40-mile radius of a Montana community. Subjects were accessed within 24 hours of delivery through a community hospital which averages 116 deliveries monthly. Low-risk determination was made prior to contact by hospital chart review and use of a Risk Assessment Tool. Forty-three primiparas met the criteria for the study, six of whom chose not to participate (84% participation rate). Subjects were interviewed in their homes within one week of delivery.

In addition to demographic questions, data was obtained by utilization of the PRQ-85, and additional questions pertaining to the new motherhood experience.

Demographics, the PRQ-85 Part I, and the additional questions were descriptively analyzed for the entire sample and for military and nonmilitary subgroups. Mean scores on the PRQ-85 Part II were calculated. Cronbach's alpha was utilized to determine if there were relationships between the perceived level of social support (PRQ-85 Part II scores) and various demographic characteristics.

The sample was homogenous. All subjects reported increased need for social support for general new motherhood concerns, psychological concerns, physiologic changes, and baby care. However, the satisfaction with available support for all new motherhood concerns is less than that in the other life situations addressed in the PRQ-85 Part I.

Scores obtained by the PRQ-85 Part II were similar between military and nonmilitary subjects. No relationship was identified between the perceived level of social support and the demographic variables of age, length of residence, education, and additional help in the home. Most of the primiparas in the study sample had neither professional nor extended family support in the home at the time of interview.

CHAPTER 1

INTRODUCTION

The birth of a first child has been shown to be a time of major adjustments and role changes within a family system. Previous research has indicated that first-time parents perceive the birth of their child and the child's integration into the family as a crisis experience (Dyer, 1963; Hawkins & Gorvine, 1985; Hobbs, 1965, 1968; LeMasters, 1957). Demands for behavioral changes are often beyond the new parents' psychological resources and result in disequilibrium (Caplan, 1964; Hawkins & Gorvine, 1985). The birth of the first child, and its attendant disequilibrium make the family more vulnerable and susceptible to influence by significant individuals in the family's environment. Overall, environment and specific sociocultural influences can affect the family's response to the crisis; the first-time parent family can either adapt or maladapt. When there is adaptation, the birthing event is seen as an opportunity or an event which results in psychosocial growth and an increased ability for future adaptation to crisis events.

Problem Statement

First-time parents traditionally enter the developmental crisis of pregnancy and childbirth with little or no formal training for this unfamiliar role. New motherhood can create the perception of a traumatic experience and feelings of being unsupported. It also can result in a lower self-concept (Curry, 1983). The first-time mother may respond to her novel role with a sense of being overwhelmed, inadequate, and feeling frustrated. As with other crisis experiences, postpartum tensions are characteristically temporary, usually lasting about four to six weeks. However, the way in which the new mother responds to and passes through this experience has future consequences. The need to adjust to each crisis experience is well documented by crisis theorists, (Aguilera & Messick, 1974; Caplan, 1964; Hill, 1967; Robischon, 1965), since each experience can provide positive emotional growth and decrease the likelihood of maladaptation in a future crisis event.

The quality of the parent-child and marital relationship can be adversely affected if positive resolution of the crisis event does not occur. Mother-infant bonding may begin at conception, then develop over a period of time after birth. If the mother is depressed or excessively anxious during the immediate

postpartum period, the ability to build a healthy mother-infant relationship can be hampered.

Western society has romanticized parenthood and considered parenting to be an intuitive function, whereas in reality it is a learned behavior (Dyer, 1965; LeMasters, 1957; Rubin, 1967a, 1967b). The new mother is expected to perform in her new role as well as she has in previous roles. Often, however, there are minimal supports for this role transition in Western society. Traditional prenatal education focuses on pregnancy, childbirth, and infant care. Although, there has been a recent trend toward more available parenting classes focused on preparing persons for coping with the stress of new parenthood, these tend to be available primarily to persons of specific socio-economic groups residing in urban or suburban areas. Those persons living in rural, outlying areas are less likely to have the opportunity to take advantage of these educational classes. In addition, very little information is provided on role changes, the physiologic alterations accompanying the birth process, body image changes, infant needs, variations in family status, and other unanticipated stressors. Coping with these stressors is critical to the new mother's transition into parenthood in an adaptive manner.

Social support has been traditionally provided by extended family members. Due to current social trends in the United States, such as high mobility, smaller families, and a change in family structure, social support from extended family is less available. Frequently, new mothers are meeting many challenges alone. Intergenerational guidance for child care and role adaptation are often not available.

Postpartum hospital discharge within 24 to 48 hours following admission to the hospital is a recent development. This can and does result in discharge within hours following delivery. There is limited time for hospital-based nursing personnel to provide postpartum education, assess the mother/child relationship, and assist the new mother in providing baby care. In addition, the effectiveness of nursing care is further reduced by the new mother's lack of receptiveness to teaching during her short hospital stay. During hospitalization, the mother is concentrating on her need and desire for physical restoration and is also devoting her thoughts and energies to developing a relationship with her infant (Rubin, 1967a).

The opportunity for hospital-based nurses to identify mother/infant relationship dysfunctions and postpartum health complications is significantly limited by early discharge. Thus, formal social support provided

by nurses following early discharge of the postpartum client may be necessary for the new family's well-being (Brown, 1986; Donaldson, 1981). All new mothers, not just those at high risk, can benefit from additional support during this developmental crisis experience (Curry, 1983; Donaldson, 1981). However, some mothers, by virtue of specific social situations may have greater need for nursing interventions in the postpartum period. Social support experts (Brandt & Weinert, 1981; Cobb (1976); Thoits (1972); Tolsdorf, 1976) point out that simply having another person present to assist may not constitute social support. The new mother must view the available person as non-judgmental and supportive in order for social support to be actually present. Thus, the availability of a spouse or parent in the new mother's home may not be adequate. For some new mothers, professional nursing intervention may be needed to meet social support as well as learning needs.

One group of primiparas that may be lacking in available supports is new mothers associated with the armed services. Thus, new mothers living on a military base may be considered a special risk group. Their lives are affected by frequent relocations to areas far-removed from family members. Further, new mothers in military families are often less aware of social support services in their surrounding community. Military primiparas may

be in greater need of mobilizing formal social support systems due to lack of integration into the community and possible deficiency of informal support systems, such as family members or close friends.

The literature indicates that the availability of social supports can positively affect reduction in postpartum health problems (Brown, 1986; Dean & Lin, 1977; Norbeck & Tilden, 1983; Nuckolls, Cassel, & Kaplan, 1972). With adequate social support, the challenge of adapting positively to a life change event can be met (Curry, 1983). The mother can sense achievement and self-mastery related to successful completion of this task.

Significance to Nursing

Because postpartum nursing intervention in the hospital is limited by early discharge, it is necessary for hospital-based nurses to prioritize client needs in the immediate postpartum period. Hospital postpartum nurses need to assess those social supports the client perceives as available after discharge. With this knowledge, the nurse can assist in mobilizing those supports and in locating others that may be needed. Nurses' efforts toward effective patient education will be maximized if teaching is offered at a time when the new mother is most receptive. Often this will require

coordination between hospital-based postpartum nurses and community health nurses for postpartum teaching.

Since most postpartum clients are being discharged from the hospital within 24-48 hours following delivery, new challenges are present for the community-based nurse. Historically, much of the information related to child care, body changes associated with pregnancy, and role change have been presented to new mothers during the prenatal period and during the immediate postpartum period before hospital discharge. However, the provision of this information may no longer be appropriate during the new mother's short hospital stay. There may be lack of receptiveness to teaching during the hours immediately following birth due to fatigue, pain, and disequilibrium from physical changes (Gruis, 1977; Rubin, 1967a, 1984). Because the client's hospital discharge occurs during an early phase of transition into the new parent role, post-discharge interventions by community-based nurses may be critical for the mobilization of social supports and assistance toward adaptation during this crisis period. Currently, community-based professional nurses follow high-risk mothers in the home, but do not routinely provide home follow-up to low-risk primiparous women.

Appropriate interventions, based on an accurate assessment of postpartum client's needs, can assist the

new mother in making her first experience with her child a positive one. Nursing interventions may aid in the development of psychosocial growth potential and reduce the disorganizing effects of new parenthood. A collaborative effort is needed between hospital-based and community-based nursing personnel in order to make appropriate interventions and meet these goals.

Purpose of the Study

The purpose of this study is to describe the perceived levels of social support of primiparas during the immediate postpartum period. Specific study objectives are: (1) to assess perceived levels of social support of primiparas during the first week postpartum following an early hospital discharge, and (2) to compare and contrast the perceptions of social support of military and nonmilitary primiparas. The military primipara may perceive less social support and thus be at higher risk. Lack of integration into the community and possible deficiency of informal support systems, such as family members, may lead to greater or different needs than those among nonmilitary primiparas.

Social support and perception of crisis have been extensively studied in new parenthood situations. Most studies, however, have focused on a period which begins at least six weeks beyond the delivery of the baby.

According to Aguilera and Messick (1974), crisis periods are temporary; most crises usually resolve, either adaptively or maladaptively, within four to six weeks. Therefore, many researchers' investigations of parenthood as a developmental crisis may have measured crisis after the experience had already been resolved.

Timing of the investigation of perceived social support in relation to a crisis experience is important to the validity of results. The investigation of a phenomenon such as the crisis of new motherhood is apt to be more valid if the perceptions of the event are elicited during the actual crisis experience.

Investigating perceptions of new mothers in the period immediately following hospital discharge, while the developmental crisis of new parenthood is occurring, is believed to yield more accurate data and limit the distortions which occur when subjects' reports are based on retrospective recall.

Jacoby (1969) contended that reported results from studies of parenthood as crisis have been contradictory, partially as a result of variability in age of the child during the investigation by each researcher. Gordon, Kapostins, and Gordon (1965) studied postpartum emotional reactions extensively, and presented a strong argument for the need for assistance from others. These investigations occurred six weeks after delivery.

LeMasters (1957), Dyer(1963), Hobbs (1965, 1968), and Beauchamp (1968), conducted their studies of parenthood as crisis in time periods ranging from three months to one year postpartum, much beyond the period in which most new parents may be experiencing the developmental crisis.

The present study will contribute new knowledge to the nursing field by providing data about the concerns of new mothers, and the types of assistance and support they desire as expressed during the period immediately following postpartum discharge. This data can form a knowledge base for enhancing professional nursing care provided to new mothers both in the hospital and in the community.

Definition of Terms

For the purposes of this study the following terms are defined as indicated below:

Primipara

A primipara is "a woman who has completed one pregnancy with a fetus or fetuses that have reached the stage of fetal viability" (Jensen & Bobak, 1985, p. 309).

Low-risk primipara

This study includes only low-risk primiparas as determined by chart review utilizing the Risk Assessment Tool (see Appendix B). A low risk primipara is defined

as a primipara who has not experienced complications during the perinatal period, based upon screening with the Risk Assessment Tool.

Prenatal period

The prenatal period refers to the time from conception to the time of delivery of the child.

Postpartum period

The postpartum period refers to the time from the delivery of a child to approximately four weeks following birth.

Perinatal period

The perinatal period refers to the period of time from the twentieth week of gestation to the end of the postpartum period.

Early hospital discharge

Early hospital discharge pertains to discharge of the postpartum client from the hospital setting to the home environment within 72 hours of delivery of the baby.

Social support

Social support refers to the degree to which an individual's social needs are fulfilled through interaction with others, and includes the meaning these interactions have for that person (Weinert, 1984). For

the purposes of this study, perceived social support will be operationally defined by the score obtained on the PRQ-85 Part. II (see Appendix C).

Military primipara

A military primipara is a first-time mother who is associated with the United States armed services. She may either be in the armed services, herself, or may report herself to be married to a man in the armed services.

Nonmilitary primipara

A nonmilitary primipara is a first-time mother who is not in the armed services of the United States, herself, and does not report herself to be married to a man in the armed services.

Assumptions

The process of giving birth is a major life transition and is experienced as such by all new mothers. New mothers will experience varying degrees of adaptation or maladaptation to this crisis experience.

New mothers are able to, and will, describe their postpartum experience with reasonable accuracy during the process of responding to a postpartum interview.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The theoretical framework for this study is based on the major concepts of the crisis of parenthood and the role of postpartum social support. Related subconcepts considered are early hospital discharge and special risk associated with the military primipara..

The literature review is divided into four sections. Parenthood as crisis and the effect of social support in the first-time parent's response to crisis are reviewed in depth. In addition, the potential consequences of early hospital discharge are explored, and literature relating to military primiparas as special risk group is investigated.

Parenthood As Crisis

People are born, grow, and develop in a social system among other people. There is an interdependence between persons and groups of persons inherent to the human sociocultural environment. Family members, community members, professional workers, and the culture overall influence each person's environment in an interactive manner. The combination of these influences

can affect resolution of a crisis experience (Caplan, 1966).

Caplan (1966) provided the following definition of crisis:

Crisis is an event which is provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved, which may or may not be in the best interest of that person and his fellows (p. 18).

Crises are generally resolved, either adaptively or maladaptively within four to six weeks (Aguilera & Messick, 1974; Caplan, 1964; Hawkins & Gorvine, 1985; Hill, 1949; Robischon, 1967). Crises during a developmental stage frequently require that the person make characterological changes (Aguilera & Messick, 1974). "There may be an awareness of increased feelings of disequilibrium, but intellectual understanding of any correlation with normal developmental change may be inadequate" (Aguilera & Messick, 1974, p. 106). Both cognitive and affective upset occur during this

transitional phase and disequilibrium may result (Caplan, 1964; Hawkins & Gorvine, 1985).

The birth of a first child has been shown to be a time of major adjustments and role changes within a family system. Because the family is a social system, its ability to respond to the stressors in the postpartum period depends upon its sociocultural environment which can provide support for subsequent successful adjustment to parenthood.

LeMasters (1957) investigated first-time parenthood experience in relation to family reorganization, reassignment of roles, and perception of the event as a crisis. He found 83% of first-time parents (N=46 couples) experienced "extensive or severe" crisis in the postpartum period. This study utilized unstructured interviews over a three year period. Both partners in the marriage responded to the interview. A five-point scale identifying varying levels of perceived crisis was utilized.

Dyer (1963) studied first-time parenthood as a crisis in which a family member was added, versus the crisis of the loss of a family member. The questionnaire utilized in this study included a Likert-type scale designed to measure the extent of crisis each couple experienced after the arrival of their first child. The scores were analyzed according to a five-point continuum

similar to LeMasters' (1957) scale. Dyer (1963) found 53% of first-time parents (N=32 couples) experienced extensive or severe crisis following birth, as well as during the postpartum period, while integration of the infant into the family structure was occurring.

Hobbs' (1965, 1968) replications of LeMasters' and Dyer's studies found somewhat conflicting results. The degree of crisis reported by married couples (N=53) was less, evidenced by no couples reporting extensive crisis, while 86.8% reported slight crisis. However, Hobbs recognized that the lack of a valid and reliable measurement for perceived crisis was a central problem in the investigations.

Beauchamp (1968) attempted to rectify the measurement problem in his study on reassessment of transition to parenthood. Again, inconclusive evidence resulted and was attributed to lack of a standard, reliable, and valid measure of difficulties experienced during the postpartum period. In his review of several studies related to parenthood as crisis, Jacoby (1969) offered possible explanations for previous discrepancies in crisis scores. In addition to the lack of valid and reliable measurements, variations in crisis scores were due to the varying time periods following delivery during which measurement occurred.

Russell (1974) extended the focus of parenthood research by identifying positive outcomes of this developmental crisis. High commitment to parenthood, good maternal health, and good communication patterns within the family were identified as variables most relevant to adaptive responses to first-time parenthood. Nearly 80% of a large sample of new parents ($N=511$) in Russell's study perceived slight to moderate crisis.

According to McGowan (1977), stresses experienced during the postpartum period are related to endocrine changes, psychological conflicts, and social and intrapsychic role reorganization. Eighty-seven percent of low-risk first-time mothers ($N=137$) studied showed subjective evidence of anxiety and/or depression, and cognitive dysfunction. In this investigation, fatigue, anxiety, and fear were frequently reported by new mothers. This was considered overwhelming and a drain on physical and emotional resources. The inhibition of parent/child attachment was noted.

Through several investigations of postpartum emotional difficulties, Gordon, Kapostins, & Gordon (1965) identified significant factors related to the new mother's adjustment during the postpartum period. Social and psychological preparation for motherhood were reported to be key factors in reducing postpartum conflict. Their longitudinal study consisted of 306

expectant mothers who were patients at one hospital. Following delivery at that hospital, the new mothers were followed in their homes immediately after discharge, and again at periods of time over a four to six year period. During the first post-discharge visit their postpartum emotional state was measured by a checklist, which had an interrater reliability of .85. Thirty percent of the new mothers reported a high degree of emotional conflict, 37% of whom continued to have emotional problems for at least six months.

LeMasters (1957) stated that even though parenthood is considered "normal", crisis cannot be eliminated, since death is also "normal" and is socially accepted as a crisis event. In the first situation, a family member is added; in the latter, one is removed. The birth of a first child and subsequent parenthood create major transitions and role changes which must be accomplished in order to re-establish a state of equilibrium. Disequilibrium occurs as a result of demands for behavioral changes beyond the new parents' psychological resources. Due to this state of disequilibrium, there is an increase in the family's vulnerability and susceptibility to influence by significant individuals in the family environment (Caplan, 1964; Robischon, 1967). This phenomenon represents a family in crisis. The family can adapt or maladapt depending upon how the

sociocultural environment is manipulated (Caplan, 1966). When described as a transitional period or developmental crisis, first-time parenthood is a stage or phase of the normal life cycle in which psychosocial growth can occur. Therefore, the crisis can either be a period of opportunity or an event that can negatively or harmfully affect future functioning (Caplan, 1964).

Since Western society has romanticized parenthood (Dyer, 1963; LeMasters, 1957), new parents often enter this transitional period with little training, which may leave them with an overwhelming sense of inadequacy and frustration. First-time parents discover that there are radical changes in their pattern of living due to alteration of their previously dyadic relationship. The birth of a first child requires new solutions to problems not previously encountered (Caplan, 1964). Thus, new parents' resources for social support, personal resources, past experience with major life changes, and previously established patterns of role organization will determine the total reaction to the developmental crisis or transitional event (Caplan, 1964).

The stress created by a crisis event cannot be resolved immediately. It may overtake the parents' psychological resources and inhibit their reaching life goals (Hill, 1949). Hill describes postpartum tensions as characteristically temporary, which mount to a peak,

then fall. Previously unresolved problems, both near and from the distant past, may be awakened during this period. A state of disequilibrium temporarily results, whereby the new mother may exhibit symptoms of anxiety and depression (Aguilera & Messick, 1974). Resolution of crisis in a positive manner can be accomplished by assisting the new mother to realistically perceive the event and regain equilibrium. During this period, there exists a challenge to cope with the crisis event so that it can serve as a catalyst to psychosocial growth and increased ability to adapt to future crises (Donaldson, 1981).

There is evidence that 75% of today's new mothers have never had experience with infants before the birth of their first child (Curry, 1983). Previous experience with infants has been shown to decrease the extent to which new mothers encounter difficulty in the postpartum period (Adams, 1963; Curry, 1983). Curry (1983) studied new mothers' adaptation to the first child 36 hours after delivery and again at three months. Subjects were recruited prenatally, at which time demographic data, related to whether or not the pregnancy was planned, and information regarding previous experience with infants and small children was obtained. The only variable with which study subjects differed prenatally was experience with infants and children. At 36 hours, all new mothers

displayed maternal attachment behaviors, such as smiling at the infant, close contact, encompassing, kissing the infant, and holding eye contact. At three months postpartum, the mothers' self-reports identified either an easy or difficult adaptation to motherhood. Those new mothers who reported a difficult time adapting during the first three months also displayed a lower number of attachment behaviors. Differences in attachment behaviors between "easy adapters" and "difficult adapters" were not statistically significant. However, previous experience with small children was determined to effect an easier adjustment to new parenthood for the study subjects. Though the study identified fewer "difficult adapters" (N=5) than "easy adapters" (N=15), Curry (1983) provided a strong argument for further study of the variables that may affect the postpartum experience during the crisis period. The author suggested utilization of a larger sample and careful selection of variables for future investigations of adaptation to motherhood.

Studies have shown that the crisis of new parenthood poses challenges to low-risk, first-time parents. With unavailable support systems, there is an increased risk for maladaptation to the crisis experience. The first-time parents may not have the resources to meet the challenge of new parenthood, which not only makes them

more vulnerable during the crisis period, but also affects their adaptation to future crises. Thus, it is evident that all new mothers, not just those considered to be at high risk for physical or psychological complications, may potentially require additional support during the postpartum period.

Effect of Social Support

Parenting is a learned behavior, not an intuitive function (Rubin, 1967a, 1967b, 1984). If an individual finds adjustment into the new role difficult and receives no assistance, maladaptation to this developmental crisis can occur. Confusion and feelings of unpreparedness are often a result of inadequate preparation for parenthood and ineffectual social support during the postpartum period (Gordon, et al., 1965; Gruis, 1977; McGowan, 1977; Nuckolls, Cassel, & Kaplan, 1972). Rubin (1984) describes the importance of a functionally supportive system of family, spouse, and relevant social groups as being central to the mother's early bond formation with the child. Rubin (1984) also contends that the child is too weak a partner to support the reciprocity required in bond formation. She states that there is a direct relationship between the strength and function of the bonds within the family overall and the quality and

strength of the mother's ability to adequately bond with her child.

Education is considered informational social support (Weinert, 1984). Although education is often provided on the topics of pregnancy, childbirth, and infant care, very little has focused on parenting and the postpartum period (Donaldson, 1981; Gruis, 1977). The areas lacking emphasis are role changes, physiologic stressors, body image changes, infant needs, changes in family status, and other unanticipated stressors. All of these factors are considered critical to the new parent's coping potential and ability to adapt (Donaldson, 1981; Gordon, et al, 1964; McGowan, 1977). As a means of reducing anxiety, some expectant parents are believed to disregard prenatal teaching related to the period following delivery because the parents need to focus completely on coping with the delivery itself (Rubin, 1984).

The literature provides more information regarding high risk mothers than regarding those women who have normal psychosocial histories and uncomplicated pregnancies, deliveries, and postnatal periods. These mothers are considered low-risk and are less likely to encounter difficulties resulting in severe maladaptive parenting behaviors. However, they often need more social support than is believed to be presently available during the postpartum period (Curry, 1983).

Role change has been studied as a stressor in first-time parenthood (Donaldson, 1981; Gordon, et al., 1965; Mercer, 1981; Rubin, 1967a, 1967b). The new mother requires the first three or four weeks after delivery to establish a new role identity through a grief work process related to the loss of her previous role (Rubin, 1967a, 1967b). The new mother's ability to accomplish role reorganization can be positively influenced by certain types of social interaction during the postpartum period. Role reorganization can be negatively influenced by stressful interactions with persons in the new mother's environment, such as overinvolvement by a person who is perceived as nonsupportive (Cronenwett, 1985a, 1985b; Gordon, et al, 1965). Positive interactions with persons, that is, genuine social support, may assist the new mother during this time of general emotional difficulty and psychosocial stress.

Cronenwett (1985a, 1985b) investigated perceived social support and network structures of generally healthy first-time parents. The four phases of her study were conducted during the following periods: 1) within the last twelve weeks of pregnancy, 2) at six weeks postpartum, 3) at five months postpartum, and 4) at eight months postpartum. The four phases were reported in two publications, the first describing the first two phases, while the second publication is a report of the final two

phases. Phase I included a sample size of 108 subjects (54 couples), who were personally interviewed during the third trimester of pregnancy. Phase II included 100 of the original subjects in the sixth week postpartum, Phase III included the 92 remaining subjects at five months postpartum. Phase IV was completed at eight months postpartum by 69 subjects from the original group.

A Social Network Inventory, developed by the investigator, was utilized in Phase I to collect data on network structure and perceived social support. Social networks of all subjects were dominated by relatives. Cronenwett (1985a) suggested that the importance of family members in the expected parents' lives was related to the focus on having a child. Yet, few of the study parents had opportunities to exchange support with other persons going through the same phase of family life development.

In Phase II (Cronenwett, 1985a), a Postpartum Self-evaluation Questionnaire, developed by Lederman, Weingarten, and Lederman (1981) was utilized to measure the dimensions of adaptation to parenthood by mothers and fathers. Relatively positive self-evaluations on the dimensions of adaptation to parenthood were determined by high scores for both mothers and fathers.

In Phase III, Cronenwett (1985b) stated that eighty percent of the women in the sample ($N=92$) perceived

themselves as having needed more social support than was available during the immediate postpartum period. Need for support in the form of information was increased in the third phase of the study. During the third and fourth phases, there was a change noted in the type of persons available for support during these phases, such as an increase in contact with friends, and a decrease in contact with coworkers. No change was noted regarding interpersonal interactions related to emotional support and cognitive guidance.

Some new mothers reported an increase in the number of persons available, yet perceived some persons to be a source of stress rather than support. Cronenwett (1985b) suggested that the nature of the help received was relevant. Other investigators have indicated that if the mother perceives the available support person as a source of stress, the mother is not receiving social support from that person (Brandt & Weinert, 1984; Cobb, 1976; Rubin, 1967a, 1967b; Thoits, 1982). Cronenwett (1985b) emphasized that social support requires an positive interdependent relationship between the individual and his/her support environment.

The women in Cronenwett's (1985a and 1985b) study perceived an increased need for support during the postpartum period. Almost half of the first-time parents reported an increase in stress on their marital

relationships. Bivariate correlations were utilized for analysis with the results indicating that emotional support was the best predictor of satisfaction with parenting role and infant care. This study provided beginning descriptions of the relationships among the kinds of persons to whom new parents turn for support, perceived level of social support, and psychological responses to new parenthood.

In his investigation of the buffering effect of social support on life stress and psychological adjustment, Wilcox (1981) contended that social support is protective in high levels of life change. This contention was supported by findings drawn from five different instruments, each measuring related aspects of social support, life stress, and psychological adjustment in 320 randomly selected subjects. The results of this study clearly supported the hypothesis that social support buffers the relationship between life stress and psychological distress.

Hoff (1978) suggests that lack of social support, needed for the process of maturation, can create stress and turmoil during a time considered to be a naturally occurring turning point. With appropriate support, Hoff contends that the challenges of growth from one stage or phase of life to another can be met. As a result, there can exist a sense of achievement and self-mastery related

to successful completion of a developmental task. Social support can positively affect this transitional or developmental process. Previous problem-solving ability can also affect a person's life-change behaviors. Societal expectation to perform equally well in the new role as mother as in previous roles can contribute to feelings of inadequacy and frustration. If social supports are perceived by the new mother as lacking, she may respond with feelings of inadequacy and frustration (Rubin, 1967b, 1984).

First-time parents are increasingly vulnerable to a crisis-provoking event because they often have no kin readily available and may have few close friends. Society's mobility, smaller families, and less structured family units contribute to the development of relationships outside the family unit. Relationships outside the family unit may be less stable than those traditionally found in the extended family and less able to offer needed support. The trend for the extended family to play a lesser role in the new parent's life was recognized nearly forty years ago (Hill, 1949) and continues to be of concern to current sociologists. Mothers and daughters are separated by greater distances, which decreases availability of maternal support and guidance with child care and adaptation to role change (McGowan, 1977).

Sumner and Fritsch (1977) contend that if the mother perceives a lack of support during the postpartum period, she may respond maladaptively to an already difficult transitional experience. In their descriptive study utilizing the method of monitoring telephone calls from new parents ($N=270$ calls), Sumner and Fritsch identified that the needs of parents during the first six weeks postpartum were largely unmet. Primiparous women called about three and one-half times more frequently than multiparous women. In their concluding statements, Sumner and Fritsch argue that health care providers have planned services as though new mothers are expected to suddenly become independent. They note that all parents could profit from social support during the postpartum period, extending beyond the hospital stay.

Social support may assist new mothers to gain, regain, or utilize inherent personal strengths during the necessarily adaptive postpartum period. Further, social support is believed to positively affect the new mother's mental health (Dean & Lin, 1977). In a study by Lin, Ensel, Simeone, and Kuo (1979), the effects of social support and stressful life events on psychiatric illness/symptoms were investigated. The researchers interviewed a sample of 121 males and 49 females; psychiatric symptomatology and social support were measured. Lin, et al., concluded that social support

performs a mediating role between stressors and psychiatric symptoms. Their study findings suggested that social support contributes significantly and to prevention of mental illness symptoms.

Psychological outcomes are positively affected by the new parents' access to available social support in their sociocultural environment (Brown, 1986; Kendell, Wainwright, Hailey, & Shannon, 1976; Norbeck & Tilden, 1983; Nuckolls, Cassel, & Kaplan, 1972). Kendell, Wainwright, Hailey, and Shannon (1976) searched a population register in London, and identified psychiatric morbidity statistics of couples who were known to have had a child in 1970. The researchers traced 2,242 live births and 15 stillbirths and found that 99 women and 39 men had had psychiatric contacts relative to the time of childbirth. The fathers' rate of new episodes as well as the total number in treatment was low, but the situation was significantly different for the mothers. A notable peak was observed in the three months immediately after the delivery of the child. This suggested that childbirth may contribute to the development of psychotic illnesses. The authors noted that there was a general tendency for new episode rates and the rates of those in treatment to be higher after childbirth than before it.

Social support has been shown to influence the outcome of pregnancy and a new mother's experience as an

environmental mediator (Brown, 1986; Norbeck & Tilden, 1983). A study of the effects of psychosocial variables on pregnancy complications ($N=117$) by Norbeck and Tilden identified high life stress and low social support as having a significant relationship to a high degree of emotional disequilibrium. Brown (1986) proposes that stress plays a consistently important role for new parents and that social support is a balancing force and makes a positive contribution to the new mother's health. Brown's sample consisted of 313 expectant couples. Though data was gathered during the prenatal period, her conclusions indicate that there is an association between social support, stress, and health. Brown (1986) suggests that the "dramatic physiologic changes accompanying pregnancy made women more vulnerable to the effects of stress on their health" (p. 75).

Nuckolls, Cassel, and Kaplan (1972) investigated psychological assets, life crisis, and the prognosis of pregnancy. Their study of relationships between social stress and psychological assets of 170 military primiparas occurred at intervals during the perinatal period. At the time of prenatal registration, subjects completed a questionnaire, developed by Nuckolls (1967). The questionnaire was designed to represent the woman's adaptive potential for pregnancy. At 32 weeks gestation, determinations were made regarding whether the subjects'

pregnancy would be considered complicated or uncomplicated by medical record review and a concomitant use of criteria established by the researcher. The level of the mother's life crisis was measured at 32 weeks gestation by the life change score obtained from the Schedule of Recent Experiences (Holmes & Rahe, 1966), which was mailed to study subjects.

Life change scores were high both before and during pregnancy, yet women with high psychosocial assets had one-third the pregnancy complication rate of women whose psychosocial assets were low. The authors indicated that socially stressful events and multiple psychosocial assets, when considered separately, will not be consistently related to poor health status. Instead, in future studies, a balance between the two should be assessed to determine their effect on disease susceptibility.

Fisher (1987), an anthropologist, analyzed divorce statistics and found that the average age at which Americans experience a divorce is 20 to 24 years for both men and women. Those couples who have only one child are most vulnerable to marital problems leading to divorce. She emphasized the importance of couples seeking help soon after encountering difficulties with their relationship.

First-time parents were subjects of a study by Belsky, Lang, and Rovine (1985). The purpose of their investigation was to determine changes in marital relationships after the birth of a first child. Changes in the marital relationship perceived by first-time mothers were greater than those perceived by first-time fathers, particularly in the early postpartum months. Marital satisfaction following the birth of a first child was noted to be decreased in studies conducted by Belsky and Pensky (1987). This change in the marital relationship is considered to be related to role change and alteration in family status. The authors suggested that the transition to new parenthood could be made easier if information and assistance were made available to new parents during crisis periods.

Crockenberg (1981) investigated maternal-child attachment, infant behavior, and the effect of social support on the development of a secure mother-child relationship. In her sample of 48 mothers and their infants, 31 were firstborn and 17 secondborn infants. All were considered to be at low risk for postpartum complications. Infant behavior was measured by the Neonatal Behavioral Assessment Examination designed by Brazelton (Brazelton, 1973). Mother-infant relationships were observed and recorded according to the Brazelton scale during a home visit on the fifth and tenth days

following birth. At three months post-delivery, another home visit was made during which three and one-half hours were utilized for observation and one-half hour was used for a structured interview to measure social support. A positive relationship was found between the mother's perceived level of social support and the security of the infant-mother attachment. Since the instrument used to measure social support did not have established reliability or validity, the results must be interpreted with caution. However, a useful theoretical approach was developed and this can be utilized in future research on infant-mother relationships and the role of social support.

Cobb (1976) discussed the moderating effect of social support on life stress. He refers to the buffering effect of social support following a major life event. In his view, social support eases adaptation to change, facilitates coping with crisis, and contributes significantly to decreasing psychiatric illness symptoms. Support services can be critical in preventing maladaptive behaviors in the postpartum period as well as positively affecting the reduction of maternal physiological trauma, such as hemorrhage, sepsis, and delayed involution (Donaldson, 1981). During the immediate postpartum period, both the new parents and the baby are attempting to adjust to one another and to their

environment; the adjustment period will ultimately affect their future adaptive progress (Sumner & Fritsch, 1977; Rubin, 1967a, 1967b, 1984).

Rubin (1984) states that the prolonged fatigue of the immediate postpartum period makes this phase one of the most difficult in the experience of parenthood. In addition, she states that disorientation, depressed mood state, and despair are more pronounced in the primipara than in the multipara. These psychological symptoms occur in "roller coaster" fashion during the first week following delivery. Rubin (1984) relates this situation as being heightened in societies which do not allow adequate time for physical recovery, while demanding fully developed maternal behavior during the early childrearing phase. Also, Rubin (1984) contends that the discrepancy between the new mother's apathy, depression, and unrealistic self-expectations, add to the overall feeling of loss, disconnectedness, and inadequacy.

Consequences of Early Discharge

Donaldson (1981) and Jansson (1985) recognized a recent trend for new mothers to be discharged from the hospital within 48 hours following the delivery of the baby and noted the concerns of many postpartum nurses. These hospital-based postpartum nurses emphasized the lack of time available for assisting new mothers in baby

care, assessing the mother/child relationship, and providing postpartum education. Since Western society has traditionally provided prenatal education for expectant parents, while virtually ignoring the postpartum period, a "fourth trimester void" has been created (Donaldson, 1981, p. 282).

Jansson (1985) discussed the advantages and disadvantages of sending mothers and newborns home 24 to 48 hours after delivery. Hospital costs are reduced and the risk of nosocomial infections is decreased. Also, with early discharge, mothers and infants are more apt to develop feeding and visiting schedules that better suit their needs. These are factors that may enhance parent/child bonding and decrease family life disruption. However, Jansson (1985) clearly noted that only with professional nursing follow-up after early discharge can parental anxieties and health risks be prevented. Jansson (1985) advocated a program of maternal neonatal follow-up as an integral part of comprehensive maternity care.

With increasingly shortened hospital stays there is a need for professional nurses to identify social supports prior to hospital discharge. Gruis (1977) utilized a mailed questionnaire to ascertain the types of concerns experienced by new mothers. In her sample (N=40), 17 subjects were primiparas and 23 subjects

were multiparas in their fourth week post-delivery, all of whom had delivered in private hospitals. Each subject met three criteria, including normal infant discharged with the mother, hospital stay of no more than four days, and the father of the baby living in the mother's home during the study period. The respondents identified areas of significant concern within the past month, ranked these concerns as minor or major, and described the resources used to deal with these concerns.

The most frequently cited concern by study subjects was the return to their pre-pregnancy body shapes (Gruis, 1977). In addition, the majority reported concerns about emotional tension, fatigue, feelings of isolation, and not having enough time to pursue personal interests and meet personal needs. Only eight of the forty respondents received a home visit by a public health nurse. All of the study subjects described prenatal classes as helpful in preparation for the postpartum period, but stated that the classes did not reduce the number of concerns they experienced after birth. In Gruis' (1977) investigation, concerns related to infant care prompted the mothers to seek help, but they were reluctant to seek advice about their physiologic status, role change, and marital relationship. These results indicate that parent teaching during the prenatal period should not preclude professional nursing support in the home during the

postpartum period. With increasingly shortened hospital stays there is a need for professional nurses to identify social supports prior to hospital discharge (Gruis, 1977), and to be available for intervention in the home following delivery.

Many postpartum nurses recognize that the new mother's receptiveness to teaching is minimized during the first three days following delivery. This lack of receptiveness to teaching was reported in an earlier investigation by Rubin (1967a, 1967b) and is related to the new mother's need and desire for physical restoration and establishment of a relationship with her infant. This phenomenon decreases the effectiveness of hospital-based postpartum education, and increases the risk for postpartum maladaptation following discharge. Rubin (1984) described the experience of childbearing as one that leaves the new mother oscillating between happiness at achieving the task of successfully giving birth and depression due to her low levels of energy, decreased feelings of intactness, and threatened sense of well-being in the immediate postpartum period. Because of early hospital discharge the uncertainties and difficulties of new parenthood are now often being experienced by mothers at home without professional support (Curry, 1983; Sumner & Fritsch, 1977).

Military Primiparous Women as a Social Risk Group

Rodriquez (1984) described the unique family dynamics of the military population, and the special needs of persons living in the armed services. Multicultural and multiethnic settings were identified as possibly threatening to service members and their families. Rodriquez (1984) described military life as being occupationally centered, regimented, with a heirarchical organization which creates "...unique supports and unique problems that emerge as elements in either adaptive or maladaptive functioning" (p. 51). In addition, military life is viewed as possibly leading to feelings of significant loss in relation to personal goals, self-image, and important persons, especially extended family members. Military life can decrease integration with many aspects of nonmilitary community life, such as social, occupational, school, and interpersonal environments. Some military families have difficulty adjusting to the multiple changes required. However, "...pride and a 'can do' military attitude" (Rodriquez, 1984, p. 53), as well as a fear of a negative effect on military career, may prevent military families from seeking appropriate support services. According to Rodriquez, the serviceman and his/her family must deal with stressful circumstances such as comparatively low

pay, limited housing, status incongruency (especially for ethnic minorities and women), and frequent moves.

Military life may have its strengths related to being regimented, rule-oriented, and predictable, all of which allow some persons to feel safe and secure. Yet, aspects of military community life pose unique problems that should be of concern to health care providers, particularly when there are limited health care and support services available within the military compound. Military families now comprise two to three percent of all United States households (O'Keefe, 1984). As such, the health and well-being of this group of persons is significant to society as a whole.

CHAPTER 3

METHODOLOGY

The design of the study, sampling procedures, and description of data collection are discussed. In addition, the plan for data analysis is reported.

Research Design

The study was descriptive, and utilized personal interview for data collection. The main purpose of the study was to describe the phenomenon of perceived social support among first-time mothers following early hospital discharge. In addition, perceived levels of social support experienced by military and nonmilitary primiparas were correlated with certain demographic variables. The investigation of perceived levels of social support occurred during the natural course of subjects' postpartum events without experimental intervention by the researcher.

Population and Sample

Target Population

The target population for this investigation consisted of low-risk primiparous women discharged from a

major Montana hospital postpartum unit within 72 hours of delivery.

Location of Study

This study was conducted in a Montana metropolitan community, and included postpartum clients residing within the surrounding 40 miles.

The study community has a population of 58,250, and is one of Montana's largest cities with a Standard Metropolitan Statistical Area population of 83,689. Located in northcentral Montana, the community includes 12 counties in its trade area of farm and ranch industries, and these form its most important economic base. A military base which was included in the study area has 9,000 military and civilian wage-earners. The military personnel and their families contribute to the quality of cultural, civic and economic life in the study community and surrounding area.

Subjects for the study were accessed through one of the two major hospitals in the community. The study hospital averages 116 live births per month, with 43 expected to be normal spontaneous vaginal deliveries of primiparous women (B. Luft, personal communication, October, 1987).

Study Sample

Sample size. The purposive sample included mothers who delivered their first child in a hospital setting, were discharged with their infants within 72 hours after delivery, and experienced an uncomplicated pregnancy, labor, delivery, and immediate postpartum period. During a period of four months, the study hospital had a total of 419 live births (B.Luft, personal communication, October, 1988). One-hundred fifty-four of these live births were to primiparous women, 43 of whom met the criteria for this investigation. Thirty-six of these 43 primiparas consented to participate in the study; an 84% participation rate. The resulting sample size was 17 military and 19 nonmilitary new mothers. This sample was judged to be adequate for this exploratory investigation. A total sample size of 36 subjects allowed adequate data for descriptive analysis procedures and permitted collection of data within a reasonable time frame.

Criteria for Inclusion in Study. The purposive sample included first-time mothers reporting themselves to be married, living with their spouse, between 20 and 35 years of age, and meeting residence criteria. Additional criteria for inclusion in the study included determination that each subject was a low-risk primipara on the basis of hospital chart review and utilization of

the Risk Assessment tool which addressed specific risk factors (see Appendix B).

Data Collection Procedures

Subject Access

Approval for Access to Subjects. Following approval by Montana State University College of Nursing Human Subjects Review Committee and approval for access to subjects by the clinical agency, potential subjects were contacted regarding study participation. Those primiparous women meeting the criteria for the study were approached by the researcher on the hospital postpartum unit prior to discharge, between six and twenty-four hours after delivery. The physical condition of each woman was determined before they were approached regarding the study. Information from the charge nurse on the postpartum unit was obtained by the researcher to determine an appropriate time to contact each potential subject.

Obtaining Written Consent. A written explanation of the study was provided to participants contacted in the hospital (see Appendix A). Written consent (see Appendix A) for interview at the participant's home within the first week postpartum was acquired. Each participant was assured regarding confidentiality. In addition, the

participant was assured that neither her consent or refusal to participate would negatively affect any health care or social services she was currently receiving or might receive in the future. No appointments for interview were made while the participant was in the hospital.

Telephone Contact. Following hospital discharge, telephone contact was made. During this call, an appointment for the interview was scheduled at a time convenient for the participant. The day prior to the scheduled appointment, the researcher contacted the participant by telephone in order to establish continued willingness to participate in the study and to verify the scheduled time for the interview. The importance of privacy during the interview was made clear to the subject during each telephone contact.

Method of Data Collection. An interview approach was used because participants were expected to be fatigued and anxious in the first week following delivery. They were believed to be more likely to respond to a personal interview than to complete a questionnaire. The interview format allowed for explanation of questions which the respondents found confusing or ambiguous. An additional advantage to the interview approach was assurance that the desired

respondent was the individual actually providing the data.

Instruments and Measures

Interview Instrument. Data were collected by personal interview conducted by the researcher in the subject's home. The interview instrument included: the demographic data sheet, the PRQ-85 Part 1, additional questions related to the childbirth experience, and the PRQ-85 Part 2 (see Appendix C).

The demographic data sheet utilized in the study is presented in Appendix C. Questions one through six address basic demographic background. Question number seven was included to indicate whether or not the new mother planned to return to her pre-delivery job. This information was used to identify co-workers as a possible support system. Demographic questions nine and ten were used to determine if a family member, relative, or friend was staying in the new mother's home during the time of the interview. If so, the participant's responses to the PRQ-Part I were expected to indicate whether or not the individual(s) was (were) perceived as supportive.

In order to identify military and nonmilitary respondents, question number 11 was included. Number of years residing in the community was viewed as indicating opportunity, or lack thereof, for integration into

community social support systems, and was ascertained through question number 12.

The Personal Resource Questionnaire (PRQ-85), developed by Brandt and Weinert (1984), was utilized for the study (see Appendix C). It is a two-part measure of sources for social support. In the PRQ Part I, respondents identify the recent necessity for support in ten life situations, describe the number and type of resources available for support, and relate the level of satisfaction with these resources. The PRQ-85 Part 1 also identifies the existence of a confidant. Weinert (1984) states that:

The PRQ Part I measures provision of attachment for intimacy; social integration, i.e., being an integral part of a group; opportunity for nurturant behavior; reassurance of worth as an individual and in role accomplishments, and availability of informational, emotional, and material help (p. 62).

These dimensions are measured in terms of the individual's perceptions, that is, that person's perceived level of social support..

The PRQ-85 Part II has a seven-point Likert format, composed of 25 items, rated from "strongly agree" (7) to

"strongly disagree" (1). These questions measure specific dimensions of social support. Part 2 of the PRQ-85 measures theoretical constructs; these are intimacy, social integration, nurturance, worth, and assistance. These five dimensions can be described by respondents as occurring within or outside the family system.

The PRQ-85 was deemed appropriate for this study because it is a widely used general indicator for perceived social support with established psychometric properties. A number of procedures have been utilized to establish validity of the PRQ. The predictive validity coefficients for Part 1 range from .21 to .23 ($p < .004$); while predictive validity coefficients for Part II range from .30 to .41 ($p < .001$) (Brandt & Weinert, 1981). Utilizing Chronbach's alpha, estimates of reliability for PRQ Part II range from .85 to .93. Some variability, yet basic consistency has been noted in estimates of subscale reliability (Weinert, 1984). Test-retest reliability estimates are .72, ($p < .001$) for Part 2 of the PRQ (perceived social support); while interpersonal resources identified in PRQ Part 1 showed a test-retest reliability of .81, ($p < .001$).

Written and verbal permission were obtained from Weinert (see Appendix A) to utilize the PRQ-85 and to add

pertinent questions specifically related to the experience of the birth of a first child.

Four questions specific to the childbirth experience, formatted in the same manner as the PRQ-85 Part 1, were used to address the life experience related to the birth of a first child, the support received, and the efficacy of that support (see Appendix C). The additional questions pertain to general concerns about becoming a new mother, body (physiologic) changes related to the birth of her baby, feelings (psychological concerns) about the new role, and baby care concerns.

Procedure for Data Analysis

The purpose of this study was to describe perceived levels of social support among low-risk primiparas following early hospital discharge and to compare the social support levels of military and nonmilitary primiparas.

Descriptive Analysis of Demographics

Demographic data were analyzed descriptively for the entire sample and separately for those in the military and nonmilitary sample groups. Age, number of years of education, length of time residing in the community, and number of persons living in the household at the time of data collection were of particular

interest as background variables, since they were believed to have an effect on the person's perception of social support. In addition, co-workers as a resource for support was ascertained.

Descriptive Analysis

PRQ-85 Part I

The study subjects' perceptions of social support were analyzed as a group and by military and nonmilitary subgroups. Life situations requiring support which were most commonly experienced by the subjects were tabulated and displayed as percentages. The individuals to whom the subjects were most likely to turn for support and the level of satisfaction with the help received was summarized. The number of supports available in each life situation was described for the total sample as well as for each subgroup.

Descriptive Analysis of New Motherhood Questions

Four specific concerns related to the childbirth experience were analyzed descriptively. Information regarding the help needed, its availability, and who provided the help was presented in percentage frequency distributions.

Analysis of the questions related to the new parenting experience indicated whether perceived levels of support were higher for general concerns,

physiological needs, psychological needs, or concerns about baby care. In addition, descriptive summaries indicated areas of greatest perceived satisfaction with available support.

Analysis of the PRQ-Part II

Cronbach's alpha was utilized to determine the reliability of the PRQ Part II with the study sample. Standard deviations and mean scores from the PRQ-85 Part II were calculated. Mean scores provided a general indicator of perceived social support for the sample and were contrasted by t-test to determine differences between the military and nonmilitary subgroups. Pearson correlation coefficients were calculated in order to examine relationships between the PRQ-85 Part II scores, as a measure of perceived social support, and the variables age, education, length of community residence, and the number of persons living in the household at the time of interview.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

The purpose of this study was to describe perceived levels of social support among low-risk primiparas following early hospital discharge, and to compare the perceived social support levels of military and nonmilitary primiparas. A descriptive design was utilized for this study. Data was collected by personal interview in the subjects' homes during the first week postpartum. The data analysis is presented as follows:

- (1) descriptive analysis of demographic characteristics,
- (2) descriptive analysis of data obtained from the PRQ-85 Part I,
- (3) descriptive analysis of the additional questions pertaining to the experience of new motherhood,
- and (4) analysis of the PRQ-85 Part II.

Descriptive Analysis of Demographics

Data obtained through demographic questions (Appendix C) included; (1) basic demographic background questions, (2) educational background, (3) employment status before delivery and plans for employment after delivery, (4) occupations, (4) presence of additional persons in the home at the time of interview, (5) number

of years of residence in the study community, and (6) military/nonmilitary status of either the subject or her husband.

Target Population

The target population for this study consisted of low-risk primiparous women discharged from a major Montana hospital postpartum unit within 72 hours of delivery. The study was conducted in a northcentral Montana metropolitan community, and included postpartum clients residing within the surrounding 40 miles. A military base is adjacent to the study community which has 9,000 military and civilian wage-earners. Subjects were accessed through one of the major hospitals in the community. The study hospital is the primary source of obstetrical care for the military and nonmilitary population.

All subjects for this investigation delivered their first child in the study hospital, were discharged with their infants within approximately 72 hours after delivery, and experienced an uncomplicated pregnancy, labor, delivery, and immediate postpartum period. All study subjects reported themselves to be married, living with their spouse, were 20 to 35 years of age, and resided within 40 miles of the study community.

Unanticipated delays in data collection occurred as a result of fewer than expected primiparas who met the criteria for this study. The study hospital averages 116 live births per month, with 43 expected to be normal spontaneous vaginal deliveries of primiparous women. At least one-third of those who would meet study criteria were expected to refuse study participation. The period of time for data collection was anticipated to be, at most, three months. Yet, of the 419 live births at the study hospital during the data collection period, 154 were normal spontaneous vaginal deliveries to primiparous women; the expected number. Only 43 of the 154 vaginal deliveries were to women who met the criteria for this investigation, that is, were determined to be low-risk. The determination of low-risk was made through utilization of a Risk Assessment Tool developed by the researcher (Appendix B). The remaining 111 deliveries were to single women of all ages, teenaged mothers, and primiparas with other risk factors. As a result, data collection spanned a four month period, with an average of ten interviews per month. Fortunately, an 84% participation rate was appreciated by the researcher in attempts to collect a workable sample size within a reasonable time frame.

Sample Characteristics

A total of 36 subjects were interviewed, including 17 military and 19 nonmilitary primiparas. One of the subjects was Hispanic, two were Black, and the remaining 33 were Caucasian. The subjects' ages ranged from 20 to 34, with five of the military primiparas' over 24 years of age, and nine of the nonmilitary subjects over 24 years of age.

Twelve subjects in the sample had earned college degrees, with five of these being military subjects and seven being nonmilitary subjects. A high school education was the highest level of education for eight subjects, seven of whom were military subjects. The remaining 16 subjects had varying levels of post-secondary education.

Twenty-five of the subjects were employed outside the home prior to delivery. Eight of the military subjects and fourteen (73.68%) of the nonmilitary subjects were gainfully employed on a full-time basis prior to delivery. Two of the military subjects and one of the nonmilitary subjects were employed part-time. The remaining eleven subjects were not employed outside the home; seven were military primiparas and four were nonmilitary primiparas.

Subjects' occupations included the following areas: military, legal/professional, student, business

ownership, practical and professional nursing, and secretarial/clerical work. Sixteen of the subjects were employed in secretarial/clerical work; eleven were military subjects and five were nonmilitary subjects. Of the subjects planning to work part-time following the postpartum period, half were nonmilitary subjects employed full-time prior to delivery. Only one military individual had plans to reduce work hours from full-time to part-time following the postpartum period. In both groups, those women who were not gainfully employed outside the home prior to delivery had no intention of seeking employment after the postpartum period.

Less than one-fourth ($\underline{n}=5$ or 13.9%) of the entire sample had anyone except their spouses and infants, residing in the household during the time of interview. One military primipara was caring for her baby alone since her husband was on tour of duty in another state. Slight difference was noted between the military and nonmilitary subgroups based on additional persons in the home at the time of interview. In this sample, military primiparas ($\underline{n}=4$) were more apt to have additional persons living in the home at the time of interview than those mothers in the nonmilitary subgroup ($\underline{n}=1$). Mothers and mother-in-laws were the additional persons most likely to be present in the home. Based on age, education, and

number of persons residing in the household at the time of interview, the sample is homogenous.

The number of years of residence in the community ranged from zero to 30 years for the entire sample. Of those who lived in the community between zero and five years, 14 were military subjects, and 11 were in the nonmilitary subgroup. Two military subjects had been residents of the study community for more than 15 years, while five of the nonmilitary subjects had lived in the community between 15 and 28 years. The number of years of residence in the community represents the variable with the most significant difference between the two subgroups.

The mean number of years in community residence for military subjects was 4.41 years, while nonmilitary subjects had been in residence an average of 8.68 years. The median number of years of residence in the study community was two years for the military subgroup, and four years for the nonmilitary subgroup. Twelve of the military subjects had lived in the community for two years or less, whereas six of the nonmilitary subjects had resided in the study community for two years or less. In this regard, the sample studied is similar to military and nonmilitary families in general. The military subjects are far less likely to experience long-term residence and integration into a community than the

nonmilitary subjects. Table 1 summarizes the demographic characteristics of the sample.

Table 1. Demographic Characteristics.

	Entire sample <u>N=36</u>		Military <u>n=17</u>		Nonmilitary <u>n=19</u>	
	mean	S.D.	mean	S.D.	mean	S.D.
Age	24.30	3.21	23.47	3.11	25.05	3.21
Yrs. of Education	14.25	2.02	13.71	2.05	14.74	1.91
No. of Persons in Home*	3.25	1.05	3.47	1.51	3.05	0.23
Yrs. of Residence	6.67	8.63	4.41	6.84	8.68	9.70

*Note: The number of persons in the home at the time of interview includes the new mother, her husband, and their baby.

Descriptive Analysis of the PRQ-85 Part I

The PRQ-85 is a two-part measure of social support. The first part of the instrument, the PRQ-85 Part I, identified the respondents' recent experience with each of ten life situations in which support was needed. The number of resources for and kinds of social support

available in each of those situations, and satisfaction with the support received was addressed.

Frequently Cited Needs

Of the ten life situations addressed in the PRQ-85 Part I, the five situations most commonly experienced by the subjects were "urgent needs", "family/friend related problems", "loneliness", "illness", and "day to day concerns". The other five life situations of "needing help caring for a sick or handicapped family member", "concerns about marital relationship", "problems with work in or out of the home", "frustration with conditions of life", and "financial problems" were infrequently cited. Each of the five commonly experienced life situations are discussed in relationship to responses from the entire sample and from the military and nonmilitary subgroups.

The needs identified by the PRQ-85 Part I were those needs which the subject had experienced in the six months prior to interview for which social support might be required. If the subject had experienced the need addressed, a subsequent question determined the satisfaction with the support available for dealing with that need.

One third of the entire sample ($n=12$) described having experienced "urgent needs" within the six months

preceding the interview. Seven military primiparas and five nonmilitary primiparas had experienced urgent needs.

Thirteen (36.11%) of the study subjects cited concerns related to "problems with family members or friends" during the past six months. More nonmilitary subjects ($\underline{n}=8$) described family-related problems than military subjects ($\underline{n}=5$).

Over one-third ($\underline{n}=14$ or 38.89%) of the entire sample indicated feelings of "loneliness" in the six months prior to delivery. Military and nonmilitary subgroup numbers were similar, with seven of the military and seven of the nonmilitary subjects having recently experienced loneliness.

One-third ($\underline{n}=12$ or 33.33%) of the entire sample described having had an "illness" which detained them from carrying out usual activities in the last six months of pregnancy. Twice as many military as nonmilitary subjects described this illness-related experience ($\underline{n}=8$ versus $\underline{n}=4$).

Most ($\underline{n}=29$ or 80.56%) of the subjects in the sample experienced "day to day concerns". A similar number of military ($\underline{n}=15$) and nonmilitary subjects ($\underline{n}=14$) described having had needs requiring social support for day-to-day concerns. Table 2 summarizes the frequent needs of subjects as described on the PRQ-85 Part I.

Table 2. PRQ-Part I-Most Frequently Cited Needs
Requiring Social Support.

	Entire sample <u>N</u> =36		Military <u>n</u> =17		Nonmilitary <u>n</u> =19	
	<u>n</u>	%	<u>n</u>	%	<u>n</u>	%
Urgent needs	12	33.33	7	41.18	5	26.32
Family/Friend Problems	13	36.11	5	29.41	8	42.11
Lonely	14	38.89	7	41.18	7	36.84
Illness	12	33.33	8	47.06	4	21.05
Day to day Concerns	29	80.55	15	88.24	14	73.68

Number of Supports Available

Each subject was questioned as to the persons available for support in relation to each of the ten life situations addressed in the PRQ-Part I. The determination of available support persons for each life situation was made even though the subject may not have recently experienced such needs. The mean number of supports available to the entire sample for all of the ten life situations addressed in the PRQ-Part I was 1.7. The military subgroup perceived an average of 1.8

supports to be available, while nonmilitary subjects could count on a mean of 2.0 support persons.

Social Support Resources

The most frequently available support persons in the order cited by study subjects were "husbands", "parents", (other) "relatives", and "friends". Few subjects described "neighbors", "professionals", "agencies", or "self-help groups" as supports on whom they would rely for help in dealing with the ten life situations. Nonmilitary primiparas cited (other) "relatives" as available supports more frequently than those in the military subgroup (60 times versus 29 times). Military primiparas cited "parents" as supports 55 times, whereas nonmilitary primiparas cited "parents" 89 times as a source of support during the ten life situations addressed in the PRQ-85 Part I.

Satisfaction with Available Support

Satisfaction with available support during times of need was reported to be moderate to high for all subjects. The mean satisfaction score was 5.7 on a scale of 6.0. Loneliness was the life situation in which the level of satisfaction was the lowest (5.4). The areas of highest satisfaction were related to needing help over an extended period of time and spousal relationships. Mean scores in those two areas were 6.0. There were no

meaningful differences between military and nonmilitary subgroups on the PRQ-85 Part I, overall, with the mean score of 5.7 for military primiparas and 5.8 for nonmilitary primiparas. Both subgroups found available supports to be satisfactory during times of need and association with the military did not significantly alter the efficacy of available social supports.

Descriptive Analysis of New Motherhood Questions

Additional questions were developed by the researcher to ascertain needs for social support specifically related to the postpartum period, identify the number and types of individuals to whom the respondents would turn for support, and assess the efficacy of the support available.

Results from the four additional questions concerning the life experience of new motherhood are described individually. These questions related to general concerns about becoming a new mother, concerns about body (physiologic) changes resulting from the childbirth experience, feelings associated with new motherhood (psychological needs), and baby care concerns.

Frequently Cited Needs

The four issues related to the new experience of motherhood were identified by all of the subjects as

areas of need for social support. The first of the four additional questions addressed "general concerns", concerns related to becoming a new mother. Such concerns were experienced by most of the subjects, both military ($n=16$) and nonmilitary ($n=17$).

Well over half ($n=25$ or 69.44%) of the entire sample expressed needs for social support in relation to "body changes experienced in the immediate postpartum period". Military primiparas ($n=12$ or 70.59%) were as apt to describe concerns about physiological changes as primiparas in the nonmilitary subgroup ($n=13$ or 68.42%).

Psychological needs were indicated by almost three-fourths ($n=25$ or 69.44%) of the sample studied. Over three-fourths ($n=13$ or 76.47%) of the military subjects described a need to discuss "feelings about the new motherhood experience" with someone, and 63.16% ($n=12$) of the nonmilitary subjects indicated such needs.

Twenty-six of the thirty-six (72.22%) study subjects cited "baby care" as an area of concern which required social support. A nearly equal number in each subgroup stated that they had needed support or help regarding baby care; 12 (70.59%) of the military subjects and 14 (73.68%) of the nonmilitary subjects expressed a need for assistance with baby care. Table 3 summarizes data related to the four questions about the new experience of motherhood.

Table 3. Expressed Needs for Help/Support With New Motherhood Concerns.

	Entire sample N=36		Military n=17		Nonmilitary n=19	
	<u>n</u>	%	<u>n</u>	%	<u>n</u>	%
General concerns	33	91.67	16	94.12	17	89.47
Physiologic needs	25	69.44	12	70.59	13	68.42
Psychological needs	25	69.44	13	76.47	12	63.16
Baby Care concerns	26	72.22	12	70.59	14	73.68

Number of Supports Available

Twenty-one of the 36 study subjects (58.33%) perceived two or fewer persons to be available for support in relation to their new motherhood concerns. Military and nonmilitary subjects were similar on the number of available supports for all new motherhood concerns except baby care. Nine (52.94%) military subjects and seven (36.84%) nonmilitary subjects perceived two or fewer persons available to answer questions concerning baby care.

Social Support Resources

Persons most often cited by the entire sample as supports in relation to the overall experience of new motherhood were "parents", "husbands", (other) "relatives", "friends", and "professionals". Nonmilitary primiparas cited (other) "relatives" as being available for support more than did the military subjects (32 citations versus 10 citations). The availability of supports, such as "parents", "husbands", "friends", and "professionals" was similar between military and nonmilitary subgroups for the three specific areas of "general concerns", "physiologic needs", and "baby care concerns".

The new motherhood concern related to "psychological needs" was an area in which the subjects indicated unavailability of "professional" persons. Subjects in both military and nonmilitary subgroups indicated that they were not as apt to turn to a "professional" person for support in relation to "psychological needs" as to "husbands", "parents", and "friends". For example, "professionals" were cited as being supports for three military primiparas and five nonmilitary primiparas for concerns related to psychological needs. For each of the other three new motherhood concerns, over half ($\bar{x} = 9$) of military subjects and almost two-thirds ($\bar{x} = 12$) cited "professionals" as supports. "Baby care" was the area of

concern for which support from "professionals" was most often cited as a source of support. Eleven of the 17 military subjects (64.71%) and 17 of the 19 nonmilitary subjects (89.47%) stated that they had "professionals" available for support in relation to "baby care concerns". Two persons stated that they had received a telephone call from a nurse at the City-County Health Department.

Satisfaction with Available Support

Satisfaction with support was indicated on a scale of one to six. Satisfaction with the available support in the four areas of concern related to new motherhood was moderate to high. All subjects gave ratings of four to six on the scale in all four areas. The area of greatest satisfaction with available support for the entire sample was related to "general concerns" about becoming a new mother, with a mean score of 5.9. The area of least satisfaction with support was for "psychological needs", with a mean score of 5.6.

No significant difference existed between the satisfaction levels of military and nonmilitary subjects in any of the four categories related to new motherhood concerns. Eight subjects, five of whom were in the military subgroup, described the lack of consistency in information from postpartum nurses as their reason for

less satisfaction with support regarding "baby care concerns". Two of the subjects described a need to discover for themselves what is involved in baby care, since the instructions provided by nurses during their hospital stay were seen as confusing and contradictory. Some subjects who offered additional information indicated that they had not received a visit by a community health nurse at the time of interview, others were not aware that this service was available. Three subjects indicated awareness of written instructions regarding expected physical and psychological changes, breast feeding, and baby care provided by the hospital nurses prior to discharge. Those subjects aware of that written resource had not yet taken the time to read it.

Analysis of the PRQ-85 Part II

The PRQ-85 Part II ascertained the subjects' perceived level of social support by measuring the five theoretical constructs of social support; intimacy, social integration, nurturance, worth, and assistance. Cronbach's alpha was utilized to determine the reliability of the PRQ-85 Part II with the study sample. Standard deviations and mean social support scores were analyzed for the entire sample and for the military and nonmilitary subgroups. T-tests were used to examine differences between the scores relating perceived levels

of social support by military and nonmilitary primiparas. Pearson correlation coefficients were calculated in order to examine relationships between the PRQ-85 Part II scores and relevant demographic variables.

Cronbach's alpha for the PRQ-Part II was 0.80, indicating a high degree of internal consistency and reliability for the instrument with the study sample. The mean score on the PRQ-85 Part II for the entire sample was 159.5, with possible scale scores ranging from 25 to 175. Higher scores indicate higher levels of perceived social support. The mean score provides a general indicator of perceived social support for the study sample. Military subjects had a mean score of 156.6, while nonmilitary subjects had a mean score of 162.1. The range of scores on the PRQ-85 Part II was from 141.0 to 175.0 for the entire sample, the range for military subjects was from 141.0 to 169.0 and for nonmilitary subjects was from 144.0 to 175.0. Contrasting the mean scores of military and nonmilitary subjects by t-tests indicated no statistically significant difference. In previous studies, the mean scores obtained on the PRQ-85 Part II have been slightly lower, ranging from 139.0 (Catanzaro, 1986) to 142.0 (Weinert, 1984). In both of those studies, the mean age of study subjects was considerably higher than in the present study ($\bar{x}=47$, $\bar{x}=49$).

Pearson Correlation Coefficients were calculated in order to determine if there was a relationship between certain demographic variables and the level of perceived social support. The total PRQ score was correlated with the variables of age, number of years of residence in the study community, number of years of education, and number of persons residing in the household at the time of interview.

The correlation coefficients for the variables were as follows: age, $r = .1048$; years of residence in the study community, $r = -.0287$; number of years of education, $r = .1892$; and number of persons residing in the household, $r = .0397$. These values indicate no significant relationship between the social support score and any of the demographic variables. Lack of such relationships appears strongly related to the homogeneity of the study sample.

CHAPTER 5

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

The theoretical framework for this study was based on the major concepts of the crisis of parenthood and the role of postpartum social support. Related subconcepts considered were special risks associated with early hospital discharge and the military lifestyle. Social support has been described as a buffer against life stresses (Cobb, 1976). The stressors of the birth of a first child create major adjustments and role changes within a family system, to which the new family can either adapt or maladapt.

This investigation was conducted in order to assess perceived levels of social support of low-risk, first-time mothers in a rural, northcentral Montana community. Personal interviews were conducted in the subjects' homes within one week of delivery. Few studies of social support of low-risk, first-time mothers have been conducted. However, a lack of social support is increasingly viewed as important in determining risk for maladaptation to new parenthood, even among women in low-risk situations (Curry, 1983; Donaldson, 1981).

Early hospital discharge is regarded as a situation which may increase risk for maladaptation to the crisis of new parenthood. At present, the usual hospital stay for new mothers, including primiparas, is 24 to 48 hours. Given the current level of mobility in society, more and more new mothers are believed to be meeting the challenges of first-time parenthood alone. New mothers are often without support from hospital and staff and without guidance from extended family members or close friends. The military primipara is believed to have less opportunities for integration into the community and have less available assistance from extended family members. As such, association with the military may place these new mothers at a greater risk for maladaptation to new parenthood.

Discussion

The discussion provides an interpretation of the findings for the sample studied and emphasizes comparisons between military and nonmilitary subgroups. Findings from this investigation are related to previous relevant studies.

The Study Sample

Approximately 43 primiparas were anticipated to meet the criteria of low-risk each month during the data

collection period, one-third of whom were expected to refuse participation. Rather, only ten primiparas each month met the criteria for low-risk during the four month study period. This was because the number of teenaged and unmarried primiparas was much higher than anticipated. However, a higher than anticipated participation rate by eligible subjects allowed for the acquisition of an adequate sample within the four month time frame.

Demographic Characteristics

The number of years of education represented an area of difference between the military and nonmilitary subgroups. More military subjects than nonmilitary subjects had only a high school education or less. Educational opportunities may be decreased for the military woman due to frequent relocations and a decreased knowledge of available educational resources in the community. Military personnel experience frequent moves and may be less inclined to begin in a program of postsecondary education due to high likelihood of loss of credits when transferring to another educational institution.

Employment outside the home was a demographic variable in which the military and nonmilitary subgroups differed. Fewer military subjects were employed outside

the home than nonmilitary subjects. Military personnel may have a decreased opportunity to obtain available jobs, since they are often viewed as temporary personnel. An employer may be more apt to hire a new employee if there is assurance that the employee will remain in the community. Also, military husbands frequently have irregular working hours. Since the husbands are a valuable social support resource, as determined by this study, the military wife may avoid any interference with the opportunity to have the husband as an available resource. Obtaining a job could reduce the spouses' time together. More military than nonmilitary primiparas are not employed outside the home, therefore the availability of coworkers as a source of social support is also reduced.

When employed, military subjects were more likely to hold secretarial/clerical jobs than nonmilitary subjects. In comparison to professional fields of employment, secretarial/clerical jobs tend to pay less and are often part-time positions with few, if any, benefits. As such, material help as an essential component of social support (Weinert, 1984) may be decreased for military subjects.

Differences existed between military and nonmilitary subjects regarding the number of years of residence in the community. Twice as many military as primiparas had lived in the community for two years or less. This

finding coincides with those of Rodriguez (1984) and O'Keefe (1984). The military family is less apt to integrate into the community due to the short duration of residence, and this may affect the family's ability to develop social support resources.

Experiences Requiring Support

Military and nonmilitary subgroups were similar in their descriptions of life situations on the PRQ-85 Part I requiring social support, such as "urgent needs", "problems with family members or friends", "loneliness", "illness", and "day to day concerns". However, military subjects were more apt to cite illness as a situation in which they had needed help within the previous six months. This difference may be due to a dissimilarity between some military and nonmilitary subjects in the perception of pregnancy as an illness versus a life change. It may also be an indicator that military subjects in the sample experienced more illness in association with pregnancy.

Most subjects in both military and nonmilitary subgroups indicated a need for social support for "day to day concerns" within the previous six months. The life event of a first pregnancy is apt to increase concerns on a day to day basis, since it is a new experience which

occurs over a period of months, and an experience in which a role change is anticipated.

New Motherhood Concerns
Requiring Support

There was a notable difference in perceptions of need between the new motherhood experience and the other ten life situations addressed in the PRQ-85 Part I. New mothers appear to focus on the major life event of pregnancy and decrease their focus on life events that are not of immediate concern. Subjects are more acutely aware of their needs and whether or not those needs are being met during the period when they are actually experiencing a particular life event. In this study, new motherhood concerns were identified by all study subjects as an area requiring social support.

The new motherhood concern which necessitated the use of social support resources for almost all study subjects was "baby care concerns". The possible lack of previous experience with infants may have increased the perceived need for social support related to "baby care concerns". Also, subjects were interviewed during the time following the initial postpartum period. The focus at the time of interview was changing from self to infant; the new mother may have been experiencing frustrations and feelings of inadequacy in her new role in caring for an infant. These feelings appear to have

resulted in an increased perceived need for social support related to baby care.

Number and Types of
Support Resources

Twenty-one of 36 subjects interviewed perceived two or fewer persons to be available for social support in relation to the ten life situations addressed in the PRQ-85 Part I. Military and nonmilitary subjects were similar in the number of available social support resources cited. During the current life situation of new motherhood, the number of available supports was not reported to be greater than during the other life situations addressed in the PRQ-85 Part I. While subjects identified a greater need for social support during the new motherhood period, they did not identify an increased number of support persons available. Thus, it appears that subjects were not able to locate new or a greater number of social support resources to address their new motherhood concerns.

Current literature indicates that due to society's mobility, new mothers may not be integrated into the community, may be unaware of available social support resources, and may be less likely to have supportive persons available during the postpartum period (McGowan, 1977). Only five of the 36 study subjects had additional persons residing in their homes (beyond husband and baby)

at the time of interview. Four of the five were military subjects. Though the number of available support persons was similar for military and nonmilitary subjects, the kinds of persons on whom the new mothers could rely differed. Military primiparas in this study perceived (other) "relatives" to be less available than nonmilitary primiparas. They were, however, more apt to have a mother or mother-in-law residing in the home during the immediate postpartum period. In contrast, nonmilitary primiparas in the study reported "parents" and (other) "relatives" to be readily available, even though they did not reside in the same home with them during the postpartum period. Due to distance from extended family members, (other) "relatives" may be less readily available to military primiparas, a finding consistent with observations by Hill (1949), McGowan (1977), and Rodriguez (1984).

"Professional persons" were frequently cited as a source of support for new motherhood by all subjects, but were rarely cited in the other ten life situations. Persons experiencing a crisis such as new motherhood may be more aware of and apt to turn to professional support systems which are not otherwise considered. Also, the subjects had recently experienced a long-term relationship with professional persons during the prenatal period through individual office visits and

prenatal education classes. During the prenatal period, professional persons had provided informational support, and to a lesser extent, emotional support.

"Professional persons" were cited by study subjects more than any other type of resource for social support regarding "baby care concerns". New mothers' feelings of inadequacy related to the new role of motherhood may be increased due to the few persons on whom they can rely for help, and their lack of previous experience with infants (Curry, 1983). The father of the baby is even less apt to have had previous experience with infants than the mother. Professionals are seen as experts in baby care and mothers are more likely to seek assistance for "baby care concerns" from such knowledgeable persons.

Satisfaction with Support Resources

Among study subjects, reported satisfaction with support for "baby care concerns" was less than reported satisfaction with support for general and physiologic concerns related to new motherhood. Confusing and conflicting information provided by hospital-based nurses was reported by some subjects to be the reason for not being "highly satisfied" with available social support for "baby care concerns".

Satisfaction with social support resources for "psychological concerns" was lower than any other new

motherhood concern for all study subjects. Subjects reported "professional persons" as being less available for "psychological concerns" related to new motherhood than the other new motherhood concerns. Professionals may not be perceived as a source of support for psychological concerns due to lack of availability, inconsistency of relationship, or lack of expressed concern. Both professional nurses and physicians do not ordinarily have personal contact with new mothers until four to six weeks after hospital discharge. This loss of professional support after delivery constitutes what has been described as the "fourth trimester void" (Donaldson, 1981). An unanticipated loss of social support during the immediate postpartum period may explain the subjects' reported dissatisfaction with professionals as sources of support for psychological concerns. Subjects may have expected more psychological support from professionals, but found that it was lacking during the immediate postpartum period.

Analysis of the PRQ-85 Part II

In the study sample, no significant relationships existed between the perceived level of social support and the demographic variables of age, number of years of residence in the community, number of years of education, and number of persons residing in the household at the

time of interview. The homogenous sample limited an accurate determination of these relationships in the present study.

While the study sample size was small and purposive in nature, analysis of the demographic variables indicates that study subjects were reasonably similar to low-risk, first-time mothers throughout areas of Montana in relation to age, occupation, and education. Length of community residence, related to the military subgroup in this study, introduced a demographic variable on which other primiparas throughout Montana may differ. Military primiparas were more apt to experience frequent relocation and fewer years in which to become familiar with the community.

The investigation was deliberately conducted during the immediate postpartum period in order to elicit more relevant and accurate responses than those based on retrospective recall. However, analysis of data indicates that it may have been advantageous to have scheduled the interviews slightly later in the postpartum period; for example, four to six weeks after delivery. At the time of data collection, which was within the first week postpartum, subjects may have been experiencing the "honeymoon" phase of new motherhood, thus emphasizing the positive aspects of their new motherhood experience.

Implications for Nursing

Findings from this study have implications for nurses in hospital, community, and educational settings. It took over four months to acquire a sample of 36 low-risk new mothers from a sizeable urban population. Thus, more risk factors may occur for first-time mothers than expected based on current literature. Recognition of risk factors during the early perinatal period can promote preventive health measures. Anticipation of risk factors prior to delivery will encourage nurses to mobilize social support resources early in the perinatal period and thus reduce the likelihood of maladaptation to new motherhood. It may be advantageous for nurses to continue to assess social support resources throughout the perinatal period, including the postpartum period, because some risk factors may not be evident prior to delivery, but occur following the birth of the child.

Awareness of varying levels of education and the effects of education on exposure to and utilization of information related to new motherhood concerns is important. Adequate information is a necessary dimension of social support, and if lacking, the new mother is at greater risk for maladaptation to her new role. Hospital-based and community-based nurses can have key roles in providing appropriate education for new mothers.

Nurses are often more accepted by new mothers as information sources because they are viewed as less intimidating than physicians.

Lack of co-workers as social support resources may require nursing interventions to mobilize other social support resources for new mothers. Since military primiparas in this investigation were less apt to be employed outside the home, nurses may need to assess availability of other social support resources and determine the possible need for locating supplemental supports.

Findings from this study indicate that support persons are not available in the new mother's home to answer questions concerning new motherhood concerns. Since both new parents are apt to have had little, if any, previous experience with infants, an increase in social support may enhance feelings of adequacy related to their new role. Home visits by professional nurses during the first four weeks postpartum can meet this need. Adequate and accurate information regarding new parenthood concerns will increase the new parents' opportunity to meet the challenges and promote a positive outcome for the new family.

Military subjects in this study reported fewer extended family members available for social support and more frequent moves to new communities. Thus, family

supports are less available to the military primipara and knowledge of community resources is apt to be decreased. These potential social support deficiencies may require the nurse to assess the person's knowledge of social support resources and identify the person's perceived needs and desires for support.

Study subjects perceived an increased need for social support during the "day to day" experience of pregnancy; a finding consistent with the characteristics of the third trimester of pregnancy described by Rubin (1984). The perceived need for assistance arises from the introspective process experienced by the pregnant woman, and the need to be protected and nurtured is increased. Assisting the new mother to develop social support resources during the prenatal period may enable the expectant mother to maintain social support relationships that can be utilized through the perinatal period and beyond. Resources used during the prenatal period are more apt to be considered during the postpartum period, since those social support systems became known and valued by the new mother (Curry, 1983; Donaldson, 1981; Gordon, Kapostins, & Gordon, 1965).

Both military and nonmilitary subjects perceived a lack of support for psychological concerns, particularly by professionals. Professional recognition and acknowledgement of psychological needs in the postpartum

period may not be well-developed, and new mothers are often reluctant to seek assistance for psychological concerns (Gruis, 1977). Increasing professional nurses' awareness of this study's findings through formal and informal education may lead to more attention by professionals to the psychological needs of new mothers. By providing psychological support during the entire perinatal period, nurses can assist the client to incorporate the experience of new motherhood into her self-system by helping her process the birth experience and life transition. This manner of assistance may foster the new mother's role adaptation while increasing the perception that professionals are a valuable source of support.

Some study subjects indicated a desire for new baby information. Nurses need to recognize and acknowledge that most new mothers have had little or no previous experience with infants or children and will require information about infant care. Concurrently, nurses must be aware of the new mother's readiness to learn new information. Prior to delivery, the mother's focus is on the upcoming labor and delivery experience. For the first few days following delivery of the baby, the new mother's focus is on physiologic changes and developing a relationship with her infant. New mothers are not believed to be receptive to information regarding baby

care until approximately the third to fourth postpartum day (Rubin, 1967a, 1984). Thus, the effectiveness of infant care information during the 24 to 48 hours postdelivery may be limited. Hospital nurses may need to incorporate home visits after hospital discharge. When the new mother's focus is on tasks associated with her infant, new information regarding infant care may not seem as contradictory or confusing.

Inconsistency of information provided by hospital-based nurses was reported by some subjects in this investigation. Since professional persons are perceived as a source of social support for new motherhood concerns, particularly informational support, nurses can increase the efficacy of that support by developing consistent guidelines for education of new mothers that would be utilized by all hospital-based and community-based nurses. These guidelines would incorporate information related to the concept of new mothers' readiness to learn and timing of presentation of new information. In addition, providing home follow-up by professional nurses, may increase satisfaction of available social support, especially if the nurses providing home follow-up visits were previously known by the new mother (Donaldson, 1981). Community-based nurses may be more effective in postpartum home follow-up if

they have had contact with expectant mothers during the prenatal period.

Recommendations

It is recommended that a similar study be conducted during the fourth to sixth week postpartum. This study's results could then be compared for determination of any difference between the perceptions of new mothers at early versus later stages in the postpartum crisis experience. Results of this exploratory, descriptive study indicate that low-risk primiparas do have social support needs, especially in the areas of new motherhood concerns. Thus, a larger study, and similar studies in other areas of the country, are warranted in order to confirm or refute the present findings.

Since 111 of the 419 live births at the study hospital during the data collection period were primiparas who did not meet the criteria for this study, an investigation of these statistics could expand the knowledge base for nursing and increase awareness of the actual numbers of low-risk and high-risk deliveries experienced in rural communities. Further investigations should be conducted to assess available services by professional nurses for both low-risk and high-risk mothers. This knowledge could have implications for nurses in community, hospital, and educational settings

in determining needs for support resources during the perinatal period.

In communities where professional nursing follow-up in the home is not feasible, nurses may play an active role in determining other supports available to the new mother. Professional nurses may increase the ability of other support persons to assist the new mother in adapting to her new role by offering informational and emotional support to husbands and other relatives. Subjects in this investigation relied heavily on their husbands for social support. Yet, the husband is often neglected in professional perinatal assessments. By including the husband in more aspects of perinatal nursing care, the new mother's support systems may be strengthened. In this way, the professional nurse can provide indirect social support that may assist the new mother when it is not possible to offer direct social support, particularly after hospital discharge.

This study may stimulate further investigations of the social support needs of persons during life crises which are usually considered low-risk, such as delivery of a child, new fatherhood, or routine surgery. Results of this study indicate that persons in "low-risk" situations do have social support needs. Meeting social support needs in a timely fashion can be an important aspect of preventive health.

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APPENDICES

APPENDIX A
STUDY EXPLANATION AND CONSENTS

SOCIAL SUPPORT OF FIRST-TIME MOTHERS

EXPLANATION OF THE STUDY

As a registered nurse enrolled in the graduate nursing program at Montana State University, Great Falls Extended Campus, I am interested in identifying what supports are available to first-time mothers when they leave the hospital. The information obtained will be used for my graduate thesis. Knowing how you feel about your first experience with parenthood can be helpful in the potential development of support services for future new parents.

I have been granted permission to contact you by the Montana State University College of Nursing and Montana Deaconess Medical Center Human Subjects Review Committees. Because your hospital records indicate that you have just delivered your first baby and meet the requirements to be included in my study, I am asking your permission to be interviewed for the purpose of this study. A signed consent is needed for you to participate in the interview (refer to the attached sheet). You can change your mind about participating at any time before or during the interview, even though you have already signed a consent. All information you provide during the interview will be held strictly confidential.

If you agree to participate, I would like to arrange to come to your home during the coming week at a time convenient for you. I will call the day before our scheduled appointment and insure that you are still interested in participating and verify the appointment time. The interview will take approximately 30 minutes of your time and you can refuse to answer any question or withdraw at any time.

A risk of this study is that some people may become stressed or tired during the interview. If this occurs to you, you may request that we stop temporarily or altogether. A realistic perception of the early phase of your new motherhood experience is of interest to me in this study. I am aware that you may be tired and stressed to some degree during the week after you deliver. Your willingness to allow me the time needed to complete the interview would be greatly appreciated.

Results of this study will be available to participants through Montana State University College of Nursing library in Great Falls located at Montana Deaconess

Medical Center, at the time my thesis is completed
(Approximately Fall- 1988).

If you have any questions, do not hesitate to call me.
My name, status, and telephone number are below:

Barbara Swehla, R.N., B.S.N.
Graduate Student, Montana State
University College of Nursing
816 47 St. S. 452-7070 or 791-2123

Social Support of Primiparas

Consent to Participate

I understand that I am giving my consent to be interviewed by Barbara Swehla, a Registered Nurse (R.N.) and a graduate student of the Montana State University Master of Nursing program. By signing this document, I am aware that I will be part of the research study on support for first-time mothers during the early phase following delivery.

I understand that Barbara will contact me by telephone on the day before the scheduled appointment for the interview in order to make sure I am still interested in participating. I know that I may refuse consent at this time if I have changed my mind. I am aware that the interview will take place in my home at a time of my choosing, and will last approximately 30 minutes.

I freely give permission to be interviewed within the coming week. My participation is entirely voluntary. I have been informed that I can withdraw my consent at any time, even after the interview begins. I have been told that any information I provide will be held confidential and that the reports of this study will not identify me. I have been assured that my consent or refusal to participate will not affect any health care services I may receive.

I understand that risks to me in this study are minimal, but that it is possible that the interview may cause me to become tired or stressed. If this occurs, I understand that I may request that we stop temporarily or altogether. When appropriate, Barbara Swehla will assist the participant to contact health personnel.

I understand that the questionnaire to be used in the interview has been utilized before without ill effects to the participants.

My participation in this study may assist the development of future support services for new mothers. Barbara Swehla is the person to contact if I have any questions about the study or about my rights as a participant in the study.

I have received the attached written explanation of the study, which also explains my rights as a participant, and includes Barbara's home address and telephone number. I have had the opportunity to ask Barbara any questions I have had regarding this study.

Signed _____

Telephone Number _____

Address _____

January 26, 1988

Clarann Weinert, Ph.D., S.C., R.N.
Associate Professor
Montana State University
College of Nursing
Bozeman, Montana 59717-0005

Dear Dr.. Weinert:

Thank you for sharing the available information regarding the PRQ-85 with me. Your critique of the additional questions related to the childbirth experience was appreciated. Enclosed is a copy of the four additional questions, one of which has been reworded as you requested.

I would like your permission to utilize the PRQ-85 with the additional questions in my study of perceived level of social support in first-time mothers. If this request is granted, please indicate your permission by signing your name on the space provided below and return it to me as soon as possible.

Sincerely,



Barbara K. Swehla, R.N.
Graduate Student
Montana State University
College of Nursing
Great Falls Extended Campus

Clarann Weinert, Ph.D., S.C., R.N.
Associate Professor

APPENDIX B
RISK ASSESSMENT TOOL

RISK ASSESSMENT TOOL

Any of the following factors documented in the postpartum client's record would prevent their inclusion in this study. This tool is to be used for screening only. No screening contact is planned with potential subjects.

YES	NO	
		MATERNAL HISTORY
		Metabolic disease in the mother
		Endocrine--thyroid disease
		Aminoacid--phenylketonuria
		Carbohydrate--diabetes
		Mucopolysaccharidosis
		Anemia
		Sickle cell disease
		Thrombocytopenic purpura
		Hematocrit below 32 percent
		OBSTETRICAL FACTORS
		Maternal age
		Elderly primipara (over 35 years)
		Age under 20 years
		PRENATAL FACTORS
		Maternal infection
		Maternal drug addiction--narcotics, barbiturates, amphetamines, LSD, marijuana, alcohol
		Socioeconomic problems
		Illegitimacy
		Lack of prenatal care--one visit or less to obstetrician prior to delivery
		Stressful events
		Severe emotional tension
		Hyperemesis gravidarum
		Operations for surgical problems during pregnancy, especially under general anesthesia--appendicitis, cholecystitis, intestinal obstruction, pelvic neoplasm
		Critical accidents
		Radiation

YES	NO	
		Cardiovascular disease Congenital heart disease Essential Hypertension
		Renal disease
		Diabetes Mellitus--gestational or primary
		Myesthenia Gravis
		Intercurrent chronic disease-- pyelonephritis, malignancy
		Abnormal presentation--breech, transverse, unengaged presenting part at term
		Fetus that fails to gain normally or is disparate in size from that expected
		Fetus over 42 weeks gestation
		Multiple birth
		Blood group incompatibility
		Toxemia of pregnancy
		Placental separation
		Polyhydramnios or oligohydramnios
		Fetal heart aberrations
		Rh sensitization
		Hemorrhagic complications--abruptio placentae, placenta previa, rupture of marginal sinus
		Uterine rupture
		Indication for caesarean delivery
		Cord prolapse
		MATERNAL OR FETAL CONDITIONS DURING LABOR
		Fever, other signs of infection

YES	NO	
		Premature onset of labor (before 38 weeks gestation)
		Premature rupture of membranes
		Fetal distress requiring caesarean delivery
If infant problems listed below exist, the mother is excluded from the study.		
		INFANT AT BIRTH
		Congenital anomalies (choanal atresia, micrognathia with cleft palate, diaphragmatic hernia, tracheoesophageal fistula, cardiovascular anomalies, imperforate anus)
		Single umbilical artery
		Apgar score of five or lower at five minutes
		Placental abnormality (massive infarction, amnionitis, amnion nodosum)
		Multiple birth
		Birth trauma
		Sepsis
		Severe blood loss
		Severe hemolytic disease
		POSTNATAL-INFANT IN THE NURSERY
		Abnormal respiration (tachypnea, apnea, or dyspnea)
		Apneic episodes
		Convulsions
		Melena
		Petechiae

(Adapted from a table of high-risk factors contributing to Perinatal Mortality and Morbidity in Infants provided in Hawkins, J.W., & Gorvine, B. (1985), pp. 120-124. Postpartum Nursing, Health Care of Women. New York: Springer Publishing Company).

Note: There are no standardized risk assessment tools available to the researcher.

APPENDIX C

INTERVIEW INSTRUMENT
PRQ-85 (WEINERT AND BRANDT) AND
ADDITIONAL QUESTIONS CREATED BY THE INVESTIGATOR

Demographic Data included in the interview instrument are:

- 1) Age in years
- 2) Marital status
- 3) Gender
- 4) Education (number of years)
- 5) Occupation
- 6) Employment status prior to delivery_____
- 7) Employment plans following postpartum period
Part-time___ Full-time___ None___
- 8) Number of persons living in household at time of
interview___
- 9) Status of persons in household at time of
interview: Husband___ Mother___ Mother-in-law___
Sister___ Other_____
- 10) Race_____
- 11) Military___ Nonmilitary___
- 12) Length of time residing in community_____

MONTANA STATE UNIVERSITY
College of Nursing

PERSONAL RESOURCE QUESTIONNAIRE (PRQ-85)

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Patricia Brandt and Clarann Weinert, S.C.
1987

In our everyday lives there are personal and family situations or problems that we must deal with. Some of these are listed below. Please consider each statement in light of your own situation. Circle the number before the person(s) that you could count on in each situation that is described. You may circle more than one number if there is more than one source of help that you count on. In addition, we would like to know if you have had this situation or a similar one in the past SIX MONTHS, and how satisfied you are with the help you received.

Q-1a. If you were to experience urgent needs, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you had urgent needs in the past six months?

- 1 YES
- 2 NO

c. If you have experienced urgent needs in the past six months, to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-2a. If you needed help for an extended period of time in caring for a family member who is sick or handicapped, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you needed help in caring for a sick or handicapped family member in the past six months?

- 1 YES
- 2 NO

c. If you have needed help in caring for a sick or handicapped family member in the past six months, to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-3a. If you were concerned about your relationship with your spouse, partner, or intimate other, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

- b. Have you had concerns about your relationship with your spouse, partner, or intimate other in the past six months?

1 YES
2 NO

- c. If you have had concerns about your relationship with your spouse, partner, or intimate other in the past six months, to what extent do you feel satisfied with the help you received?

6 VERY SATISFIED
5 FAIRLY SATISFIED
4 A LITTLE SATISFIED
3 A LITTLE DISSATISFIED
2 FAIRLY DISSATISFIED
1 VERY DISSATISFIED

- Q-4a. If you needed help or advice for a problem with a family member or friend who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (NO ONE AVAILABLE)
12 NO ONE (PREFER TO HANDLE IT ALONE)
13 OTHER (EXPLAIN) _____

- b. Have you needed help or advice regarding a problem with a family member or friend in the past six months?

1 YES
2 NO

- c. If you have needed help or advice in the past six months regarding a problem with a family member or friend, to what extent do you feel satisfied with the help you received?

6 VERY SATISFIED
5 FAIRLY SATISFIED
4 A LITTLE SATISFIED
3 A LITTLE DISSATISFIED
2 FAIRLY DISSATISFIED
1 VERY DISSATISFIED

Q-5a. If you were having financial problems, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you had financial problems in the past six months?

- 1 YES
- 2 NO

c. If you have had financial problems in the past six months to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-6a. If you felt lonely, who would you turn to?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you felt lonely in the past six months?

- 1 YES
- 2 NO

c. If you have felt lonely, in the past six months, to what extent do you feel satisfied with the help you have received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-7a. If you were sick and not able to carry out your usual activities for a week or so, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. During the past six months, have you been sick for a week and not able to carry out your usual activities?

- 1 YES
- 2 NO

c. If you have been sick for a week during the past six months to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-8a. If you were upset and frustrated with the conditions of your life, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you been upset and frustrated with the conditions of your life in the past six months?

- 1 YES
- 2 NO

c. If you have been upset and frustrated with the conditions of your life in the past six months, to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-9a. If you were having problems with your work at home or at your place of employment, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you had problems related to your work in the past six months?

- 1 YES
- 2 NO

c. If you have had problems with your work situation in the past six months, to what extent do you feel satisfied with help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-10a. If you needed someone to talk to about your day to day personal concerns, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you needed someone to talk to about day to day personal concerns in the past six months?

- 1 YES
- 2 NO

c. If you have needed someone to talk to about day to day personal concerns in the past six months, to what extent do you feel satisfied with help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Interview Instrument Page 7a

ADDITIONAL QUESTIONS RELATED TO NEW MOTHERHOOD CONCERNS
CREATED BY THE INVESTIGATOR

Q-11-a. If you needed someone to talk to about concerns related to becoming a new mother, who would you turn to for help?

- 1 PARENT
- 2 CHILD or CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you needed someone to talk to about concerns related to becoming a new mother in the past six months?

- 1 YES
- 2 NO

c. If you have needed someone to talk to about concerns related to becoming a new mother in the past six months, to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

ADDITIONAL QUESTIONS RELATED TO NEW MOTHERHOOD
CREATED BY THE INVESTIGATOR

Q-12a. If you needed someone to talk to about body changes related to the birth of your baby, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you needed someone to talk to about body changes related to the birth of your baby?

- 1 YES
- 2 NO

c. If you have needed someone to talk to about body changes related to the birth of your baby, to what extent do you feel satisfied with the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

ADDITIONAL QUESTIONS RELATED TO NEW MOTHERHOOD
CREATED BY THE INVESTIGATOR

Q-13a. If you needed someone to talk to regarding your feelings about being a new mother, who would you turn to for help?

1. PARENT
2. CHILD OR CHILDREN
3. SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4. RELATIVE OR FAMILY MEMBER
5. FRIEND
6. NEIGHBOR OR CO-WORKER
7. SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
8. PROFESSIONAL (NURSE, COUNSELOR, ETC.)
9. AGENCY
10. SELF-HELP GROUP
11. NO ONE (NO ONE AVAILABLE)
12. NO ONE (PREFER TO HANDLE IT ALONE)
13. OTHER (EXPLAIN) _____

b. Have you needed someone to talk to regarding your feelings about being a new mother?

1. YES
2. NO

c. If you have needed someone to talk to regarding your feelings about being a new mother, to what extent do you feel satisfied with the help you received?

6. VERY SATISFIED
5. FAIRLY SATISFIED
4. A LITTLE SATISFIED
3. A LITTLE DISSATISFIED
2. FAIRLY DISSATISFIED
1. VERY DISSATISFIED

ADDITIONAL QUESTIONS RELATED TO NEW MOTHERHOOD
CREATED BY THE INVESTIGATOR

Q-14a. If you needed someone to talk to about baby care,
who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (MINISTER, PRIEST, ETC.)
- 8 PROFESSIONAL (NURSE, COUNSELOR, ETC.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (NO ONE AVAILABLE)
- 12 NO ONE (PREFER TO HANDLE IT ALONE)
- 13 OTHER (EXPLAIN) _____

b. Have you needed someone to talk to about baby
care?

- 1 YES
- 2 NO

c. If you have needed someone to talk to about baby
care, to what extent do you feel satisfied with
the help you received?

- 6 VERY SATISFIED
- 5 FAIRLY SATISFIED
- 4 A LITTLE SATISFIED
- 3 A LITTLE DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 1 VERY DISSATISFIED

Q-11. Below are some statements with which some people agree and others disagree. Please read each statement and circle the response most appropriate for you. There is no right or wrong answer.

- 7 STRONGLY AGREE
6 AGREE
5 SOMEWHAT AGREE
4 NEUTRAL
3 SOMEWHAT DISAGREE
2 DISAGREE
1 STRONGLY DISAGREE

STATEMENTS

-
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| a. There is someone I feel close to who makes me feel secure | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| b. I belong to a group in which I feel important | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| c. People let me know that I do well at my work (job, homemaking) | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| d. I can't count on my relatives and friends to help me with problems | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| e. I have enough contact with the person who makes me feel special | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| f. I spend time with others who have the same interests that I do | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| g. There is little opportunity in my life to be giving and caring to another person . . | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| h. Others let me know that they enjoy working with me (job, committees, projects) . . . | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| i. There are people who are available if I needed help over an extended period of time | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| j. There is no one to talk to about how I am feeling | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| k. Among my group of friends we do favors for each other | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| l. I have the opportunity to encourage others to develop their interests and skills . . | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

7 STRONGLY AGREE
6 AGREE
5 SOMEWHAT AGREE
4 NEUTRAL
3 SOMEWHAT DISAGREE
2 DISAGREE
1 STRONGLY DISAGREE

STATEMENTS

m.	My family lets me know that I am important for keeping the family running	7	6	5	4	3	2	1
n.	I have relatives or friends that will help me out even if I can't pay them back	7	6	5	4	3	2	1
o.	When I am upset there is someone I can be with who lets me be myself	7	6	5	4	3	2	1
p.	I feel no one has the same problems as I	7	6	5	4	3	2	1
q.	I enjoy doing little "extra" things that make another person's life more pleasant	7	6	5	4	3	2	1
r.	I know that others appreciate me as a person	7	6	5	4	3	2	1
s.	There is someone who loves and cares about me	7	6	5	4	3	2	1
t.	I have people to share social events and fun activities with	7	6	5	4	3	2	1
u.	I am responsible for helping provide for another person's needs	7	6	5	4	3	2	1
v.	If I need advice there is someone who would assist me to work out a plan for dealing with the situation	7	6	5	4	3	2	1
w.	I have a sense of being needed by another person	7	6	5	4	3	2	1
x.	People think that I'm not as good a friend as I should be	7	6	5	4	3	2	1
y.	If I got sick there is someone to give me advice about caring for myself	7	6	5	4	3	2	1

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