PSYCHOSOCIAL ADAPTATION TO PREGNANCY OF THE SECUNDIGRAVIDA

by

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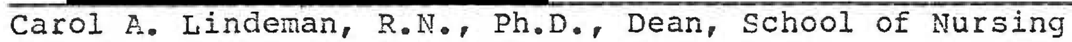

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Chapter I

Introduction

Pregnancy is a time of transition for all women. It is more than just a period of growth and development of the fetus but a time of growth, development, and role change for the mother as well.

Pregnancy has been studied from the viewpoint of the primigravida, both physically and emotionally. However, little has been written about the multigravida and her physical and psychosocial concerns. It has been established that the multigravida has fewer complications during her pregnancy and usually an easier and faster labor and delivery. Thus, the assumption is frequently made that since she has experienced pregnancy and birth before, she knows what to expect and what is expected of her and therefore does not have as many fears and concerns as the primigravida.

As an obstetrical nurse, the author has observed this attitude among nurses and physicians. But as a childbirth educator in close contact with multigravidas antenatally, it has become obvious from their questions and comments that they have many of the same fears and concerns regarding pregnancy as primigravidas. In addition they have concerns about their older children.

The author's interest in the needs and concerns of the multigravida and the secundigravida in particular, led to this study. Antenatal nursing care of the secundigravida

needs to include the assessment of her concerns. This study may help establish what, if any, differences or similarities are present in the concerns of the secundigravida as compared to those of the primigravida, as well as examining her concerns for her older child. This knowledge may eventually be incorporated into the nursing care of the secundigravida.

Review of the Literature

Every pregnancy, no matter how enthusiastically welcomed and experienced, requires that the prospective parents engage in the psychological work of preparing themselves emotionally for the arrival of their new child (Grossman, Eichler, & Winickoff, 1980). This review of the literature will include the examination of adaptation to pregnancy from both the intrapsychic and developmental frameworks. The variables that have been identified as influencing adaptation are reviewed next. In conclusion, the literature specific to the multigravida and her concerns is critiqued and summarized.

Adaptation to Pregnancy

Theorists studying the psychological adaptation to pregnancy have defined and measured it in numerous ways. Cohen (1979) perceived adaptation, as derived from developmental and crisis theory, as evolving from an interaction between constitutional endowment in the person and past and current environmental influences. He concluded

that pregnancy is the most striking example of this construct.

Lederman (1984) used developmental and role theory to form her definition of adaptation in pregnancy. She defined adaptation as patterns of responses that are progressive in nature as the gravida advances toward an orientation to a maternal parenting role. This would be operationalized by assessing the woman's acceptance of pregnancy and her progressive development toward the maternal role. Lederman (1984) further identified pregnancy as "a test which comes as part of growth, and as a challenge rather than a crisis" (p. 13).

Adaptation will be the term used to label the psychological process women go through when pregnant. Whether adaptation is indeed the best word to define this process will not be debated by this author. The process of adaptation to pregnancy has been examined from different theoretical frameworks. The most prevalent frameworks used are the intrapsychic and developmental, though these often overlap. Elements of crisis and role theories are also integrated into these frameworks.

Intrapsychic Framework

The intrapsychic framework is the oldest view of adaptation to pregnancy and originated with the work of psychoanalysts. Much of their data were gathered from subjects that were either current psychiatric patients or referred by physicians for mental health disorders. As a

result, this framework presents a rather biased view of a woman's adaptation to pregnancy and assumes that a certain degree of psychopathology is inherent in pregnancy.

According to the intrapsychic framework, a woman's adaptation to pregnancy involves a reordering of her interpersonal space, her sense of self, as well as her relationships with significant others (Ballou, 1978; Benedek, 1970; Deutsch, 1945; Leifer, 1977; Rubin, 1975; Wolkind & Zajicek, 1981). These changes take place gradually throughout the pregnancy (Deutsch, 1945). There is a turning inward, an increased preoccupation with self and a decline of emotional interest in the outside world (Deutsch, 1945; Leifer, 1977). This inner directed psychologic state of pregnancy has a regressive pull which brings about the characteristic mood swings in pregnancy (Benedek, 1970).

In addition, some intrapsychic theorists (Benedek, 1970; Bibring, 1959; Deutsch, 1945) view pregnancy as a natural crisis or critical phase in a woman's life similar to puberty and menopause. With the adaptational tasks of pregnancy before the woman, there is an emergence of unresolved conflicts from past developmental tasks. For many, old conflicts are reworked until the woman reaches a new level of integration. This integrative task of pregnancy both physically and psychologically is the greatest task a woman ever faces (Benedek, 1970).

Developmental Framework

Another major way of conceptualizing the adaptation to pregnancy is the developmental model. A critical assumption of developmental models is that each successive stage of life builds on the foundation achieved in previous stages. Therefore, the mastery of major tasks in one stage contributes to the successful mastery in succeeding stages (Tilden, 1980). Tilden (1980) incorporating the works of major theorists (Bibring, 1959; Cohen, 1979; Colman, 1969; Deutsch, 1945; Rubin, 1975) identified the developmental tasks of pregnancy as: incorporation of the fetus; the development of an emotional affiliation with the fetus, which involves an identification of the fetus as part of self; then a differentiation of the self from the fetus which usually occurs after quickening. Valentine (1982) concurs but adds the acceptance and resolution of the relationship with her own mother and the resolution of dependency issues as additional developmental tasks of pregnancy.

Rubin (1975) identifies four tasks of pregnancy that seem to combine a developmental approach to pregnancy with psychic reorganization. The first task is seeking and ensuring safe passage through pregnancy and delivery. In the first trimester the concern is for self. By the second trimester with quickening the woman is so aware of the fetus that she becomes protective of the child. In the third trimester, the concern is for both herself and the fetus.

Often the seventh month of pregnancy is characterized by a heightened awareness of vulnerability to danger from the environment.

Securing and assuring acceptance of the child by significant others is the second task identified by Rubin (1975). Pregnant women are most concerned with this aspect in the first and third trimesters. The women realign their current relationships to assure acceptance of the newborn. Rubin states that security in acceptance is the "keystone" of a successful pregnancy.

Like Tilden (1980) and Valentine (1982), Rubin identifies the binding-in to her unknown child as a task of pregnancy. This is a process by which the woman incorporates the child to be into her entire self system: her body image, self image, and her ideal image. The process of binding-in progresses quite rapidly after quickening and continues, though at a slower rate, through the last trimester of her pregnancy.

Learning to give of herself is the remaining task of pregnancy identified by Rubin (1975). In the beginning the woman spends her time in evaluation and assessment of the new demands to be made of her by the pregnancy and child to be. With identification of the child the woman shifts to an exploration of the act of giving and being given to. In the third trimester, with the woman's growing girth, she again is aware of the demands of pregnancy and the coming child.

Variables Influencing Adaptation

Some authors have examined adaptation to pregnancy by studying the gravida's concerns and anxieties. Hirst and Strousse (1938) report that among 100 "presumably normal" pregnant women, 75% showed anxiety related to economic stress; 7% to their husbands; and 10% to other members of the family. Sixteen percent showed definite phobias concerned with fear of ill health or death, or the child being defective. It is understandable that financial concerns were a major source of anxiety as the data was gathered during the depression. Later studies, with samples drawn from the lower socioeconomic classes, have also found stress due to economic concerns (Glazer, 1980; Klein, Potter, & Dyk 1950; Rich, 1979).

In their study of 27 primigravidas, Klein et al. (1950) reported that none of their subjects were without anxiety at some time during their pregnancy. The subjects ranged in age from 17 to 24 and were all of lower socioeconomic status. Five were unmarried. The main concerns of these young women centered around the baby and themselves, including concern about miscarriage, deformity, and injury or death of the fetus in utero. Their concerns about themselves related to their health and fear of death in labor was well as concerns about hospital and clinic procedures. The authors found that these subjects had many misconceptions about the fetus, pregnancy, and birth. These misconceptions seemed to stem from family attitudes,

especially the pregnant woman's mother and her childbearing experiences as well as group attitudes to which the gravida has been exposed.

Wenner et al. (1969) with data gathered from 52 white, married, lower to upper middle class primigravidas and multigravidas found that many subjects, not just neurotic ones displayed "irrational" fears. These included fears of death of the fetus, producing an abnormal child, being damaged herself or dying in childbirth, and being an inadequate mother. The authors hypothesized that these fears were related to low self-esteem, feelings of isolation and depression, hostility toward the husband, and often competitive rivalry or hatred toward the gravida's mother.

In more recent years these fears and concerns have been recognized as common in pregnant woman and not necessarily an indication of mental handicap. Glazer (1980) in her study of anxiety and concerns used a sample of 100 randomly selected pregnant women of lower to upper socioeconomic status, 26 of whom were primigravidas. She found the major concerns in the third trimester pertained to self, baby's health, childbirth, finances, family, and subsequent pregnancies. The women with the highest levels of anxiety were younger, less educated, married or involved in a relationship for a shorter period of time, and of a lower socioeconomic status than were the woman with lower anxiety levels.

These studies indicate that a certain amount of stress and anxiety is present in all pregnancies. Besides stress and anxiety, other variables have been measured in an attempt to assess a woman's adaptation to pregnancy. Lederman (1984) organized many of these variables into her seven dimensions of adaptation.

Dimensions of Adaptation

Lederman (1984) used review of the literature, clinical experience, and a conceptual blend of the intrapsychic and developmental frameworks to formulate seven psychosocial dimensions pregnancy. These dimensions are: acceptance of pregnancy; identification of the motherhood role; relationship with mother; relationship with husband; preparation for labor; fear of pain, helplessness, and loss of control in labor; and concern for well-being of self and baby.

Acceptance of pregnancy.

According to Lederman, the gravida must first accept the idea of pregnancy and make it a part of her life. Zemlick and Watson (1953) hypothesized that acceptance of pregnancy is a determinant of the woman's adjustment both antepartum and postpartum. Mental handicap during pregnancy (as measured by number and severity of mental symptoms) was found to be significantly correlated with a negative first reaction to the pregnancy or a strongly undesired pregnancy by Uddenberg (1974). Several studies of primigravidas (Klein et al. 1950; Leifer, 1977; Pleshette, Asch, & Chase

1956; Porter & Demeuth, 1979; Wolkind & Zajicek, 1981) found that even women with pregnancies that were initially unplanned and unwanted eventually became accepting of the pregnancy. For some, the change came with quickening, but for many it was a gradual process (Klein et al. 1950). Likewise, Pohlman (1968) stated that acceptance was not always totally positive but often involves some ambivalence. He believed that the change from rejection to acceptance must involve some rationalization on the woman's part.

Marital adjustment is another factor that has been reported as influencing a woman's acceptance of her pregnancy (Helper, Cohen, Beitenman, & Eaton, 1968; Klein et al. 1950; Porter & Demeuth, 1979; Wenner et al. 1969). Women with husbands that accept the pregnancy are more accepting themselves than women who have rejecting spouses. The degree of somatic symptoms (Grimm & Venet, 1966; Harvey & Sherfey, 1954) and concern over body changes (Pleshette et al. 1956; Wolkind & Zajicek, 1981) have been both positively and negatively associated with acceptance of pregnancy.

Identification of the motherhood role.

Lederman (1984) proposes that identification of a motherhood role is related to a pregnant woman's acceptance of her pregnancy. As described by Deutsch (1945), pregnancy is a bridge leading to motherliness, a path by which the relationship with the child is prepared. Women do this by giving up their emotional interests for the sake of the idea of a child. According to Deutsch the more motherly the

woman, the easier this is to fulfill. Benedek (1970) hypothesizes that developmental conflicts from the past play a role in a woman's identification of a motherhood role. These conflicts influence a woman's feelings about motherhood and her attitude toward her child.

Identification of the motherhood role was defined by Rees (1980) as the extent to which a woman formulates a mental conception of the attitudinal and behavioral attributes that characterize a mother and then assumes these attributes herself. Rubin (1967a) found the attainment of the maternal role to be quiet and continuous, though not passive. She defined three operations that women perform in attainment of the motherhood role. These operations are mimicry, the adoption of simple behavioral manifestations of the new role; role play, an acting out of the new role; and fantasy, an internalization of the new role. The motherhood role is incorporated into her being by successive and progressively refined ideal images of the self as a mother (Rubin, 1984). Rubin further hypothesizes that there is no transference of a maternal identity from one child to another. A woman must reevaluate her new role in the expanding family with each pregnancy.

Conflict in identification of the motherhood role was found by Lederman, Lederman, Work, & McCann (1979) to be associated with slower progress of both first and second stage of labor and increased anxiety in labor. Similarly,

the data suggests that the gravida's relationship with her mother can effect her progress in labor.

Relationship with mother.

A woman's relationship with her mother plays a significant part in her identification of the motherhood role. During pregnancy there is an opportunity for reconciliation with her mother (Ballou, 1978), and the pregnant women often begins to see her mother in a better light, frequently as more caring and giving. Thus, the resolution of ambivalent feelings toward one's mother is one of the major tasks of pregnancy (Ballou, 1978). Accordingly, Deutsch (1945) views the pregnant woman's relationship with her mother as at the center of the psychologic problems of pregnancy and the whole reproductive function.

The pregnant woman's mother functions as her major role model (Lederman, 1984; Rubin, 1984; Uddenberg, 1974). The grandmother-to-be functions as a giver of comfort, a reality tester, and as a companion and supporter (Rubin, 1967b). Levy and McGee (1975) in their study of 70 married primigravidas, found the daughter's birth experience to be related to her mother's experience. If the daughter receives information about childbirth from her mother she tends to evaluate her own delivery more favorably. Further, if the daughter receives an extreme evaluation from her mother, either positive or negative, she tends to view her

birth more negatively then those daughters receiving moderate evaluations.

Uddenberg (1974) in his longitudinal study of 95 primigravidas and their mothers, obtained evidence to indicate that there is a transmission of reproductive behavior from one generation to the next. He found that mothers with mental and psychosomatic symptoms indicating conflicts in reproduction and motherhood had daughters with symptoms of similar conflicts. Good adaptation to motherhood was found in women with mothers who were well adjusted and socially powerful models for their daughters.

Relationship with husband.

The strength of the marital relationship is important to an unconflicted pregnancy (Helper et al. 1968; Uddenberg, 1974; Wenner et al. 1969). Further, the pregnant woman's relationship with her husband appears to be the most critical one in the reorganizational process of pregnancy (Richardson, 1981).

In a study of five primigravidas and nine multigravidas Richardson (1983a), found the two major categories of changes in the marital relationship were in task performance and affective involvement. Usually these changes occurred early in the pregnancy, with most of the problems encountered solved at this time.

The pregnant woman has an increased need for love and appreciation from her husband and displays an increased dependency on him (Cohen, 1966; Richardson, 1983a). Yet,

this increased dependency may be unsettling for the husband because he must use the feminine side of his nature to nurture his wife (Ballou, 1978). If the father is not secure in his own sexual identity, he may not be able to meet his wife's increased needs, assume the responsibilities of fatherhood and accept the new mother's absorption and relationship with the baby without undue anxiety (Cohen, 1966).

The husband's anxiety level may be influenced by his own adaptation to pregnancy. May (1982) describes three phases of a father's involvement in pregnancy. The first is the announcement phase in which the pregnancy is suspected and confirmed. In the moratorium phase the father is adjusting to the reality of pregnancy. An emotional distance from his wife allows him to work through his feelings about the pregnancy. The length of time he remains in this phase depends on his readiness for pregnancy. In the final focusing phase, the man focuses in on his own experience of pregnancy and becomes more in tune with his wife. Thus, he is better able to meet her increased needs for love and affection. Benedek (1970) concludes that the security of a good marriage, the considerate affection of her husband, the pleasure of her children and the support of her parental family supply the feedback which help to keep in balance the emotional household of a pregnant woman.

Preparation for labor.

Both the relationship with her husband and her mother were found by Lederman et al. (1979) to be positively correlated with a woman's preparation for labor, that is the less conflict in her relationships the more her preparation and vise versa. Preparation for labor includes attending prenatal classes, reading books about labor, and confronting her fears and anxieties (Lederman, 1984). A woman will often fantasize about how she will cope with labor and make checklists of things to do in preparation (Sherwen, 1981).

Preparation for childbirth was found by Willmuth (1975) to give a woman a sense of being a participant and collaborator in her birth, with a greater sense of control. Grossman et al. (1980) found in their sample of predominantly upper middle class primigravidas and multigravidas that those most prepared for labor had more children, rated themselves happier with their marriage, and were of higher socioeconomic status.

In the study by Lederman et al. (1979) preparation for labor had only a moderate correlation with fear of pain and low correlations to fears of pain, helplessness, and loss of control in labor. This would appear to indicate that preparation for labor is not influenced by a woman's fears of labor.

Fear of pain, helplessness, and loss of control and in labor.

Fear of pain in labor among pregnant women is a commonly reported (Areskog, Uddenberg, & Kjessler, 1981; Glazer, 1980; Klein et al. 1950; Pleshette et al. 1956). In a study of pain and locus of control using a sample of 30 laboring women, Scott-Palmer and Skevingtion (1981) found that women with a high external locus of control perceived less pain in labor than those with a high internal locus of control. Further, those with an external locus of control had longer labors with significantly less reported pain per hour than those with an internal locus of control. It would appear that women who believe that they have control over their labor perceive labor as shorter but more painful than those women who believe that they have no control.

Locus of control has also been associated with birth satisfaction. Willmuth, Weaver, and Borenstein (1978) found that women very satisfied with their birth experiences had a tendency toward internal locus of control. A woman's perception of maintaining control in labor has also been associated with a positive birth experience (Willmuth, 1975).

Concern for well-being of self and baby.

Pregnant women worry about the well-being of themselves and the baby. While they worry about how they will behave in labor, (Areskog et al. 1981) of even greater concern is

fear for the safety of self and baby, anxieties that can trouble the peace of pregnancy (Deutsch, 1945).

Pleshette et al. (1956) reported that 62% of their sample of 50 primigravidas were concerned about the baby dying in utero and half worried about fetal anomalies. Glazer (1980) found that over 90% of the sample were concerned whether the baby would be healthy and normal as well as the condition at birth. Of the same sample, 80% were concerned for their own health and condition during birth.

Leifer (1977) credited a decreased satisfaction with pregnancy in the second and third trimester to anxiety about the baby. She found that women emotionally invested in the baby would focus their anxiety on the fetus, whereas, the women who were moderately invested tend to be concerned about themselves as well as the fetus. Women minimally attached to their fetuses focused exclusively on themselves. However, other authors (Hirst & Strousse, 1938; Klein et al. 1950; Larsen, 1966; Lederman, 1984; Westbrook, 1978) have reported subjects having concerns about both themselves and the fetus although they made no attempt to link these concerns with the mother's attachment to the fetus.

Concerns, worries, fears, and anxieties appear to be common in most pregnancies. Many of these studies included only primigravidas as subjects but a few had mixed samples that included multigravidas. The results of these studies indicate that multigravidas also have anxiety and concerns

related to their pregnancies. However, it is unclear whether their concerns are similar or different from those of primigravidas.

Concerns of Multigravidas

The multigravida seems to experience less awe and wonder at pregnancy than the primigravida, for whom pregnancy is a much more consuming and emotionally compelling experience (Grossman et al. 1980). Therefore, it has been speculated that the multigravida requires less adaptive work during pregnancy. Benedek (1970), theorizes that the emotional maturation of the first pregnancy usually makes motherhood easier with the second and third child. However, research data conflicts with these theories.

Colman and Colman (1971) found in their interviews with 30 multigravidas, that the third trimester is an increasing anxious time. The multigravida does not usually receive the support she needs from her husband and physician because they assume that since she has been through the pregnancy and birth experience before, this time will be easier. However, due to the fact that she has been through it all before and labor and delivery are not unknowns, she knows things can go wrong and she remembers what it is like to care for a demanding newborn. Further, Grimm and Venet (1966), using a standardized pregnancy questionnaire on a middle class sample of 124 primigravidas and multigravidas, found that multigravidas were as anxious and concerned about the pregnancy and impending birth as were the primigravidas.

Larsen (1966) in an exploratory study of the stresses of the childbearing year, found several differences between primigravidas and multigravidas. This pilot study used retrospective recall, with a sample size of 130 which was drawn from two geographic locations in the United States. The subjects were predominantly upper middle class, and all had attended childbirth classes. Thirty three of the subjects were primigravidas, 40 secundigravidas, 25 women were having their third child, and 32 women were having their fourth or greater child. An open ended questionnaire was used to gather data regarding problems that were upsetting to the women during pregnancy, labor and delivery, the first three months postpartum, and the later months postpartum.

Results suggested that antenatally, 67% of the primigravidas complained of physical discomforts, while only 33% of the secundigravidas, 44% of those having their third child, and 59% of women pregnant with their fourth or greater child had similar complaints. However, the multigravida complained more about fatigue. Thirty-two percent of the secundigravidas, 48% of women having their third child and 31% of those having four or more children were fatigued compared to 18% of the primigravidas. Surprisingly, the data suggest that with each successive pregnancy a women's fears for her unborn baby and for herself increase. Perhaps this is a function of increasing fear that something may go wrong because everything has gone

well in past labor and births. Larsen concluded that the secundigravida appeared to remember less stress during the childbearing year than any other group.

Westbrook's (1978) study which examined the effect of birth order on a woman's childbearing experience also found differences between women with different parity. A sample of 200 women representing a cross section of socioeconomic classes was interviewed two to seven months postpartum. Ninety-two of the women were primiparas, 58 secundiparas, 32 were having their third child, and 18 a fourth or later child. Interviews were used to assess the women's attitudes regarding the degrees of stress experienced as a result of potentially negative aspects of childbearing and the degree of satisfaction experienced from potentially positive aspects. Six different types of anxiety (death, mutilation, separation, guilt, shame, and diffuse) were measured by the Gottschalk-Gleser scales to obtain a total anxiety score.

The results suggest that women having their second and fourth babies suffered significantly more mutilation anxiety ($p<0.01$) and were more rejecting of their infants ($p<0.001$) than were primiparas. Negative attitudes toward the physical discomforts of pregnancy were increased in women having second and third babies over those having their first ($p<0.001$). As a result, Westbrook concluded that the multiparous woman exhibits more signs of being in a crisis situation than the first time mother.

Norr, Block, Charles, and Meyering (1980) obtained similar results in their study of parity and the birth experience. Their sample consisted of 118 primigravidas and 113 multigravidas, who were predominantly middle class women delivering in private institutions. The subjects were interviewed one to three days postpartum about their preparation for childbirth and their actual childbirth experience. A self-administered questionnaire supplied information on social characteristics, attitudes, and the woman's assessment of pain and enjoyment of labor. Medical records were also used to gather information. The study explored the effects of parity on three areas of the childbearing year, the pregnancy, the birth, and the interaction with the baby immediately postpartum.

Antenatally, it was found that multigravidas were less likely to feel physically excellent during their pregnancy than primigravidas. Also, 40% of the multigravidas reported feeling fatigued during the pregnancy compared to 25% of the primigravidas. Multigravidas were more worried about the birth itself and less likely to receive support from those around them, especially their husbands. The authors stress the importance of health professionals becoming aware that the benefits of parity may be limited primarily to obstetrical factors and not the physical and emotional components.

These studies had adequate sample sizes but used retrospective recall. The women were measured postpartum

about their subjective antenatal experience. Their view of the pregnancy would likely be biased by the birth and experiences with the newborn and her family postpartum.

Using a prenatal self-evaluation questionnaire, she had developed, Lederman (1984) validated many of these findings. Data were collected from a group of 59 primigravidas and 54 multigravidas. When the results were compared by parity, Lederman found the multigravidas had more conflict during pregnancy with their husbands and mothers. There were no significant differences with parity on the scales of acceptance of pregnancy; identification of a motherhood role; fears pertaining to pain, helplessness, and loss of control in labor; preparation for labor; or concerns about the well-being for self and baby. Lederman (1984) concludes, that although one might expect the multigravida to have fewer fears and conflicts about motherhood and childbirth, the data suggest that this is not the case.

Moss (1981) in a study of the postpartum concerns of multigravidas, used a card sort to identify three areas of concern. These areas included the baby, the mother, and family relationships. On the third postpartum day, 56 married multiparas were asked to sort the cards into three headings: interests (defined as something the mother was curious about); worries (defined as something the mother was anxious about); and not of concern (defined as something she felt comfortable about at that time). After the card sort was completed the subjects were given a chance to identify

their major concern whether it was already mentioned in the card sort or not. The results indicated that the women were more concerned with their family relationships than with the baby or themselves. Family subjects comprised only 15% of the items, but made up 24% of the worries and 35% of the interests. The item "how children at home will act towards the baby" was chosen as a concern by all but one mother.

Most of the women were not concerned about themselves except for weight and the return of their figure to normal. The mothers' interest in their newborns was in the area of behavior, and growth and development rather than physical care. Three groups of mothers showed the most concerns: those having their second child; those under 20 years; and the mothers of sons. The author attributed the increased concerns of the mothers of sons to concern over care of the circumcision. Further, women who had finished high school or who had attended up to two years of college had fewer interests and worries than did those who had not completed high school or who had completed graduate work.

Concern for their other children appears to be a common theme with the multigravidas studied. Richardson (1983b) in her study of change in relationships shared with children during pregnancy, found that for the nine multigravidas reordering the relationship with her older child was a time consuming and energy depleting task. Usually the subject's relationship with her child was seen as good in early pregnancy but became increasing problematic as the pregnancy

progressed. By the end of pregnancy the mothers of older children (7 to 14 years) or those with children aged less than two years reported more satisfactory relationships with their children than did the mothers of toddlers and preschool children. The child's concern about being displaced by the expected baby was one of the most difficult responses with which the mother had to deal. One of the pervasive themes in the women's descriptions of their relationships with their children was a sense of emotional distance and feelings of loss between the mother and child during pregnancy.

Several case studies (Jenkins, 1976; Rich, 1979; Ulrich, 1982) have examined the individual woman's psychological adaptation to pregnancy. A common thread found in these studies was the multigravida's concern about her relationship with her older child and changes in the family structure. Due to the anecdotal nature of these studies, the ability to generalize to a population of multigravidas is limited. They may, however, illustrate the presence of concerns for multigravidas.

Employing a review of the literature and her clinical experience, Mercer (1979) described the following as special needs of the multigravida: possible increased anxiety about mutilation during birth; worries about her ability to handle the increasing complexity of her family unit; and doubts of being able to love and mother an additional child (especially if it is the second child). Mercer suggests

group or individual counselling might help the multigravida deal with these concerns. Jimenez, Jones, and Jungman (1979) agree that the multigravida has distinct needs and have put together a course to help meet those needs. The course consists of two classes in which the physical, emotional and social changes unique to the multigravida are discussed as well as ways to prepare children for the arrival of the new baby.

Summary

The literature encompassing the concerns of the multigravida supports the need to address the stated practice problem. The multigravida appears to have more physical discomfort and fatigue than the primigravida. This is not surprising considering she has other children, the home, and possibly a job to which she must attend. Further, she may not be getting the support she needs from her husband, health care provider, and possibly her mother. The multigravida may be more concerned about the well being of the fetus and her labor and birth than with her first pregnancy, especially if she had an unsatisfactory birth experience the first time. The multigravida, particularly the secundigravida, also has concerns about her older child.

Theoretical Framework

Concepts from role theory and developmental theory were selected to guide this study. During pregnancy, critical role transitions occur in all families and serve as a demarcation for this stage of the family life cycle

(Valentine 1982). Individual family members and the family as a whole experience development simultaneously. Individuals are each faced with their own tasks at different stages of human development, while the family unit is working toward the family's developmental tasks.

The role transitions of pregnancy also require a change in family role patterns. With these changes in family patterns, new developmental tasks emerge (Rowe 1981). A developmental task was defined by Havighurst (1972) as:

> A task which arises at or about a certain period in the life of an individual, successful achievement of which leads to his happiness and success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks. (p.2)

Each pregnant woman has her own developmental tasks to accomplish during her pregnancy; these tasks relate to both her pregnancy as well as her individual stage of development. The secundigravida must negotiate all of the developmental tasks of pregnancy and prepare for the role transition of being a mother of one to the mother of two.

From the review of the literature it appears that the secundigravida has many of the same concerns and fears as the primigravida antenatally. In addition, the secundigravida experiences increased family complexity and possibly lack of support from her husband and mother. In addition she has concerns about her older child. These

concerns could make the role transitions of pregnancy as difficult for the secundigravida as the primigravida, thereby, affecting her adaptation to pregnancy. Thus, the following research questions and hypothesis are asked.

Research Questions

1. What are the concerns of the secundigravida antenatally as measured by the Lederman prenatal self-evaluation questionnaire?

2. What are the concerns of the secundigravida antenatally with regard to her older child?

Hypothesis

There will be no significant differences in the psychosocial adaptation to pregnancy between the primigravida and the secundigravida as measured by the Lederman prenatal self-evaluation questionnaire.

Chapter II

Methods

This chapter describes the design, sample and instruments used in this study. The procedure used for data collection is then discussed followed by a description of the data analysis.

Design

The study employed a nonexperimental correlational design. The research goal was to compare the adaptation to pregnancy of a sample of secundigravidas with a sample of primigravidas. In addition, the concerns of the secundigravida with regard to her older child were studied.

The design involved the administration of the Lederman prenatal self-evaluation questionnaire, an assessment tool that measures the psychosocial adaptation in pregnancy, to a group of secundigravidas registered for refresher childbirth classes. Their scores were then analyzed and correlated with Regina Lederman's original data gathered from a sample of middle class primigravidas and multigravidas who attended Lamaze childbirth education classes in an metropolitan area. The demographic characteristics of the two samples should be similar. In addition, a tool developed for this study to measure the concerns of secundigravidas regarding their older child was administered.

Threats to internal validity in this study included history and selection. It took approximately two months to collect data and external events during this time may have

affected the participant's responses. Selection also posed a threat as a convenience sample of secundigravidas registered for refresher childbirth classes was used.

As a nonexperimental design was used the usual threats to external validity are not applicable. Relevant threats to generalization include:

1. The inability to generalize to all socioeconomic groups from the predominantly white middle class sample.

2. The unknown differences between a secundigravida that attends childbirth classes and those who do not.

3. A pseudo Hawthorn effect may cause the respondents to answer the questions with socially accepted answers.

Extraneous variables controlled for were parity, gestation, and prenatal care.

Sample and Setting

The secundigravidas were self selected from those registered in a series of prepared childbirth refresher courses December 1985 through March 1986. A convenience sample of secundigravidas was used in the study. It was decided to limit the study to second time mothers to avoid the confounding effects of women having various numbers of children. All respondents were in their late second or early third trimester and under the care of private health care providers. The sample size was 30.

Variables Studied

The secundigravida's adaptation to pregnancy was measured by the prenatal self-evaluation questionnaire

developed by Lederman (1984). The second variable, concerns for her older child, was measured by an additional tool developed for this study.

Instruments.

The prenatal self-evaluation questionnaire (Appendix A) is a paper and pencil questionnaire which uses a Likert-like scale. It consists of 79 statements made by pregnant women to describe themselves. These statements are worded both positively and negatively. The respondents are asked to what degree they are in concurrence with the statement--very much so, moderately so, somewhat so, or not at all. The questionnaire takes approximately 30 minutes to complete.

The Lederman self-evaluation questionnaire measures seven dimensions of maternal development (Appendix B). These dimensions with an example of positively and negatively worded items are:

1. Acceptance of pregnancy (14 items).

   "This is a good time for me to be pregnant."

   "It is difficult for me to accept this pregnancy."

2. Identification of the motherhood role (15 items).

   "I look forward to caring for the baby."

   "I have doubts about being a good mother."

3. Relationship with mother (10 items).

   "It's easy to talk to my mother about my problems."

   "My mother criticizes my decisions."

4. Relationship with husband (10 items).

   "I can count on my husbands support in labor."

   "My husband feels I burden him with my feelings and problems."

5. Preparation for labor (10 items).

   "I am preparing myself to do well in labor."

   "There is little I can do to prepare for labor."

6. Fear of pain, helplessness, and loss of control in labor (10 items).

   "I think I can bear the discomfort of labor."

   "I feel sure that I will lose control in labor."

7. Concern for well-being of self and baby (10 items).

   "I think my labor and delivery will progress normally."

   "I am worried that the baby will be abnormal."

Review of the literature, clinical experience and data from a study designed to measure the relationship of psychological factors in pregnancy to the progress in labor (Lederman et al. 1979) formed the framework for the seven dimensions of pregnancy. The individual items on the scales were developed from the responses of subjects interviewed during the last trimester of their pregnancy. Rating scales were developed to quantify this data and average pregnancy ratings were then obtained by the author and a research assistant. The mean correlation for the two sets of ratings was .93, indicating good inter-rater reliability.

The prenatal self-evaluation questionnaire scales were constructed using the item intercorrelations obtained from the interview ratings. Statements were written to define the dimensions identified and a questionnaire was administered in a pilot study consisting of 122 pregnant women. Item analysis was used to revise the items. The final form of the questionnaire was administered to a sample of 119 women, both primigravidas and multigravidas.

Psychometric characteristics.

The reliability of the questionnaire was determined by the use of Cronbach's alpha. Alpha levels for the sample (N = 119) were generally high indicating good reliability. Alpha levels ranged from a low of .75 for fear of pain, helplessness, and loss of control in labor, to a high of .92 for relationship with mother (see Appendix C).

The interscale correlation coefficients ranged from .06 for relationship with husband and fear of pain, helplessness and loss of control in labor, to a high of .54 for acceptance of pregnancy and identification with a motherhood role. Lederman (1984) concludes that the low correlations among the scales show that they are relatively independent and that separate measures are justified for the constructs.

In a study of 48 multigravidas (Lederman 1984), congruence between the self-evaluation questionnaire and interviews were examined. The internal consistency coefficients for the questionnaire scales ranged from .73 to .93, similar to the alpha levels in the previous study

(N = 119). The correlation coefficients for the ratings of the interviews were generally lower than the alpha levels of the questionnaire. This is not surprising since Pearson r coefficients are lower than Cronbach alpha levels due to the computational formula. Lederman (1984) concluded that the degree of congruence between the questionnaire and the ratings was a function of the reliability of the measures and the nature of the dimensions being assessed.

The Lederman prenatal self-evaluation questionnaire appears to have content validity. The items on the instrument were derived from statements made by pregnant women during antenatal interviews. The content also was obtained from the literature and clinical experience.

Lederman (1984) attempted to establish predictive validity between the questionnaire and average pregnancy ratings (obtained from the interviews) with observed stress and reported anxiety in labor. The sample was derived from the multigravida congruence study (n = 29). A nurse researcher determined stress ratings from observations of the laboring woman at six to seven centimeters of dilatation. After the observation period the woman was asked to respond to a 21 item self-report anxiety inventory. Lederman (1984) found significant correlations between the prenatal self-evaluation questionnaire with stress ($p < 0.05$) and anxiety ($p < 0.01$) in labor in the following dimensions: acceptance of pregnancy, identification of the motherhood role, and relationship with mother. Reported anxiety

correlated ($p<0.05$) with fear of pain, helplessness, and loss of control in labor and preparation for labor and concern for well-being of self and baby. Lederman concludes that the prenatal self-evaluation questionnaire can identify those patients prone to high anxiety and stress in labor.

The validity of measuring multigravidas at this point in labor must be questioned. From clinical experience most multigravidas would be very close to the birth at this point in labor, and would be experiencing a high degree of stress.

The Lederman prenatal self-evaluation questionnaire was administered to a sample of high-risk hospitalized pregnant women (Curry, 1985). The alpha levels reported in the study, though not as high as Lederman's (1984), demonstrated good reliability. Alpha levels ranged from .70 for identification of motherhood role to .89 for relationship with mother (see Appendix C).

This study (Curry, 1985) appears to add evidence of construct validity to the Lederman tool. It would be expected that a group of high-risk gravidas would experience more difficulty adapting to pregnancy than women experiencing normal gestations. The hospitalized antenatal women had significantly different mean scores on the scales of acceptance of pregnancy, preparation for labor and concern for well-being of self and baby in labor than Lederman's (1984) normative sample (see Appendix C). When examined at the item level, the conflict in acceptance of pregnancy appeared to be in the physical aspect rather than

emotional acceptance. In general, the Lederman prenatal self-evaluation questionnaire appears to have good reliability and growing evidence of validity.

Scoring.

The responses were scored directionally depending on whether the item is positively or negatively stated. For a positive statement the points for responses are: very much so, 4; moderately so, 3; somewhat so, 2; and not at all, 1. With a negative statement the points were reversed: very much so, 1; moderately so, 2; somewhat so, 3; and not at all, 4. Means are computed for each scale or dimension.

The Lederman prenatal self-evaluation questionnaire was originally scored so that high scores indicated high conflict or fear with low scores indicating low conflict. For this study, as in Curry (1985), the opposite applied. High scores on a scale indicate low conflict or fear and low scores indicate high conflict or fear. To compare scale means with Lederman's (1984) data the following formula was used for adjusting the Lederman means:

Maximum Score - norm mean + number of items

Instrument - Concern for the older child.

The second area that was measured was concern for the older child. To measure this variable, an additional tool was developed (Appendix D). Drawing from clinical experience and the literature, ten statements were developed which embraced areas of concern about the older child mentioned by secundigravidas. Concerns such as jealousy,

regression and loss of the special mother-child relationship were developed into a Likert-like scale. The statements were then chosen at random to be positively or negatively worded. An example of each are: "I am confident that my child will feel I have enough time for him/her" and "I worry that my child will not accept the new baby".

The scoring of this tool was as described with the Lederman prenatal self-evaluation questionnaire. The responses are scored directionally depending on whether the item is positively or negatively stated. For a positive statement the points for responses are: very much so, 4; moderately so, 3; somewhat so, 2; and not at all, 1. With a negative statement the points were reversed: very much so, 1; moderately so, 2; somewhat so, 3; and not at all, 4.

To test the tool, two pilot studies were conducted in Spring 1985. Two samples of secundigravidas (N=10, N=9) meeting the study criteria were used. The tool appears to have a high degree of reliability as measured by the split half technique. The split half reliabilities for the scale in the two pilot studies were .88 and .91 respectively (see Appendix E). The scale appears to have evidence of face validity.

Procedure

It was important to the internal validity of the study to measure the secundigravida's concerns before the subjects had class content which could confound the results. Due to the limited number of refresher classes offered in December

1985, two methods of data collection were used in this study to obtain enough subjects in the time available. Six subjects were contacted by the investigator at their first childbirth class. The purpose of the study and the assessment tool were explained. Those willing to participate in the study were given a packet of information. This included the informed consent form, complete instructions, the Lederman prenatal questionnaire, the concerns for older child tool, and the demographic questionnaire (Appendix G). The subjects were then asked to read the statements on the questionnaires, decide which response best describes their feelings and circle the appropriate letter next to each statement. The investigator remained to answer questions and gather the completed questionnaires.

The remaining subjects were obtained through the mail. A list of secundigravidas registered for refresher childbirth classes was obtained from the association which sponsored them. A packet of information was mailed to 31 prospective subjects which included a cover letter explaining the study, the informed consent form, complete instructions, the Lederman prenatal questionnaire, the concerns for older child tool, the demographic questionnaire, and a stamped self addressed envelope. The subjects were instructed to return the informed consent form with the completed questionnaires. When returned, the consent form and questionnaires were placed in separate

envelopes by the researcher to maintain confidentiality. Twenty four women responded resulting in a response rate of 77%.

Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS). Specific methods of analysis will be described in the next chapter as the findings of the study are presented.

Chapter III

Results and Discussion

This chapter will report and discuss the findings of the study. The demographic characteristics of the sample will be described followed by a discussion of the results in view of the research questions and hypothesis.

Sample Characteristics

The demographic characteristics of the sample of 30 secundigravidas was much as expected. The women ranged in age from 24 to 37 years, with a mean age of 31. Sixty-seven percent of the sample were 30 years of age or older. Their partners were slightly older with an age range of 24 to 42 years, a mean age of 33 (Table 1).

The socioeconomic status of the sample as measured by family income and education was predominantly middle to upper middle class. All had at least a high school education with 61% of the women being college graduates including eight subjects who had done post graduate work (Table 1). The mean family income was 31,000 to 35,000 dollars with 43% of the sample earning over 40,000 dollars annually (Table 2). The subjects' employment status was evenly distributed with ten women listing homemaker, twelve working part-time or working at home for money, and eight of the subjects were employed out of the home on a full time basis.

The majority of the subjects' children were toddlers. Fifty-three percent of the women had a child under three

years old while only two subjects had a child over five years of age (Table 3).

Table 1

Sample Demographics

Characteristic	Mean	SD	Range
Mother's Age	31.0	3.5	24-37
Partner's Age	32.7	4.3	24-42
Mother's Education	15.3	2.2	12-20

Table 2

Family Income

Category	Absolute Frequency	Adjusted Frequency(%)	Cummulative Frequency(%)
10,000-15,000	1	3.3%	3.3%
16,000-20,000	1	3.3%	6.7%
21,000-25,000	4	13.3%	20.0%
26,000-30,000	6	20.0%	40.0%
31,000-35,000	4	13.3%	53.3%
36,000-40,000	1	3.3%	56.7%
>40,000	13	43.3%	100.0%

Table 3

Age of Child

Age	Absolute Frequency	Adjusted Frequency(%)	Cummulative Frequency(%)
1 to 1.5 years	3	10.0%	10.0%
1.5 to 2 years	4	13.3%	23.3%
2 to 2.5 years	8	26.7%	50.0%
2.5 to 3 years	1	3.3%	53.3%
3 to 3.5 years	8	26.7%	80.0%
3.5 to 4 years	2	6.7%	86.7%
4 to 4.5 years	2	6.7%	93.3%
> 5 years	2	6.7%	100.0%

Research Question 1

The first research question asked, "what are the concerns of the secundigravida antenatally as measured by the Lederman prenatal self-evaluation questionnaire?"

Scale item means on the Lederman prenatal questionnaire (Table 4) provides evidence that the sample appears to be making satisfactory adaptation to pregnancy. Values on the four point scale ranged from a low of 3.0 for relationship with mother to a high of 3.5 for identification with the motherhood role. High scores indicate less conflict or concern about the item or scale. When the scales were examined at the item level, very few items fell more than one standard deviation above or below the mean. These items will be discussed in the context of each scale.

Table 4

Scale Item Means for Lederman Prenatal Questionnaire

Scale	Item Mean	SD	Range
Acceptance of Pregnancy	3.4	0.36	2.8-3.9
Identification of Motherhood Role	3.5	0.42	2.6-3.9
Relationship with Mother	3.0	0.45	2.4-3.5
Relationship with Husband	3.3	0.36	2.6-3.7
Preparation for Labor	3.4	0.35	2.6-3.7
Fear of Pain, Helplessness, and Loss of Control in Labor	3.4	0.28	3.0-3.8
Well-Being of Self & Baby	3.4	0.32	3.0-3.8

Acceptance of Pregnancy

The responses of the sample indicate that they are finding it difficult to deal with the changes brought about by their pregnancies and find many things disagreeable. However, their responses also indicate that they are adjusting well and wish to be pregnant at this time. The item mean for the reversed scored statement "It's difficult for me to accept this pregnancy" was 3.93, indicating these women are very accepting of their pregnancies. As a whole, the data suggests some ambivalence on the subjects' part with regard to their pregnancies. Similar results were found by Pohlman (1968) who hypothesized that acceptance of pregnancy is not always totally positive but often involves some ambivalence.

It is possible that many of the things these women are finding disagreeable are physical in nature. This would be consistent with the findings of other studies (Westbrook, 1978; Norr et al., 1980) which found multigravidas with more complaints of fatigue and physical discomforts than primigravidas.

Identification of the Motherhood Role

This scale has the highest item mean among the scales, 3.5, indicating these women have a strong identification with the motherhood role. Two items however, suggest that these women are concerned about the demands made on their time by motherhood. Both items "It will be hard for me to balance child care with my other commitments and activities"

and "I am concerned that caring for a baby will leave me little time for myself" had means of 2.5. It appears that the increasing complexity of their family situations is causing these women to worry about how they will handle it all after the baby is born. Moss (1981) reported similar findings in her study of postpartum concerns of multigravidas.

Relationship with Mother

These women do not appear to have close relationships with their mothers. The item mean on this scale is 3.0, the lowest of the seven scales. Items relating to their mothers' reactions to the pregnancy indicated a positive response. However, items relating to the subjects' relationship with their mothers suggest some conflict. As indicated by item responses the women do not find their mothers reassuring nor someone they can talk to about their problems. Lederman (1984) reported similar results, with the multigravidas in her sample having more conflict in their relationships with their mothers than the primigravidas.

The grandmother-to-be functions as a giver of comfort, support, and as a companion (Rubin, 1967b). The data suggests the women in this sample do not percieve their mothers filling these roles. One can only speculate as to why this may be so. Perhaps the grandmother does not sense her daughter's emotional needs, as she has been pregnant before. The grandmother may not even live in the area and

what support she does give may be by long distance. Other possible areas of conflict may be in lifestyle or childrearing practices.

Relationship with Husband

On the whole the subjects' relationships with their husbands were satisfactory. Item responses indicate the women did not find their husbands critical of them but did fail to find them understanding when upset. These women also were concerned that their husbands were not satisfied with the sexual adjustment made during the pregnancy. However, responses indicate these women were confident that they could count on their husbands support in labor.

The pregnant woman has an increased need for love and appreciation from her husband and displays an increased dependency on him (Cohen, 1966; Richardson, 1983a). The data suggests that this sample may not be having all of their dependency needs met. Colman and Colman (1971) found the multigravidas in their sample were not receiving the support they needed from their husbands. Likewise, Lederman (1984), found the multigravidas in her sample demonstrated more conflict with their husbands than the primigravidas.

As with the grandmothers, perhaps the husbands are not aware of their wives needs at this time. Whether this is due to poor communication or lack of expectations is impossible to assess. Perhaps, the husband is involved in his career or has concerns about his growing-family's financial support. He too, may be busy helping his wife

meet her physical needs with childcare and housework and may not be able to give the psychological support to meet her emotional needs.

Preparation for Labor

These women indicate they are not looking forward to childbirth. However, the data suggests they look upon childbirth as a natural event and are not concerned about the process of labor and birth. It appears that this sample is well prepared for childbirth but perhaps from prior experience do not find it something to joyously anticipate.

It could be expected that this sample would rate themselves high in preparation for labor. As secundigravidas, they have experienced birth before and are registered for their second series of childbirth classes to further increase their preparation. The demographic characteristics of this sample of secundigravidas is much like that of Grossman et al. (1980) who found the women most prepared for labor in their sample had children, rated themselves happier with their marriage, and were of higher socioeconomic status.

Fear of Pain, Helplessness, and Loss of Control in Labor

The data suggests these women are confident of their performance during childbirth. This scale had a item mean of 3.4 with the least variance of any scale. Only two items, "I can cope well with pain" and "I can perform well under stress" fell below one standard deviation from the

mean. However, both had item means of 3.0, indicating only moderate concern about these items.

Locus of control has been associated with a woman's perception of her birth experience in several studies (Willmuth et al., 1978; Scoot-Palmer & Skevingtion, 1981). Women with an internal locus of control are reported to have shorter labors and are more satisfied with their birth experiences than women with external locus of control. The item responses from this sample of secundigravidas would indicate the group may have an internal locus of control, a feeling that they had some element of control over the childbirth process. Given this sense of control and the knowledge that their husbands will be supportive in labor, it is not surprising that these women are confident.

Concern for Well-Being of Self and Baby

This sample is not especially concerned about the safety of themselves nor their babies in labor. The item responses indicate the women are confident they will not be harmed in labor and just as confident that they will not lose the baby in labor. However, they did express some concern that complications may occur. As Larsen (1966) reported with her sample of multigravidas, these secundigravidas are concerned that the baby might not be normal. Most women worry during their pregnancy that the baby may not be normal. There are no guarantees and after having one healthy child it is understandable that women may

worry that the odds might be higher that something could be wrong with the next child.

Research Question 2

The second research question asked, "what are the concerns of the secundigravida antenatally with regard to her older child?" This was measured by the Concern for Older Child tool. High values on the four point scale indicated little concern while low values suggest much concern.

The scale item mean on the Concern for Older Child tool is 2.59 indicating these women have more conflict in this area than any of the dimensions measured by the Lederman prenatal self-evaluation questionnaire. Item means (Table 5) ranged from a low of 1.9 for "I do not think my child will be more demanding of me" to a high of 3.3 for the negatively scored items "I worry that my child will not accept the new baby" and "I worry that my child will hurt the baby".

The degree of concern for their older child expressed by this group of secundigravida's validates the findings of other studies (Jenkins, 1976; Moss, 1981; Richardson, 1983b). From the literature and clinical experience this researcher expected significant differences to be found with the older mothers, those working full time, and those with younger children expressing more concerns than the others.

When this assumption was tested by chi square and analysis of variance no significant differences between

Table 5

Item Means for Concern for Older Child Tool

Item	Mean	SD	Range
1. I am sure my child will not feel neglected by me after the baby's birth.	2.5	.86	1-4
2. I worry that my child will hurt the baby.	3.3	.70	2-4
3. I am concerned that my child will be jealous when I feed the baby.	2.6	.89	1-4
4. I know my child will not regress after the baby is born.	2.2	.92	1-4
5. I am confident that my child will feel I have enough time for him/her.	2.6	.81	1-4
6. I do not think my child will be more demanding of me.	1.9	.71	1-3
7. I worry that my child will not accept the new baby.	3.3	.83	1-4
8. I am afraid that my child will feel she /he is losing our special relationship.	2.7	.96	1-4
9. I am confident my child will not misbehave more after the baby is born.	2.0	.93	1-4
10. I am concerned that my child will feel rejected by me.	2.9	.92	1-4

various demographic characteristics were found to account for the lower scores. A median split was used to divide the tool scores into two groups and comparisons were made with maternal age, maternal education, maternal employment and age of the older child. Maternal age was the one factor that neared significance. Women 30 years of age or younger scored higher on the tool less often than women 31 years or older.

Hypothesis

The stated hypothesis for this study was there will be no significant differences in the psychosocial adaptation to pregnancy between the primigravida and the secundigravida as measured by the Lederman prenatal self-evaluation questionnaire.

Using the t-test for independent samples, significant differences were found when comparing the scale means of this sample of secundigravidas with Lederman's (1984) original sample of primigravidas. Three scales were significantly different; relationship with mother, relationship with husband and fear of pain, helplessness, and loss of control in labor (Table 6). Therefore the null hypothesis was rejected.

The secundigravidas had more conflict in their relationship with their mothers than Lederman's sample ($p<0.02$), which Lederman (1984) also found with her sample of multigravidas (Table 7). Likewise, the secundigravidas

Table 6

Comparison of Lederman Prenatal Questionnaire Scores of Secundigravida and Primigravida Samples

Scale	Secundigravida (Gerlt)	Primigravida (Lederman)
Acceptance of Pregnancy	M = 48.4 sd= 6.3 N = 30	M = 49.1 sd= 4.9 N = 59
Identification of Motherhood Role	M = 53.2 sd= 4.5 N = 29	M = 54.8 sd= 4.3 N = 59
Relationship with Mother	M = 30.6 sd= 7.1 N = 25	M = 34.5 * sd= 6.2 N = 56
Relationship with Husband	M = 32.6 sd= 5.1 N = 29	M = 35.4 * sd= 4.3 N = 56
Preparation for Labor	M = 33.7 sd= 3.9 N = 30	M = 33.7 sd= 4.5 N = 59
Fear of Pain, Helplessness, and Loss of Control in Labor	M = 33.8 sd= 3.5 N = 30	M = 31.8 * sd= 3.5 N = 58
Well-Being of Self & Baby	M = 34.3 sd= 4.3 N = 30	M = 33.2 sd= 4.5 N = 59

* $p<0.02$

Table 7

Comparison of Lederman Prenatal Questionnaire Scores of Secundigravida and Multigravida Samples

Scale	Secundigravida (Gerlt)	Multigravida (Lederman)
Acceptance of Pregnancy	M = 48.4 sd= 6.3 N = 30	M = 46.5 sd= 8.2 N = 54
Identification of Motherhood Role	M = 53.2 sd= 4.5 N = 29	M = 54.5 sd= 4.8 N = 54
Relationship with Mother	M = 30.6 sd= 7.1 N = 25	M = 30.8 sd= 7.3 N = 54
Relationship with Husband	M = 32.6 sd= 5.1 N = 29	M = 32.3 sd= 4.8 N = 53
Preparation for Labor	M = 33.7 sd= 3.9 N = 30	M = 34.8 sd= 4.3 N = 54
Fear of pain, Helplessness, and Loss of Control in Labor	M = 33.8 sd= 3.5 N = 30	M = 31.8 * sd= 5.0 N = 54
Well-Being of Self & Baby	M = 34.3 sd= 4.3 N = 30	M = 33.5 sd= 5.1 N = 54

* $p<0.05$

had more conflict in their relationship with their husbands ($p<0.02$). But in contrast to the Lederman (1984) sample these women had less fear of pain, helplessness, and loss of control in labor than either Lederman's primigravidas or multigravidas ($p<0.02$ for primigravidas and $p<0.05$ for multigravidas). Apparently these secundigravidas felt they could handle labor although they were not looking forward to it. Strong correlations were found between fear of pain, helplessness, and loss of control in labor with acceptance of pregnancy, identification of a motherhood role, preparation for labor and concern for well-being of self and baby (Table 8). Perhaps this can account for some of the difference between this sample and Lederman's (1984) which had lower correlations (Table 8).

Instrument Reliability

The Cronbach's alphas on the Lederman prenatal self-evaluation questionnaire for this sample are slightly lower than the values reported by Lederman (1984) (Table 9). However, the alpha levels, ranging from .73 for fear of pain, helplessness, and loss of control in labor to .91 for relationship with mother follow patterns similar to Lederman's and demonstrate good reliability. Likewise, the alpha level for the Concern for Older Child tool was .87 indicating excellent reliability.

Table 8

Correlations Among the Subscales on the Lederman Questionnaire and Concern for Older Child Tool

	ACP	IDMR	RWM	RWH	PRL	PHC	WBSB	COC
ACP	---	.53(.54) P=002	.44(.27) P=014	.07(.25) NS	.25(.33) NS	.64(.36) P=000	.58(.31) P=001	.54 P=001
IDMR		---	.68(.35) P=000	.31(.24) NS	.47(.28) P=005	.51(.28) P=002	.44(.21) P=009	.37 P=025
RWM			---	.48(.30) P=008	-.05(.25) NS	.05(.18) NS	.16(.11) NS	.35 P=042
RWH				---	.35(.15) P=033	.35(.06) P=031	.15(.19) NS	.36 P=027
PRL					---	.73(.47) P=000	.34(.35) P=032	.35 P=027
PHC						---	.53(.52) P=001	.41 P=012
WBSB							---	.58 P=000
COC								---

Note
ACP = Acceptance of Pregnancy
IDMR = Identification with a Motherhood Role
RWM = Relationship with Mother
RWH = Relationship with Husband
PRL = Preparation for Labor
PHC = Fear of Pain, Helplessness, and Loss of Control in Labor
WBSB = Well-Being of Self and Baby
COC = Concern for Older Child

Values in parenthesis are correlations reported by Lederman (1984).

Table 9

Cronbach's Alphas for the Lederman Prenatal Questionnaire

Scales	Gerlt Sample Alpha	Lederman Sample Alpha
Acceptance of Pregnancy	.88	.90
Identification of Motherhood Role	.78	.79
Relationship with Mother	.91	.92
Relationship with Husband	.82	.82
Preparation for Labor	.77	.80
Fear of Pain, Helplessness, and Loss of Control in Labor	.73	.75
Well-Being of Self and Baby	.82	.83

Additional Findings

The correlation matrix for the Concern for Older Child tool demonstrates the items form a reliable scale (Table 10). Only one item "I worry that my child will hurt the baby" had poor correlations with the other items. However, if deleted, the alpha level if the tool would not change. The decision was made to keep the item since this is a statement the researcher has heard clinically from secundigravidas. Perhaps this is a concern this sample could not commit to paper.

The Concern for Older Child tool had significant correlations with all of the scales of the Lederman prenatal self-evaluation questionnaire indicating a positive relationship between all of the scales (Table 8). The data indicates the Concern for Older Child tool adequately measures the concern of the secundigravida for her older child.

Table 10

Correlations for Items of Concern for Older Child Tool

	G1	G2	G3	G4	G5	G6	G7	G8	G9	G10
G1	--	.41 P=012	.47 P=005	.47 P=005	.71 P=000	.48 P=003	.37 P=021	.60 P=000	.41 P=012	.68 P=000
G2		--	.47 P=004	.22 NS	.27 NS	.27 NS	.21 NS	.26 NS	.12 NS	.21 NS
G3			--	.23 NS	.39 P=017	.26 NS	.34 P=035	.52 P=002	.44 P=007	.45 P=006
G4				--	.43 P=009	.45 P=006	.20 NS	.23 NS	.53 P=001	.31 P=049
G5					--	.35 P=031	.47 P=004	.57 P=000	.62 P=000	.73 P=000
G6						--	-.07 NS	.25 NS	.52 P=002	.19 NS
G7							--	.55 P=001	.10 NS	.58 P=000
G8								--	.45 P=006	.74 P=000
G9									--	.44 P=008
G10										--

Note

G1 = I am sure my child will not feel neglected by me after the baby's birth.
G2 = I worry that my child will hurt the baby.
G3 = I am concerned that my child will be jealous when I feed the baby.
G4 = I know my child will not regress after the baby is born.
G5 = I am confident that my child will feel I have enough time for him/her.
G6 = I do not think my child will be more demanding of me.
G7 = I worry that my child will not accept the new baby.
G8 = I am afraid that my child will feel she/he is losing our special relationship.
G9 = I am confident my child will not misbehave more after the baby is born.
G10= I am concerned that my child will feel rejected by me.

Chapter IV

Summary

Pregnancy has been studied from the viewpoint of the primigravida, both physically and emotionally. However, little has been written about the multigravida and her physical and psychosocial concerns. The author's interest in the needs and concerns of the multigravida and the secundigravida in particular, led to this study.

From the review of the literature the multigravida appears to have more physical discomfort and fatigue than the primigravida. Further, she may not be getting the support she needs from her husband, health care provider, and possibly her mother. The multigravida may be more concerned about the well being of the fetus and her labor and birth than with her first pregnancy, especially if she had an unsatisfactory birth experience the first time. The multigravida, particularly the secundigravida, also has concerns about her older child.

Concepts from role theory and developmental theory were selected to guide this study. Each pregnant woman has her own developmental tasks to accomplish during her pregnancy; these tasks relate both to her pregnancy as well as her individual stage of development. The secundigravida must negotiate all of the developmental tasks of pregnancy and prepare for the role transition of being a mother of one to the mother of two.

Two research questions were asked and one hypothesis was tested. The research questions were: 1) What are the concerns of the secundigravida antenatally as measured by the Lederman prenatal self-evaluation questionnaire? 2) What are the concerns of the secundigravida antenatally with regard to her older child? It was hypothesized that there would be no significant differences in the psychosocial adaptation to pregnancy between the primigravida and the secundigravida as measured by the Lederman prenatal self-evaluation questionnaire.

The study employed a nonexperimental correlational design which involved the administration of the Lederman prenatal self-evaluation questionnaire to a group of secundigravidas. Their scores were then analyzed and correlated with Lederman's (1984) original data from a sample of primigravidas and multigravidas. In addition, a tool developed for this study to measure the concerns of secundigravidas regarding their older child was administered and analyzed.

The convenience sample of 30 secundigravidas was predominantly middle to upper middle class. The mean age was 31 and the majority of their children were toddlers.

The data suggests that these women are concerned about the demands made on their time by motherhood and that their their mothers' and husbands' may not be giving them the support they need. The data further suggests that the concern for the older child is pervasive among this sample

of secundigravidas. However, these women are confident of their performance during childbirth and had little concern for the well-being of themselves or their baby in labor.

The findings did not support the null hypothesis. When compared to Lederman's (1984) primigravidas, this sample of secundigravidas had significantly more conflict in their relationships with their mothers and husbands. However, they had significantly less fear of pain, helplessness, and loss of control in labor than Lederman's sample of primigravidas.

Limitations

Several limitations of this study could have influenced the findings. The major limitation is the small, non random sample. Although a sample size of 30 is large enough to estimate the population, the inherent bias in non random sampling would make generalizations to other populations circumspect. The homogeneous sample is another limitation. This sample of middle class women taking childbirth classes is not representative of all secundigravidas.

A third limitation is the method of data collection. Six subjects were recruited at their childbirth class while the other 24 were recruited through a mailing. Although clarifying questions were not asked, what subtle differences may have influenced the subjects by the author being present at the class is unknown. The subjects from the mailing may have had more time to fill out the questionnaires as well an opportunity for collaboration with their husbands. The

fourth limitation that could have influenced the findings is that the Concern for Older Child tool has not been previously tested with a large sample.

Implications for Nursing Practice

While generalizations to all secundigravidas can not be made from this homogeneous sample, the findings suggest that some secundigravidas do have concerns and unmet needs that should be addressed. The nursing care of these women should include assessment of their concerns, worries, and fears.

Antenatally, the nurse should assess the secundigravida at prenatal visits. Many of her needs and concerns, including those of fatigue, worry over normalcy of the fetus, lack of support by her husband and mother, and her concern about her older child could be addressed by individual counseling at this time. However, some women may benefit from classes or a support group designed for multigravidas. These classes should address the possible lack of support, change in relationships and/or conflict with their husbands and mothers. The secundigravida's concern for her older child should also be addressed. The data collected with the Concern for Older Child tool suggests that behavioral changes may be of upmost concern followed by changes in the mother-child relationship. With this knowledge, suggestions could be given to help the secundigravida ease the adjustment of her older child to the new baby. Further, incorporating the developmental tasks and role changes of the expanding family the nurse could

offer anticipatory socialization to the secundigravida's new role as a mother of two.

During hospitalization the concerns of the secundigravida should continue to be assessed. The labor nurse can offer support and encouragement being aware of the secundigravida's possible increased expectation of control in labor. The postpartum nursing staff should further assess the secundigravidas support system and learning needs with specific interventions planned to meet her individual needs. The postpartum nurse can also assist the family with the integration of the newborn into the family by encouraging sibling visitation and involvement with the baby. Role play could possibly be used to give the secundigravida suggestions to help her child through the transition period.

The nursing process should continue postpartum with phone calls and possibly home visits as well as the assessment at the postpartum check up. The nurse should assess the support the secundigravida is receiving from her husband and mother, how she is handling her time commitments, her fatigue level, as well as the adjustment of her older child. Special support groups for the secundigravida addressing the above issues may be of value at this time. The continued support of the secundigravida by nursing staff throughout her childbearing year could help meet her psychosocial as well as physical needs.

Recommendations for Research

Recommendations for further research include replication of this study with a larger and/or more heterogeneous sample. The Lederman prenatal self-evaluation questionnaire has been used primarily with middle class samples and it is not known what differences might be found with a lower socioeconomic class sample. Similarly, the Concern for Older Child tool might only address concerns of the middle class population from which it was drawn.

Further study into the relationship of the multigravida with her mother and husband might give insight into the findings of this study. A qualitative study employing inductive interview could be used to define different factors which may be influencing these relationships.

A longitudinal study examining the adaptation to pregnancy of secundigravidas and primigravidas antenatally and through the postnatal period would be helpful. The differences between the two groups reported in this study may change over time.

Another area of further research would be to examine the influence of classes or support groups giving content on preparation for the second child. The expressed concerns of the secundigravida could be measured before and after classes using the Concern for Older Child tool.

Only through research can we as health care professionals gain insight into the possible factors

influencing the psychosocial adaptation to pregnancy of the secundigravida.

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Appendix A

Lederman Prenatal Self-Evaluation Questionnaire

PRENATAL SELF-EVALUATION QUESTIONNAIRE II

Directions

The statements below have been made by expectant women to describe themselves. Read each statement and decide which response best describes your feelings. Then circle the appropriate letter next to each statement.

	Very Much So	Moderately So	Somewhat So	Not At All
1. This is a good time for me to be pregnant.	A	B	C	D
2. I like to watch other parents and children together.	A	B	C	D
3. I can tolerate the discomforts that I've had during pregnancy.	A	B	C	D
4. My husband and I talk about the coming baby.	A	B	C	D
5. My husband has been critical of me during the pregnancy.	A	B	C	D
6. I feel that rearing children is rewarding.	A	B	C	D
7. I feel it is necessary to know a lot about labor.	A	B	C	D
8. I can cope well with pain.	A	B	C	D
9. It's hard for me to get used to the changes brought about by pregnancy.	A	B	C	D
10. My husband is understanding (calms me) when I get upset.	A	B	C	D
11. I can perform well under stress.	A	B	C	D
12. I think my labor and delivery will progress normally.	A	B	C	D
13. There is little I can do to prepare for labor.	A	B	C	D
14. My mother shows interest in the coming baby.	A	B	C	D
15. I have confidence in my ability to maintain composure in most situations.	A	B	C	D
16. I am worried that the baby will be abnormal.	A	B	C	D
17. I think the worst whenever I get a pain.	A	B	C	D
18. Realizing that labor has to end will help me maintain control in labor.	A	B	C	D
19. I look forward to caring for the baby.	A	B	C	D
20. My mother is happy about my pregnancy.	A	B	C	D
21. My mother offers helpful suggestions.	A	B	C	D

	Very Much So	Moderately So	Somewhat So	Not At All
22. I have enjoyed this pregnancy.	A	B	C	D
23. My husband is interested is discussing the pregnancy with me.	A	B	C	D
24. I have a good idea of what to expect during labor and delivery.	A	B	C	D
25. I understand how to work with the contractions in labor.	A	B	C	D
26. I look forward to childbirth.	A	B	C	D
27. I suspect the doctors and nurses will be indifferent to my concerns in labor.	A	B	C	D
28. It's easy to talk to my mother about my problems.	A	B	C	D
29. I have doubts about being a good mother.	A	B	C	D
30. I dwell on the problems the baby might have.	A	B	C	D
31. My mother looks forward to this grandchild.	A	B	C	D
32. I am glad I'm pregnant.	A	B	C	D
33. I like having children around me.	A	B	C	D
34. It will be hard for me to balance childcare with my other commitments and activities.	A	B	C	D
35. My husband helps me at home when I need it.	A	B	C	D
36. I find it hard to talk to my husband about any changes in sex drive during this pregnancy.	A	B	C	D
37. I feel good when I'm with my mother.	A	B	C	D
38. I am preparing myself to do well in labor.	A	B	C	D
39. I feel sure that I will lose control in labor.	A	B	C	D
40. I can count on my husband's support in labor.	A	B	C	D
41. I am afraid that I will be harmed during delivery.	A	B	C	D
42. I feel that babies aren't much fun to care for.	A	B	C	D
43. My husband feels I burden him with my feelings and problems.	A	B	C	D
44. When we get together my mother and I tend to argue.	A	B	C	D
45. It will be difficult for me to give enough attention to a baby.	A	B	C	D
46. I think the baby will be a burden to me.	A	B	C	D

	Very Much So	Moder-ately So	Some-what So	Not At All
47. I feel prepared for what happens in labor.	A	B	C	D
48. I know some things I can do to help myself in labor.	A	B	C	D
49. When the time comes in labor, I'll be able to push even if it's painful.	A	B	C	D
50. I think about the kind of mother I want to be.	A	B	C	D
51. I am anxious about complications occurring in labor.	A	B	C	D
52. I feel that the stress of labor will be too much for me to handle.	A	B	C	D
53. I think I can bear the discomfort of labor.	A	B	C	D
54. I am concerned that caring for a baby will leave me little time for myself.	A	B	C	D
55. My mother reassures me when I have doubts about myself.	A	B	C	D
56. I feel well informed about labor.	A	B	C	D
57. I am worried that something will go wrong during labor.	A	B	C	D
58. It's difficult for me to accept this pregnancy.	A	B	C	D
59. My mother encourages me to do things in my own way.	A	B	C	D
60. I think my husband would say we have made a satisfactory sexual adjustment during this pregnancy.	A	B	C	D
61. This has been an easy pregnancy so far.	A	B	C	D
62. I wish I wasn't having the baby now.	A	B	C	D
63. I worry that I will lose the baby in labor.	A	B	C	D
64. If I lose control in labor it will be hard for me to regain it.	A	B	C	D
65. My mother criticizes my decisions.	A	B	C	D
66. I'm having a problem adjusting to this pregnancy.	A	B	C	D
67. I am worried that my baby may not like me.	A	B	C	D
68. I focus on all the terrible things that could happen in labor.	A	B	C	D
69. This pregnancy has been a source of frustration to me.	A	B	C	D
70. I can count on my husband to share in the care of the baby.	A	B	C	D
71. I am confident of having a normal childbirth.	A	B	C	D

	Very Much So	Moder-ately So	Some-what So	Not At All
72. I feel that childbirth is a natural, exciting event.	A	B	C	D
73. I feel I already love the baby.	A	B	C	D
74. I have found this pregnancy gratifying.	A	B	C	D
75. I believe I can be a good mother.	A	B	C	D
76. I have regrets about being pregnant at this time.	A	B	C	D
77. I find many things about pregnancy disagreeable.	A	B	C	D
78. I feel I will enjoy the baby.	A	B	C	D
79. I am happy about this pregnancy.	A	B	C	D

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Appendix B

Items for the Seven Scales of

Lederman Prenatal Self-Evaluation Questionnaire

Items for the Seven Scales of Lederman Prenatal Self-Evaluation Questionnaire

Scale 1 - Acceptance of Pregnancy

This is a good time for me to be pregnant.

I can tolerate the discomforts that I've had during pregnancy.

It's hard for me to get used to the changes brought about by pregnancy.

I have enjoyed this pregnancy.

I am glad I'm pregnant.

It's difficult for me to accept this pregnancy.

This has been an easy pregnancy so far.

I wish I wasn't having the baby now.

I'm having a problem adjusting to this pregnancy.

This pregnancy has been a source of frustration to me.

I have found this pregnancy gratifying.

I have regrets about being pregnant at this time.

I find many things about pregnancy disagreeable.

I am happy about this pregnancy.

Scale 2 - Identification of a Motherhood Role

I like to watch other parents and children together.

I feel that rearing children is rewarding.

I look forward to caring for the baby.

I have doubts about being a good mother.

I like having children around me.

It will be hard for me to balance childcare with my other commitments and activities.

I feel that babies aren't much fun to care for.

It will be difficult for me to give enough attention to a baby.

I think the baby will be a burden to me.

I think about the kind of mother I want to be.

I am concerned that caring for a baby will leave me little time for myself.

I am worried that my baby may not like me.

I feel I already love the baby.

I believe I can be a good mother.

I feel I will enjoy the baby.

Scale 3 - Relationship with Mother

My mother shows interest in the coming baby.

My mother is happy about my pregnancy.

My mother offers helpful suggestions.

It's easy to talk to my mother about my problems.

My mother looks forward to this grandchild.

I feel good when I'm with my mother.

When we get together my mother and I tend to argue.

My mother reassures me when I have doubts about myself.

My mother encourages me to do things in my own way.

My mother criticizes my decisions.

Scale 4 - Relationship with Husband

My husband and I talk about the coming baby.

My husband has been critical of me during the pregnancy.

My husband is understanding (calms me) when I get upset.

My husband is interested is discussing the pregnancy with me.

My husband helps me at home when I need it.

I find it hard to talk to my husband about any changes in sex drive during this pregnancy.

I can count on my husband's support in labor.

My husband feels I burden him with my feelings and problems.

I think my husband would say we have made a satisfactory sexual adjustment during this pregnancy.

I can count on my husband to share in the care of the baby.

Scale 5 - Preparation for Labor

I feel it is necessary to know a lot about labor.

There is little I can do to prepare for labor.

I have a good idea of what to expect during labor and delivery.

I understand how to work with the contractions in labor.

I look forward to childbirth.

I am preparing myself to do well in labor.

I feel prepared for what happens in labor.

I know some things I can do to help myself in labor.

I feel well informed about labor.

I feel that childbirth is a natural, exciting event.

Scale 6 - Fear of Pain, Helplessness and Loss of Control in Labor

I can cope well with pain.

I can perform well under stress.

I have confidence in my ability to maintain composure in most situations.

Realizing that labor has to end will help me maintain control in labor.

I suspect the doctors and nurses will be indifferent to my concerns in labor.

I feel sure that I will lose control in labor.

When the time comes in labor, I'll be able to push even if it's painful.

I feel that the stress of labor will be too much for me to handle.

I think I can bear the discomfort of labor.

If I lose control in labor it will be hard for me to regain it.

Scale 7 - Well-Being of Self and Baby

I think my labor and delivery will progress normally.

I am worried that the baby will be abnormal.

I think the worst whenever I get a pain.

I dwell on the problems the baby might have.

I am afraid that I will be harmed during delivery.

I am anxious about complications occurring in labor.

I am worried that something will go wrong during labor.

I worry that I will lose the baby in labor.

I focus on all the terrible things that could happen in labor.

I am confident of having a normal childbirth.

Appendix C

Comparison of Lederman Prenatal Questionnaire Scores of High-Risk and Normal Samples

<u>Comparison of Lederman Prenatal Questionnaire Scores of High-Risk and Normal Samples</u>

Scale Scores	High-Risk (Curry)	Alpha	Normal (Lederman)	Alpha
Acceptance of Pregnancy	M = 44.8		M = 47.7 *	
	sd= 7.0		sd= 7.0	
	N = 95	.86	N = 199	.90
Identification of Motherhood Role	M = 55.4		M = 54.8	
	sd= 4.1		sd= 4.6	
	N = 95	.70	N = 119	.79
Relationship with Mother	M = 33.3		M = 32.7	
	sd= 6.2		sd= 6.9	
	N = 89	.89	N = 119	.92
Relationship with Husband	M = 33.4		M = 33.8	
	sd= 6.1		sd= 5.1	
	N = 89	.79	N = 115	.82
Preparation for Labor	M = 31.7		M = 34.1 **	
	sd= 4.7		sd= 4.5	
	N = 87	.74	N = 119	.80
Fear of Pain, Helplessness and Loss of Control in Labor	M = 32.1		M = 31.8	
	sd= 4.6		sd= 4.2	
	N = 84	.75	N = 118	.75
Well-Being of Self & Baby	M = 29.8		M = 33.5 **	
	sd= 5.9		sd= 4.8	
	N = 90	.82	N = 119	.83

* $p<0.01$
** $p<0.002$

Appendix D

Concern for Older Child Tool

Directions

The statements below have been made by expectant women to describe themselves and their child. Read each statement and decide which response best describes your feelings. Then circle the appropriate letter next to each statement.

	Very Much So	Moder-ately So	Some-what So	Not At All
1. I am sure my child will not feel neglected by me after the baby's birth.	A	B	C	D
2. I worry that my child will hurt the baby.	A	B	C	D
3. I am concerned that my child will be jealous when I feed the baby.	A	B	C	D
4. I know my child will not regress after the baby is born.	A	B	C	D
5. I am confident that my child will feel I have enough time for him/her.	A	B	C	D
6. I do not think my child will be more demanding of me.	A	B	C	D
7. I worry that my child will not accept the new baby.	A	B	C	D
8. I am afraid that my child will feel she/he is losing our special relationship.	A	B	C	D
9. I am confident my child will not misbehave more after the baby is born.	A	B	C	D
10. I am concerned that my child will feel rejected by me.	A	B	C	D

Appendix E

Concern for Older Child Tool

Pilot Studies

Concern for Older Child Tool Pilot Studies

Statistic	Pilot Study I (N=10)	Pilot Study II (N=9)
Mean	27.3	24.4
Median	28.5	24.0
Mode	32.0	31.0
Range	18.0	17.0
Variance	31.8	34.8
Standard Deviation	5.64	5.89
Split Half Reliability	0.88	0.91

Appendix F

Consent Form

INFORMED CONSENT

I agree to participate in a masters thesis research study entitled "Psychosocial Adaptation to Pregnancy of the Secundigravida". This study is being conducted by Teral Swanson Gerlt R.N., graduate student in nursing at Oregon Health Sciences University under the direction of Mary Ann Curry R.N. D.N.Sc. The purpose of this study is to examine the needs and concerns of the secundigravida (a woman pregnant with her second child) and compare and contrast them to those of the primigravida (a woman pregnant with her first child).

I understand participation in this study will involve filling out questionnaires taking approximately 20-30 minutes of my time. I further understand the only "risk" foreseen in this study is my inconvenience in terms of time. Although there may be no direct benefit to me in my participation, it is hoped that my participation will contribute to nursing knowledge and therefore nursing care of the secundigravida.

My confidentiality will be maintained as names are not required on the questionnaires.

The Oregon Health Sciences University as an agency of the State is covered by the State Liability Fund. If I suffer any injury from the research project, compensation would be available to me only if I establish that the injury occurred through the fault of the Center, its officers, or employees. If I have any further questions I may call Dr. Michael Baird, M.D. at (503) 225-8014.

Teral Gerlt has offered to answer any questions I might have concerning the study and to supply results of the study at my request. She may be reached at 245-2773.

I understand I may refuse to participate, or withdraw from this study at any time without affecting my relationship with, or treatment at, the Oregon Health Sciences University.

I have read the foregoing and agree to participate in this study.

______________________ ______________________

Date Name

Appendix G

Demograhic Questionnaire

Background Information

Please answer the following questions to help with data analysis.

1. What is your age? ______

2. What is your partner's age? ______

3. How many years of formal education have you completed? ______

4. What is your family income per year? (please check one)

<10,000 ______
10,000-15,000 ______
16,000-20,000 ______
21,000-25,000 ______
26,000-30,000 ______
31,000-35,000 ______
36,000-40,000 ______
>40,000 ______

5. What is your employment status? (please check one)

Homemaker ______
Work for money at home ______
If you work for money outside the home, do you work
Part time ______
Full time ______

6. What is the age of your first child? (please check one)

Less than 1 year ______
1-1 1/2 years ______
1 1/2-2 years ______
2-2 1/2 years ______
2 1/2-3 years ______
3-3 1/2 years ______
3 1/2-4 years ______
4-4 1/2 years ______
4 1/2-5 years ______

AN ABSTRACT OF THE THESIS OF

TERAL SWANSON GERLT

For the MASTER OF SCIENCE

Title: PSYCHOSOCIAL ADAPTATION TO PREGNANCY OF THE SECUNDIGRAVIDA

APPROVED: ______________________________
Mary Ann Curry, R.N., D.N.Sc., Thesis Advisor

The purpose of this study was to examine the concerns, worries, and fears of the secundigravida and compare and contrast them to those of the primigravida. The sample was 30 secundigravidas registered for refresher childbirth classes. Most were middle to upper middle class and had a toddler.

A nonexperimental correlational design was used. The Lederman prenatal self-evaluation questionnaire was administered to the sample and their scores were compared to a sample of primigravidas. In addition, a tool developed for this study to measure the concerns of secundigravidas regarding their older child was administered and analyzed.

Two research questions were asked and one hypothesis tested. The research questions were: 1) What are the concerns of the secundigravida antenatally as measured by the Lederman prenatal self-evaluation questionnaire? 2) What are the concerns of the secundigravida antenatally with regard to her older child? It was hypothesized that there

would be no significant differences in the psychosocial adaptation to pregnancy between the primigravida and the secundigravida as measured by the Lederman prenatal self-evaluation questionnaire.

The data suggests that these women are concerned about the demands made on their time by motherhood and that their their mothers and husbands may not be giving them the support needed. The data further suggests that the concern for the older child is pervasive among this sample of secundigravidas.

The findings did not support the null hypothesis. When compared to Lederman's (1984) primigravidas, using the t-test for independent samples, this sample of secundigravidas had significantly more conflict in their relationships with their mothers and husbands. However, they had significantly less fear of pain, helplessness, and loss of control in labor.

Limitations of the study which could have influenced the findings include non random sampling, the homogeneous sample, and methods of data collection. Implications for nursing practice include individual assessment and support of the secundigravida as well as classes and support groups to meet her unique needs. Recommendations for further research include replication of this study with a lower socioeconomic class sample and studies to further examine the relationship of the secundigravida with her mother and husband.