AN INVESTIGATION OF THE COPING RESPONSES AMONG AFRICAN-AMERICAN AND CAUCASIAN WOMEN WHO SUFFER FROM POSTPARTUM DEPRESSION

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Abstract

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An Investigation of the Coping Responses Among African-American and Caucasian Women Who Suffer From Postpartum Depression

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Postpartum depression has increased among women in the postnatal stage of childbirth. With the occurrence of this escalation among women, more research and attention has been focused on prevention and intervention methods. These methods emphasize education awareness, symptom recognition, and effective support systems. The notion that if an expectant mother and her family utilize such techniques, postpartum depression may not become an issue. In this study the Beck’s Depression Inventory and the Coping Response Inventory instruments were used to investigate postpartum depression and coping responses in 150
African-American and Caucasian women. The results of this study revealed that only a small minority of women surveyed experienced postpartum depression and those that did not reported a high level of support network influence. This fact may reveal the relationship that certain coping responses may play in the prevention and intervention of postpartum depression.
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In recent years there has been a growing awareness in our society regarding the issue of postpartum depression among women. Researchers, as well as, the common everyday reader, are profoundly interested in the contributing factors that may induce an onset of postpartum depression. This interest has created a heightened need to explore the prevalence of postpartum depression among women, in particular, African-American women and Caucasian-American women, and their different coping responses.

It has been proposed that African-American women relieve or prevent postpartum depression by using appropriate coping responses. The coping response this study investigated was the social support response. It was predicted that the findings would show that African-American women would not show a difference in coping responses based on social support compared to Caucasian women. The differences proposed were that
African-American women and Caucasian-American women experience postpartum depression in different ways, and may be precipitated by different factors. The key factor in the proposed study was the differences between African-American women and Caucasian women who suffer from postpartum depression and their means of social support in response to the disorder.

**Background Statement**

The research of postpartum depression appears to be a rather new study in society's list of acceptable disorders. There often tends to be an enormous amount of confusion expressed with the mere mention of the subject. People tend to convey feelings ranging from disbelief to sympathy when discussing postpartum depression. Postpartum depression causes feelings of anxiety, hopelessness and lack of self-worth. Subsequently, these feelings can even lead to mothers having difficulties forming bonds with their babies ("Baby boost", 1994).

Women experiencing postpartum depression after childbirth has been present for centuries. Postpartum depression has been recognized since the time of
Hippocrates, 460 B.C.. "Puerperal fever" was the term used to described postpartum depression. At that time it was thought that lactation, breast-feeding, was the origin of problems (Landy, Montgomery & Walsh, 1989). Gruen (1993) states that postpartum depression was also then referred to as "milk fever", a phenomenon that occurred in some women after childbirth. Postpartum depression later became known as "puerperium depression" and by the middle of the 19th century the first study was published containing the adverse emotional reactions of the postnatal period (Landy, Montgomery & Walsh, 1989).

In the past, society has dismissed postpartum depression as having jitters, over-reacting or merely an attempt to receive additional attention. Although society has made efforts to afford women empathy on certain gender related issues, there remains a significant amount of skepticism concerning women issues only. In today's media, postpartum depression has been linked to such tragedies as abandonment and/or abuse toward children, as well as, hospitalizations or incarceration for the abusive parent. This disorder is
one that should be taken seriously by everyone in society.

Postpartum depression is among the most controversial of psychiatric disorders. Numerous attempts have been made for over 200 hundred years to treat postpartum depression, yet systematic methods of treatment are just beginning to evolve (Gruen, 1993). According to Affonso (1992) postpartum depression is documented as a women's health problem on the rise. In the 1960's, three to six percent of childbearing women were reported as experiencing postpartum depression. Current prevalence rates estimate as many as 20% of childbearing women are affected to some degree by symptoms of depression. Although the occurrence of postpartum depression has begun its incline, the United States minimally has been involved in researching this topic.

According to Millis and Kornblith (1992) in the United States, postpartum disorders have generally been considered exclusively psychosocial problems. Postpartum is transitional in nature where almost everything changes in the life of the mother. The
mother's familiar patterns and relationships are renegotiated. Research suggests that women are more prone to suffer debilitating depression following childbirth than at any other time (Pfost, Stevens & Lum, 1990). In fact, a woman's risk of admission to a psychiatric hospital is greater during postpartum than at any other time in her life.

Health care professionals lack the training to recognize or treat postpartum depression, consequently, often they do not assist in the process of treatment and/or prevention. Research shows that childbirth educators frequently do not discuss postpartum depression to expectant mothers. Gruen (1990) suggests that postpartum depression is an illness often neglected, or possibly even dismissed by health professionals, leaving the majority of mothers and their families untreated. One reason suggested is that the educators do not want to increase the anxiety or stress levels of their patients. Obstetricians, midwives, and pediatricians tend to lack the specific training needed that can help alleviate some of the difficulties mothers may experience during postpartum.
Millis & Kornblith (1992) concluded that mental health professionals tend to overlook or minimize the seriousness of postpartum depression by insisting it is simply an adjustment disorder.

Although most new mothers are made aware of the experiences occurring during labor and delivery, parents lack the preparation for the dramatic changes a new infant brings to a family. Cultural expectations also exercise a major role in addressing postpartum depression. It appears that the cultural expectation is that birth and parenting come naturally, with minimal discomfort, and that most women adjust without difficulties to the changes (Gruen, 1990). Similarly, Gitlin and Pasnau (1989) concluded that postpartum depression has been viewed as, "a woman unable to accept the full responsibilities of her feminine role in society".

The occurrence of postpartum depression has not been handled as an urgent problem. The lack of information regarding this disorder, in conjunction with the lack of support from health professionals, may be the primary reasons for the neglect of this problem.
There remains such confusion and controversy surrounding the causes of postpartum depression until researchers are not clear on its facts or assumptions. The current literature on postpartum depression does not include information describing the choices childbearing women are forced to make during this time. Additionally, Affonso (1992) says the literature fails to identify or describe the distresses pregnancy imposes on expectant mothers.

The literature does confirm the necessity for future studies in the area of postpartum depression. In a recent study, Landy, Montgomery and Walsh (1989), found that during an episode of postpartum depression, a woman may need to use a variety of services, ranging from close friends to serious psychiatric treatment and psychotherapy, to medication and even hospitalization. The need for careful assessment and monitoring of postpartum depression is crucial. Moreover, if mental health workers, physicians, psychiatrists, patients, and family members are unaware of the related symptoms and their seriousness, prevention and intervention of postpartum depression could remain a challenge. Gruen
(1990) suggested that as the need increases for understanding postpartum depression, the need for research to evaluate treatment will become clearer. Logsdon, McBride and Birkimer (1994) suggest there is a need for studies to be directed in the area of prenatal expectations as a means of decreasing postpartum depression.

Research indicates there is a need for professionals who treat patients suffering from postpartum depression to use reliable measures to measure self-esteem, mothering, and sexual difficulties. These studies can be used to identify their effect on postpartum depression (Gitlin & Pasnau, 1989).

In investigating postpartum depression, it is imperative to retrieve some insight on theory regarding its existence. The theory most mentioned concerning the treatment of postpartum depression is Aaron Beck's cognitive theory. According to Corey (1991) cognitive therapy is an active, directive, time-limited, structured approach. It is considered an insight therapy that focuses on recognizing and modifying
negative thoughts and poor adaptive beliefs. This approach is based on the theoretical rationale that the way people feel and behave is determined by how they view their experience. The goal is to help clients recognize and relieve themselves of any self-defeating thoughts.

Corey (1991) also suggests Beck's cognitive model as having a basic theory of understanding the nature of an emotional episode of disturbance by focusing on the cognitive content of an individual's reaction to an upsetting event. The principle is to focus on the problem of individuals practicing self-depreciating behaviors, and distortions that lead to harmful misconceptions about themselves or others.

In treating postpartum depression, as well as, any other type of depression, cognitive therapy helps clients gain insight into their unrealistic negative thoughts and are trained to change those thoughts to reality testing, by examining the evidence for and against their thoughts. This therapy appears to be helpful with postpartum depression because of the cognitive triad Beck describes as triggers for
depression. The first component of the triad involves the client holding a negative view about themselves. They blame their setbacks on personal inadequacies without considering circumstantial explanations. The second component of the triad consists of the client tending to interpret experiences in a negative manner. The third component of the triad includes the depressed client's gloomy vision and projection about the future (Corey, 1991). All three of these components seem to be common complaints or situations reported by women suffering from postpartum depression, and/or their family members.

There are other possible explanations or theories of triggers for postpartum depression that also makes one believe that cognitive therapy may be helpful. Pfost, Stevens and Lum (1990) suggest, that somatic and emotional complications of pregnancy may induce depressive symptoms that appear or persist after childbirth in vulnerable women. Gruen (1993) researched four major areas of postpartum adjustment: physical adjustment, initial insecurities about new roles and expectations, the establishment of strong
social support networks, and the loss of former identity. The transition to parenthood involves physical, emotional, social and relational changes that may lead to a state of crisis. The discrepancy between the expectation and an infant's actual behavior may cause the new mother to experience some degree of postpartum depression. Graff, Dick and Shallow (1991) posit that if a woman's expectations were different than the baby's actual behaviors, she could very well become a candidate for depression.

According to Millis and Kornblith (1992) the transition from couplehood to parenthood represents a normal developmental crisis. A mother's fears that she will be unable to master the challenges of motherhood may become apparent during pregnancy. Many women may experience unsettling fantasies concerning their future with the baby (Trad, 1995). Trad (1995) also posits, psychologically, the mothers view the change in the dyadic relationship as a loss and, as with other experiences of loss during the life cycle, feelings of depression are likely to appear.

Depression serves as a period of physiological
recuperation from a previous agitation phase. Depression, helplessness, and passive coping, however, are often considered unhealthy experiences that may contribute to disease and death. This may be especially true when experienced for prolonged periods. Temporary depression may serve as effective coping mechanisms until physiological equilibrium is restored.

Gruen (1990) presented the idea that social pressure of expectations as being a possible cause of postpartum depression. The expectations from family, society and the mother herself are that new parenthood is to be idealized. Research reveals that physical delivery for the baby is the forethought in preparing for a baby, not postpartum depression. Negative feelings such as anger or fear are patronized, minimized or denied. Depression in response to the arrival of a new child is culturally not accepted. The families experience shame, and embarrassment, and their fears of being perceived as failures prevent them from seeking help.

Some studies have explored the possibility of a woman's psychiatric history being a factor in the onset
of postpartum depression. Women with a history of premenstrual syndrome appear to be at a higher risk for postpartum disorders. According to Millis and Kornblith (1992) there is often a strong family history of affective disorders, particularly depression and postpartum depression among women researched with postpartum disorders. The most accurate documented risk factor for postpartum depression is a past history of psychiatric illness; higher risks are associated with affective disorders and bipolar disorders. In general, the risk for affect disorder in the families of women with postpartum episodes is similar to that of women with affect illnesses that is other than postpartum (Gitlin & Pasnau, 1989).

One could not discuss causes of postpartum depression without exploring the biological aspect, or changes of a woman's body during pregnancy. Affonso (1992) provides research with insight into the physiologic events that occur with childbearing women. Some of the changes include: uterine contractions, placental-fetal uterine hemodynamics, fetal positions and biochemistry, uterine capacity and tone,
fluctuations in hormonal levels, and other biochemical alterations inherent in conception and gestation. According to Gitlin and Pasnau (1989) gynecologic symptoms as well as, normal physical changes during childbearing may become a potential focus for psychological vulnerabilities and profoundly affect an individual's self-esteem and personal worth.

Millis and Kornblith (1992) believe that any significant life stress poses an additional risk factor for postpartum depression. Included in these stressors are; single mothers, women with unplanned pregnancies, and women who have a poor relationship with their own mothers. Miracle and Skehan (1995) discuss the social bonding theory which includes attachment commitment, involvement, and belief. This bonding process continues throughout the child's adolescent years and can lead into adulthood, therefore it is imperative for children to have a strong bond with their mothers. Whiffen (1990) has become interested in the development of behavioral disturbances among children of women who once suffered with postpartum depression.
Postpartum Depression and Women

A review of the literature on postpartum depression and support systems among African-American women and Caucasian-American women necessitates an examination of several components. In this study, a recognition of postpartum depression as a condition with varying stages is important. This is especially true in terms of prevention. In order to create interventions that can lessen the effects of postpartum depression, one must investigate and clearly understand what factors could cause its occurrence. A review of current research on postpartum depression and possible coping strategies are thoroughly examined.

Most individuals in the health profession are fairly knowledgeable about the meaning of postpartum depression and would agree that it is a kind of depression experienced after childbirth. However, for the purpose of clarity and general understanding in this paper, distinct definitions will be discussed.

A general definition of the word postpartum derives from the Latin roots post, meaning after, and papere, meaning to bring forth (Laird, 1987).
According to Nevid, Rathus and Greene (1994) a postpartum period is a time when some new mothers undergo severe mood changes that may persist for months or even a year after childbirth. Postpartum depression is viewed as a type of depression experienced after childbirth, a universal definition that covers all facets involved in this condition does not exist. Landy, Montgomery and Walsh (1989) define it as a recurrent and pervasive state of apathy, despair, disorientation, agitation, or helplessness occurring in women within the first year following childbirth. These authors explain that an accurate definition of postpartum depression is difficult to determine as estimates vary from author to author depending on the assessment strategy and diagnostic criteria employed to identify postpartum depression. The DSM III-R did not regard postpartum depression as unique except in its particular timing for an onset, and it does not list it as a separate category. The DSM IV on the other hand, has in its most recent edition listed postpartum depression as a separate category of depression.

Landy, Montgomery and Walsh (1989) also say
postpartum depression can be described as a shift in one's identity, with a loss of former self and confusion about how to establish a new sense of self. Emotions become unpredictable and all that was normal becomes abnormal as related to mood levels triggered by formerly common issues. Gruen (1990) says experts are continuing to struggle over an acceptable definition of postpartum disorders. Pfost, Lum and Stevens (1989) describe postpartum depression as a time following childbirth, when women are at their greatest risk of suffering debilitating depression, and are more likely to be admitted to a psychiatric facility.

After childbirth, the mother is treated as the primary attachment object, and the other family members are considered only secondary attachment figures. According to Field (1996) attachment is considered a near-universal process and a life-span phenomenon. Attachment is viewed as a relationship that develops between two or more organisms as they become attuned to one another, each providing the other meaningful stimulation and feelings of arousal. The loss or lack of this stimulation and arousal may result in
behavioral and physiological disorganization. The lack of attachment, as it is defined here, may very well induce an onset of postpartum depression.

In most literature, postpartum disorders are divided and discussed in three major categories: Postpartum Blues which is also known as baby blues, new mother's blues, maternity blues and transient dysphoria (Trad, 1995). In this category new mothers have just experienced childbirth within two weeks. Symptoms include frequent crying outbursts, mood swings, sadness, unexplainable confusion, anxiety, difficulty sleeping, fatigue, feelings of loss and sadness, hostility and poor concentration (Gitlin & Pasnau, 1989). This type of depression is temporary and viewed as a normal or an acceptable part of childbirth (Gruen, 1993; Landy, Montgomery & Walsh, 1989). This type of depression is not considered a postpartum disorder. Treatment consists of validation, reassurance, assistance with care for self and baby, and observations for worsening symptoms (Millis & Kornblith, 1992).

Postpartum Depression, a more moderate form of
postpartum depression is also known as moderate depression, postpartum neurotic depression, and nonpsychotic clinical depression. In this category the blues the new mother experiences after the first few days of childbirth advance into a more serious condition (Landy, Montgomery & Walsh, 1989). The moderate level may appear at anytime in the first year of postpartum, sometimes magnified when a mother terminates breast-feeding or the return of the menstrual cycle (Gitlin & Pasnau, 1989). Symptoms that are common during this condition are: appetite and sleep disturbances, frequent loss of sleep, lack of energy, lack of sex drive, depressed mood, intense anxiety, fear of open spaces, suicidal thoughts, panic attacks, no feelings or concerns for the baby, extreme guilt, and several physical impairments (Gruen, 1993).

This category of postpartum is referred to as serious and abnormal due to the suicide ideations and possible harm towards the baby (Millis & Kornblith, 1992).

Postpartum Psychosis, a more severe level of postpartum depression, is also referred to as postnatal psychosis, puerperal psychosis, borderline depression
and psychotic depression (Gruen, 1990). This type of postpartum depression is labeled as severe, including frequent psychotic episodes following childbirth (Trad, 1995). Psychiatric hospital admission is usually the ending result for alleviation of this level of postpartum disorder along with possible shock therapy and/or medications (Gitlin & Pasnau, 1989).

An investigation of coping resources should be considered to help alleviate the many problems associated with postpartum depression. Support from significant others may help in the process of adjustment and acceptance of changes one encounters in life. The lack of such support can cause difficulties within relationships. According to Kagan and Segal (1995) an important element in coping appears to be the quality of relationships people have with others. They contend that social support networks consist of devoted family members, friends and colleagues or fellow members of organizations. Members of social networks can provide support in a variety of ways through companionship and assistance with daily tasks and hassles, reassurance and emotional strength, practical
advice, guidance and perhaps most importantly, the sense that one is important, valued and cared about, etc.

Jung and Khalsa (1989) suggest that seeking social support can be viewed as a coping strategy, whereas the availability of such support can be viewed as a resource. According to Staples (1989), support systems include family, friends, significant others, ministers, therapists and other formal or informal advocates. Any or all of these systems may be used by individuals in trying times for the alleviation of stress. Support systems should provide a safe, comfortable environment for individuals to achieve a state of homeostasis. Matlin (1995) defines coping as the thoughts and behaviors used in handling stress or anticipated stress. Methods of coping can be divided into two major categories: problem-focused coping and emotion-focused coping. Problem-focused coping entails taking a direct action to alleviate problems as well as changing thoughts. Emotion-focused coping includes directly regulating emotional responses to problems by the use of denial, social support, and miscellaneous
stress-reduction approaches.

Support systems as a coping method can provide the necessary reassurance to women experiencing such emotions. If effective and systematic networks are provided to women suffering from postpartum depression, the occurrence could decrease substantially. For example, If a woman feels isolated and resentment regarding her new role as a mother and is allowed to vent her feelings and concerns in a supportive environment, she stands a better chance of successfully coping with and overcoming those feelings. On the other hand, the new mother who is not afforded such an opportunity, may harbor pent up frustrations, guilt, and anger, which could lead to serious consequences for her and her baby.

A decrease in social support, and role and lifestyle constraints may help in eliminating postpartum stressors after childbirth. Pfost, Stevens and Lum (1990) suggest the absence of a spouse or demographic status (e.g., isolation, economic hardship) are important factors to consider when examining a women for postnatal disorders. Graff, Dyck and
Schallow (1991) report that support from a childbearing woman's partner, both prenatally and postnatally influence postpartum depression. Gruen (1993) says the less affection and cohesion perceived by the women in the relationship, the more likely she would show signs of postnatal depression.

Psychosocial factors including lack of social support, negative thought patterns or interpersonal relationships also have been identified in one study as potentially significant predictors of postpartum depression. According to Logsdon, McBride and Birkimer (1994) the intensity of the depression a new mother may experience because of a lack of support ranges from disappointment to clinical disorders.

**African-American Women and Postpartum Depression**

There appears to be very limited research conducted on African-American women and postpartum depression. Research reveals that the occurrence of postpartum depression among African-American women and Caucasian-American women is significantly different. Ritter, Lavin and Cameron (1995) researched the phenomenon of depression during pregnancy and
postpartum among poor women. Ethnicity and lower socioeconomic status (SES) were found to be related to clinical expression through self-report measures of depressive mood or symptoms. The higher frequency of chronic stressful life events, less control over occurring stressors, and increased vulnerability to negative effects of stressful events were found to help emanate feelings of chronic helplessness, hopelessness, alienation and marginalization. According to this study, women of lower SES, tend to have a higher occurrence of pregnancy during younger years, are less educated, and have more children than middle class women.

The majority of research conducted on postpartum depression and women's coping responses focuses on the general Caucasian-American female population. The researcher investigated the same issues, and discusses how postpartum depression relates to the African-American population. The researcher explored these African-American women's coping methods and their outcomes. This study was chosen because of the limited research being conducted on postpartum depression and
depression and the perceived strong coping responses among most African-American mothers.

Hobfull, Ritter, Lavin, Hulsizer and Cameron (1995) suggest that African-American mothers are represented disproportionately in the study of postpartum depression. Studies on African-American and Caucasian-American groups tend to use samples that are not economically comparable which leads to possible stereotyping about the fragility of African-American women. The relationship between African-American women and postpartum depression appears to be incited by the lack of social support extended towards these women in their time of need. Due to the alarmingly high rate of low income families and episodes of single parenting researchers believe there may be some connection between depression and social economic status with African-American women. According to Hulsizer and Cameron (1995) poor women are faced with more burdens than women of a higher social economic status such as difficulties with finances, lack of education and social support.

African-American women must employ some method of
support during the trying times of child birth in order to ensure proper coping methods. Affonso (1992) suggests there needs to be an increase in research on lifestyles that may lead to postpartum depression due to inadequate coping responses, support systems.

The increasing rate of postpartum depression among African-American women demands some answers. Gruen (1990) says that assistance is generally not requested until the depressed mother is in a state of crisis, and most of her emotional and supportive resources have been exhausted. It is possible that African-American women may be in need of alternative interventions that are culturally-specific. Research may reveal those necessary interventions. Research on postpartum physical difficulties among African-American women as opposed to Caucasian-American women revealed a higher incidence of weight gain during pregnancy. This occurrence may lead to high fetal weight and complications leading to an increase in the chances of an onset of postpartum obesity, that could in turn lead to postpartum depression (Susser, 1993).

Jewell (1988) defines support as "a feeling and an
attitude, or an act of concern or compassion provided by friends, good neighbors and relatives. Informal support systems tend to be homogeneous on the basis of race, ethnicity, and social class. African-American women use support networks as a method of alleviating stress. Social networks tend to be the most widely used compared to formal systems for these women.

Literature reveals two basic categories of support systems. The first is the informal support system, which provides individuals with feelings that they belong to someone or something. The African-American women's informal support system consists of her family, friends, and spiritual advisors (Staples, 1989).

According to Ramseur (1991) African-American women are subject to seek assistance from a more informal support system to cope with problems. The family and church remain the strongest of the network of support. African-Americans have always embraced a strong regard for a more personal relationship with those who support them. Ramseur (1991) also posits that when most African-Americans encounter marital, economic, or any other difficulties, they recruit support from family,
friends or ministers as their method of coping. Moreover, the most common form of coping response to worries or stressful events for African-Americans seems to be prayer.

The second category of support systems is the formal support systems, which provide assistance when family and friends cannot offer a solution to a problem. The formal support system consists of professionals in the health field such as therapists, psychiatrists, and psychologists (Staples, 1989).

According to research, the formal support system African-Americans seek out tend to be in desperate times. African-American women usually feel they have no need for the services or have a lack of awareness concerning the services that may be provided in a formal support setting.

**Prevention and Intervention**

Prevention and intervention is necessary in the alleviation of postpartum depression is the ideal objective. This study identified the risk factors regarding postpartum depression in order to provide intervention/prevention treatment. One study
encourages prevention of postpartum depression for women by health professionals formulating a consonant that should include psychotherapy with emphasis on educating the mother on parenting a young child, and family therapy, to enhance and maximize social support (Gitlin & Pasnau, 1989).

Trad (1995) suggests that pregnant women should learn more about the psychological correlates of postpartum depression. In essence, information regarding the mother's own experiences with caregivers, might be a predictor for the type of attachment relationship she would share with her infant. This study examines suspected postpartum cases and the mother's representation of her own status, and ability to interact with the infant, and the infant's responsivity to the mother. These studies provide information for health care professional to focus on such as; key parental skills, holding behaviors, engagement and disengagement, and a complete evaluation of the mother's interpersonal competence with the infant.

Another study based on a nursing perspective on
postpartum depression suggests that on an intervention level, psychiatric and psychological practices should include early case-finding through diagnostic work-up and follow-up treatment through the use of primarily psychotherapy and/or medications. Nurses are encouraged to participate in a health and behavior orientation, so that the following can be realized: a description of women's experiences with symptoms of depression to expand their knowledge of the context of depression and childbearing, establish the nature and cause of affective changes associated with childbearing, documenting varying levels of the distress associated with depressive symptoms and identifying possible new conceptualizations of the symptom distress experienced by women during pregnancy and the postpartum period (Affonso, 1992).

In a study conducted by Landy, Montgomery and Walsh (1989) an inventory of high risk factors childbearing women may possess is a suggested preventive method offered from one study. The risk factors they identified included: no evidence of warm or supportive spouse or visitors' a rejective view of
pregnancy; the baby being viewed as a "monster"; mother experiencing sleeping disturbances or nightmares; a lack of interest during feeding time; intense feelings of loss (body image, status, routine, independence); and a display of extreme emotions (sadness, guilt, anxiety, anger). They encourage counseling for all new mothers to enable them to vent in a safe and supportive environment.

Gruen (1990) conducted a study focused on social work practitioners. The results indicated a psychosocial and multi system approach to working with postpartum depression which can be provided by developing community awareness, educating professionals, and creating support groups by using advocacy and community organization skills. Medication and psychotherapy are methods most used in the prevention and intervention of postpartum depression.

Another study by Gruen (1993) suggests that societies with social structure which facilitates the adjustment to new parenthood show a lower incidence of postpartum depression. The facilitation is done through decreasing the intensity and duration of
symptoms of postpartum depression by providing peer support, decreasing isolation, creating an atmosphere of common purpose for learning to cope with postnatal depression. Relatives, friends and public health nurses were encouraged to help monitor and support the mother/baby relationship. These measures could certainly help alleviate if not prevent an onset of postpartum depression.

Millis & Kornblith (1992) suggest early detection and assessment and prenatal education. These two approaches can enhance the couple's ability to seek appropriate assistance. Health care professionals are advised to possess appropriate tools for identifying women at high risk of postnatal illness. The treatment model includes the identification of the problem, counseling new parents on issues of guilt, blame, and isolation, and discussing communication skills and family origin issues. Millis and Kornblith (1992) also discussed England's method of preventing postpartum depression. This study delineated how psychiatrists have been successful in administering progesterone or estrogen, or both, immediately on delivery and for
several months thereafter as prophylactic treatment of postpartum.

In an international study on prevention of postpartum depression, Leu Chien-Ai (1991) studied the special treatment Chinese women receive during postnatal periods. In this culture a new mother is expected to do very little after childbirth outside of eating, sleeping and getting adjusted to her new role for thirty days. In Chinese society the family invests incredible amounts of manpower and financial resources ensuring the health of both the mother and the newborn. The birth of a baby provides the women and other family members some time to adjust and gives them an opportunity to develop strong emotional bonds with the new baby. This study revealed a connection between family members and societal support and a decreased occurrence of postpartum depression.

Millis and Kornblith (1992) state that postpartum illnesses are potentially devastating, not only for the new mother, but for the entire family system. Landy, Montgomery and Walsh (1989) ascertain that every baby has a right to a happy and rational mother; therefore,
it is imperative that each individual and organization involved with the mothers and infants be knowledgeable of postpartum depression and aware of referral services for support. These services need to be intensive, multifaceted, and available for at least one year after a childbirth. These authors believe to provide less would place babies at risk for impaired development.

In summary, the literature suggests that recent studies have contributed to the overwhelming aspects of understanding postpartum depression and its causes. The theories discussed have attempted to define, explain and classify postpartum depression. We have learned a little more about women at risk and the possible risk factors that may induce an onset of this debilitating illness. We also have a starting point for prevention and intervention of postpartum depression. It is the hope of this study to extend the research endeavors already in motion to contribute to effective measures of postpartum depression prevention by assessing coping strategies, support systems, in particular, used by the sample group.
Purpose and Rationale

Although previous research has found postpartum depression in women to be a psychosocial problem (Millis & Kornblith, 1992), and have underpinnings in the psychiatric community (Gitlin & Pasnau, 1989), there has been limited research that has specifically focused on African-American women and their support systems as it relates to postpartum depression and coping. Therefore, the purpose of this study is to investigate the differences in African-American women and their coping responses based on the variable of support systems and seeking guidance.

Hypotheses

This investigation has lead to two hypotheses. First, there will be no significant difference in the coping responses of African-American women and Caucasian women when comparing the responses on the seeking guidance and support scale of the Coping Response Inventory.

Secondly, as reported on the Beck’s Depression Inventory, there will be no significant difference in the reported symptoms of depression of
African-American women in comparison to that of the Caucasian women.
CHAPTER 2

METHODS and PROCEDURES

Site and Setting

There were several sites that were selected for the study's setting including various physician's offices and outreach programs for mothers. All of the sites were located in Atlanta, Georgia and surrounding areas. Atlanta, Georgia is the financial, commercial and industrial center of the Southeast. It continues to facilitate as one of the nation's pivotal distribution areas. Atlanta is well known for its great homes and natural landscape. The churches and schools work as a system to enhance its children in cultural and national information. Atlanta is estimated to be the tenth largest metropolitan area in the United States. The city is situated 1,050 feet above sea level, one of the highest of any city of over 3,400,000 population, which explains its year round climate (Atlanta City Directory, 1991).
Population

The population for this study were Caucasian and African-American mothers of children who are under the age of one year old. The ages of the women ranged from eighteen to thirty-five years of age.

The Sample Population

The sample group was chosen from a pool of women under a physician's care or who are participants in a provided program for assisting new parents. This population of mothers included 150 subjects. The sample consisted of women whose physicians or program director consented to their participation. The group was a homogeneous subset of the larger population. The sample consisted of women between the ages of eighteen and thirty-five years of age attending postnatal care classes or sessions. The sample population was divided into two separate groups. One group was 75 Caucasian women in the postnatal stage of childbirth. The second group was an equal number of 75 African-American women in the postnatal period of childbirth.
**Human Services Contract**

A human services contract was provided for this study due to direct services provided. The participants were required to read and sign forms that express their cooperation and understanding of the ethical principle of research, which are informed consent, confidentiality and duty to warn (Corey, Corey & Callahan, 1993)

**Apparatus**

Three instruments were used for this study. The primary instrument was the Beck's Depression Inventory (BDI), and the secondary instrument was the Coping Response Inventory (CRI). A demographic survey was used to collect background information.

**Instrument Description**

The Beck's Depression Inventory was designed to measure the severity of depression in adolescents and adults already diagnosed with depression (Kramer & Close, 1983). This instrument examines specific items as significant information about a person's experience
of depression. The Beck's Depression Inventory has been used for over twenty-five years and translated into many languages. This instrument correlates as predicted with somatological issues, suicidal behaviors, adjustments and life crisis. The Beck's Depression Instrument is probably the most widely used clinical self-report test of depression. Its usage has expanded from clinical settings to screening operations and research on many non-clinical samples. Beck's Depression Inventory is proposed to be the most accurate indicator for distinguishing between major depression and anxiety disorders. Reading requirements are low for this instruments and it is relatively state-oriented because answers are based on the past week (Buros, 1992).

The Beck's Depression Inventory consist of twenty-one items, or sets of statements, answered on a 0 to 3 scale of severity of depressive problems. All of the items and item weights were derived judgmentally, not empirically. Each of the items has four sentences, ranging from no complaint to a severe complaint. These scale items range from "I do not feel like a failure"
to "I feel I am a complete failure as a person". The first thirteen items cover the Cognitive-Affective Subscale (guilt, crying, indecisiveness). The remaining eight items forms the Somatic-Performance Subscale (body image, sleep difficulties). The Beck's Depression Inventory is easily administered and can be scored by paraprofessionals. The total score is typically the only score used. The guidelines provided for scoring include cut off scores for normal, mild-moderate depression, moderate-severe depression and extremely severe depression (Buros, 1992).

The second instrument, the Coping Response Inventory is a measure of eight different categories of responses people use during stressful situations. There is a total of forty-eight items. The first set of four scales measure approach coping. The following set of four scales measure avoidance coping. The eight scales measure different cognitive and behavioral responses. The scales are categorized as follows: Logical Analysis (LA), Positive Reappraisal (PR), Seeking Guidance and Support (GS), Problem Solving (PS), Cognitive Avoidance (CA), Acceptance or
Resignation (AR), Seeking Alternative Rewards (SR), and Emotional Discharge (ED) (Moos, 1993). Respondents focus on and describe a recent stress and use a four point scale that varies from "not at all" to "Fairly Often" to rate their reliance on each coping item.

There are two types of responses, the approach coping and the avoidance coping responses. The Approach Scales and their responses are: Logical Analysis: cognitive attempts made to understand or prepare for a stressor and its consequences. Positive Reappraisal: cognitive attempts to examine and re-evaluate a problem or stressor in a positive way, but continuing to accept the reality of the situation. Seeking Guidance and Support: behavioral attempts used to obtain information, guidance, or support. Problem Solving: behavioral attempts to take action to resolve a problem directly. The Avoidance Scales and their responses are: Cognitive Avoidance: cognitive attempts made to avoid thinking about a problem or stressor realistically. Acceptance or Resignation: cognitive attempts to resolve a problem by accepting it. Seeking alternative Rewards: behavioral attempts to become
involved in alternate or substitute activities while creating new sources of satisfaction. Emotional Discharge: behavioral attempts to decrease stress by expressing negative emotions. The third instrument used in this study was a demographic questionnaire. This section consisted of several closed-ended questions regarding information about the participants background. The purpose was to obtain a certain profile of the respondents.

**Procedures**

There were three study periods for this study. The three periods included the pre-research period, the research period and the post-research period. The following information describes each of the said periods.

The Pre-Research Period includes three procedures. First the researcher contacted the physicians and program directors of the subjects by letter requesting permission to conduct research on their premises with their patients and participants. The letter included an introduction of the researcher
and an overview of the study including the study's goals and objectives. The next procedure included the researcher securing the instruments by reading test manuals and reviewing test materials for administration and interpretation. The final procedure in this period included the researcher contacting all facilities working with women experiencing postpartum. A confirmation of their participation was then secured via letter and/or telephone.

The Research Period included two procedures. In the first procedure an administrative schedule was designated for each facility. In the next procedure the researcher introduced the study to each participant and answered any questions related to the study information and procedure and then began the research process. The demographics and the Beck's Depression Inventory was administered following the Coping Response Inventory.

The Post-Research Period involved the retrieval of data from the research. This material was then collected, reviewed and interpreted. The researcher allowed for this time for any questions, difficulties
or odd circumstances that may have arisen during the study.

Data Collection

The researcher collected all study data from the participants at each site. After a brief overview of the study, the subjects were read aloud the directions of each questionnaire and instructed to complete all of the items. The researcher was present during every session as to check for completion of questionnaires and to answer any questions.

Data Analysis

The researcher used descriptive and inferential statistics in analyzing data retrieved from the study. Those statistics and their findings are reported in the results section.
Chapter 3
RESULTS OF THE STUDY

This survey research sought to examine coping responses among African-American and Caucasian women who suffer from postpartum depression. The results of the study are reported in two sections. The first section, Section A, reports data on the demographic profile of the participants. Section B provides an analysis of relativity to the two research hypotheses.

Section A: Demographic Profile

This section represents the demographic profile of 75 African-American women and 75 Caucasian women. Results from the demographic profile are presented in Table 1 through Table 8. More specifically, Table 1-4 represents demographic data on the age, marital status, education and situation of the participants. However, item 3, which asked "What ethnic group best describes you", was eliminated from data analysis since each group was either African-American or Caucasian in total.
Table one contains information about the ethnic identity of the participants in this study.

Table 1. Chronological Ages of Participants

<table>
<thead>
<tr>
<th>Race</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>Age</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>16-20</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>21-25</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>26-30</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>31-35</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>75</td>
</tr>
</tbody>
</table>
Table two contains information about the participant’s marital status.

Table 2. Participants’ Marital Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>MARRIED</td>
<td>23</td>
<td>30.7</td>
</tr>
<tr>
<td>SINGLE</td>
<td>35</td>
<td>46.7</td>
</tr>
<tr>
<td>SEPARATED</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>DIVORCED</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Living W/ COMPANION</td>
<td>11</td>
<td>14.7</td>
</tr>
<tr>
<td>Missing Data</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table three contains information about participants' level of education.

Table 3. Participants' Level of Education

<table>
<thead>
<tr>
<th>Variable</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH SCH</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>1-2 COLL</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>3-4 COLL</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>COLL DEG</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>GRAD WORK</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

Table four contains information about the participants' employment status.
As shown in Tables 1-4, results indicate the majority of African-American women reported their age of between 26-30 (33.3%) and the majority of Caucasian women reported their age 21-25 (30.7%). Also indicated is the majority of African-American women, 35 (46.7%) reported their marital status as single while 26 (34.7%) Caucasian women reported being single and married. As shown in the tables, 32 (42.7%) African-American women reported having a high school diploma, and the majority of Caucasian women 35 (46.7%) reported a high school diploma also. The majority of African-
American women 39 (52%) reported being employed, and the majority of Caucasian women 37 (49.3%) reported also being employed.

Tables 5-8 shows demographic data relevant to the number of children, who raised the participant, psychiatric history, religion, support network, past history of emotional problems and whether participants were involved in prenatal classes.

Table five contains information about participants’ children.

Table 5. Participants’ Children

<table>
<thead>
<tr>
<th>Race</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
<td><strong>Children</strong> N %</td>
<td><strong>N %</strong></td>
</tr>
<tr>
<td>NONE</td>
<td>3 4.0</td>
<td>-</td>
</tr>
<tr>
<td>1-2</td>
<td>54 72.0</td>
<td>52 69.3</td>
</tr>
<tr>
<td>3-5</td>
<td>16 21.3</td>
<td>20 26.7</td>
</tr>
<tr>
<td>6-8</td>
<td>2 2.7</td>
<td>3 4.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>75 100.0</td>
<td>75 100.0</td>
</tr>
</tbody>
</table>
Table six contains information about who raised the participants.

**Table 6. Person Rearing Participants**

<table>
<thead>
<tr>
<th>Race</th>
<th>Variable</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised By N</td>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>PARENT(S)</td>
<td>54</td>
<td>72.0</td>
<td>46</td>
</tr>
<tr>
<td>GRAND PARENT(S)</td>
<td>13</td>
<td>17.3</td>
<td>18</td>
</tr>
<tr>
<td>AUNT/UNCLE</td>
<td>4</td>
<td>5.3</td>
<td>7</td>
</tr>
<tr>
<td>OTHER</td>
<td>4</td>
<td>5.3</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
<td>75</td>
</tr>
</tbody>
</table>

Table seven contains information about the participants' history of psychiatric history.
Table 7. Participants' Psychiatric History

<table>
<thead>
<tr>
<th>Variable</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>No</td>
<td>59</td>
<td>78.7</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Siblings</td>
<td>6</td>
<td>8.0</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table eight contains information about how the participants handle their emotional problems.
Table 8. Participants’ Sources of Help With Problems

<table>
<thead>
<tr>
<th>Variable</th>
<th>African-American</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk to</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>GOD</td>
<td>20</td>
<td>26.7</td>
</tr>
<tr>
<td>FRIEND</td>
<td>25</td>
<td>33.3</td>
</tr>
<tr>
<td>RELATIVE</td>
<td>14</td>
<td>18.7</td>
</tr>
<tr>
<td>PASTOR/</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>PRIEST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIGNIFICANT</td>
<td>6</td>
<td>8.0</td>
</tr>
<tr>
<td>OTHER</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>COUNSELOR</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>OTHER</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>MISSING</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td>DATA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As reported in Tables 5-8 in general, 72% of African-American women reported having 1-2 children, for Caucasian women, 69.3% reported having 1-2 children. 72% of the African-American participants were raised by their parents and 61.3% of Caucasian
rate was, 18 or 24% of the Caucasian participants were raised by their grandparents. The tables indicate that 59 (78.7%) African-American women reported having no history of psychiatric illnesses, while only 54 (72%) of the Caucasian women reported they also had not. 51 (24%) of the African-American women reported being religious while only 37 (49.3%) of the Caucasian women reported being religious. The tables also show that 46 (61.3%) of the African-American women reported having a support system, and 36 (48%) of the Caucasian women also reported having a support system. When asked who would they seek help from, the majority of African-American women 25 (33.3%) reported a friend, and 29 (38.7%) Caucasian women reported a friend also. The majority 40 (53.3%) of African-American women reported not having taken a prenatal class, while 41 (54.7%) of the Caucasian women reported that they had also not taken any prenatal classes.

Section B: Analysis of Study Hypotheses

There were two hypotheses in the study. Hypothesis one predicted that there would be no
Hypothesis one predicted that there would be no significant difference in the coping responses of African-American women and Caucasian women when comparing the responses on the seeking guidance and support scale of the Coping Response Inventory. Please refer to Table 9 for these data.

Table nine contains the results of a statistical analysis of the performance of the participants on the seeking guidance subscale.

Table 9. Statistical Analysis of Participants' Performance on Seeking Guidance

<table>
<thead>
<tr>
<th>Groups</th>
<th>N=75 African-American</th>
<th>N=75 Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>9.8533</td>
<td>9.8400</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>3.3559</td>
<td>2.3018</td>
</tr>
<tr>
<td>Standard Error of Measurement</td>
<td>.3901</td>
<td>.2676</td>
</tr>
<tr>
<td>Difference</td>
<td>.0133</td>
<td></td>
</tr>
<tr>
<td>Standard error of difference between the means</td>
<td>.4731</td>
<td></td>
</tr>
<tr>
<td>t-value</td>
<td>.0281</td>
<td></td>
</tr>
</tbody>
</table>

As shown in Table 9, the mean score for African-
9.8533 with a standard deviation of 3.3559. For the Caucasian women, their mean score was 9.8400 with a standard deviation of 2.3018. One most salient observation is the fact that the two groups were about equal as indicated by a t-value of .0281. Therefore we must accept the null hypothesis that there is no significant difference in the coping responses of African-American and Caucasian women when comparing the responses on the Seeking Guidance subscale of the Coping Response Inventory.

Hypothesis two stated that as reported on the Beck’s Depression Inventory, there will be no significant difference in the reported symptoms of depression of African-American women in comparison to that of the Caucasian women. Please refer to Table 10 for data analysis.

Table ten contains the results of a statistical analysis of the performance of the participants on the depression scale.
Table 10. Statistical Analysis of Participants' Performance on Depression Scale

<table>
<thead>
<tr>
<th>Statistic</th>
<th>N=75 African-American</th>
<th>N=75 Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>14.3867</td>
<td>16.3600</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>13.0890</td>
<td>13.0763</td>
</tr>
<tr>
<td>Standard Error of Measurement</td>
<td>1.5216</td>
<td>1.5201</td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td>-1.9733</td>
</tr>
<tr>
<td>Standard error of difference between the means</td>
<td>2.1508</td>
<td></td>
</tr>
<tr>
<td>t-value</td>
<td></td>
<td>-.9175</td>
</tr>
</tbody>
</table>

The results in Table 10 reveal that, the mean score for African-American women on the Beck's Depression Inventory was 14.3867 with a standard deviation of 13.0890. For the Caucasian women, their mean score was 16.3600 with a standard deviation of 13.0763. One most salient observation is the fact that the two groups were almost equal as indicated by a t-value of -.9175. Therefore the null hypothesis that as reported by the Beck's Depression Inventory, there will be no significant difference in the reported symptoms of depression of African-American women in comparison to that of the Caucasian women was accepted.
Chapter 4
DISCUSSION

The intent of this study was to investigate by survey, the prevalence of postpartum depression and coping responses utilized by African-American and Caucasian women. These survey respondents were of particular interest due to the limited literature available on African-American women who suffer from postpartum depression.

Research indicates an increase in postpartum depression among women. Increased research and attention on postpartum depression has led to closer examination of indicators of depression and prevention and intervention techniques. The population being studied has shown an increase in recent years of postpartum depression symptoms. This population has also evoked interest because the children produced may lack the maternal bond children need to grow up healthy and emotionally balanced.

Even with the increased rate of postpartum depression, most women remain without assistance or
treatment. One should wonder why some women are affected by this problem and some new mothers are not. Although the answers to this question are multiple and at times complex, the role coping responses, support systems in particular, plays a significant role. To be more specific, for those respondents scoring high on the depression scale, their coping responses were examined to be low on the support system subscale. For new mothers this is crucial because it provides some information about how coping responses and support networks may prevent postpartum depression.

Survey results show that in the majority of women used in this study, only 26 out of 150 participants were assessed as suffering from postpartum depression while 68 were not. According to this study, it appears that support systems as a coping response may be an imminent factor in preventing and treatment for symptoms of postpartum depression.

This study was chosen to investigate a topic that concerned this researcher in a selected population, African-American and Caucasian women in the postnatal period and coping methods. Postpartum depression is a
condition that is of concern and continue to remain that way as long as the occurrence of it is taken lightly. Appropriate education and awareness efforts are much needed to lessen the harmful effects of postpartum depression. An examination of coping responses and support systems could prove to be a very valuable asset in the prevention and intervention of this condition.

**Research Implications**

The survey results revealed that, for both the African-American and Caucasian women, 26 out of the 150 respondents, did suffer from depression in the postnatal stage. Research indicates that the lack of coping responses utilized by this group may have encouraged more postpartum depression symptoms. Moreover, research implicates that with the use of appropriate coping responses, a mother in the postnatal stage may not experience any depressive symptoms.

**Limitations of the Study**

The study has limitations that should be considered when interpreting the results. The researcher chose to investigate two populations in one
city. While the results of this study may be
generalizable to similar populations in different
cities, this particular research only involves African-
American and Caucasian women in Atlanta, Georgia.

Recommendations for Counselors

As a result of this study, the recommendation for
counselors are two-fold. The first one involves
education as a tool for prevention. Those women who
suffer from postpartum depression may not seek
assistance due to not being aware of their problem.
The entire family should be made aware of the possible
complications and debilitating symptoms of this
condition. This education should include a definition
of postpartum depression, symptom recognition, and the
appropriate professional assistance to seek.

The other recommendation involves the coping
method utilized by the women. Coping responses assist
people everyday with problems and difficult situations.
If the women in the postnatal period are aware of their
support systems and have a healthy network established
and identified, maladaptive coping methods should be
minimal.
Individual, family and group therapy is strongly recommended for forementioned concerns. Women can identify and relate with other women who feel the way they do in group therapy. This may help alleviate feelings of isolation and provide support that may be lacking in the family structure. The family therapy will assist members in becoming aware of possible difficulties and encourage empathic and systemic communication among the family members.

Recommendations for Future Research

This study has examined postpartum depression and coping responses among African-American and Caucasian women. The scope of this study should be expanded for future research. One recommendation is to research a more expansive population including women of all races. More demographic data may be collected as well. An investigation of coping responses of women in the postnatal period of different cultures, may provide invaluable information.
Appendices

A–E
Directions:
On the accompanying answer sheet, please fill in your name, today's date, and your sex, age, marital status, ethnic group, and education (number of years completed). Please mark all your answers on the answer sheet. Do not write in this booklet.
Part 1

This booklet contains questions about how you manage important problems that come up in your life. Please think about the most important problem or stressful situation you have experienced in the last 12 months (for example, troubles with a relative or friend, the illness or death of a relative or friend, an accident or illness, financial or work problems). Briefly describe the problem in the space provided in Part 1 of the answer sheet. If you have not experienced a major problem, list a minor problem that you have had to deal with. Then answer each of the 10 questions about the problem or situation (listed below and again on the answer sheet) by circling the appropriate response:

Circle "DM" if your response is DEFINITELY NO.
Circle "MN" if your response is MAINLY NO.
Circle "MY" if your response is MAINLY YES.
Circle "DY" if your response is DEFINITELY YES.

1. Have you ever faced a problem like this before?
2. Did you know this problem was going to occur?
3. Did you have enough time to get ready to handle this problem?
4. When this problem occurred, did you think of it as a threat?
5. When this problem occurred, did you think of it as a challenge?
6. Was this problem caused by something you did?
7. Was this problem caused by something someone else did?
8. Did anything good come out of dealing with this problem?
9. Has this problem or situation been resolved?
10. If the problem has been worked out, did it turn out all right for you?
Part 2

Read each item carefully and indicate how often you engaged in that behavior in connection with the problem you described in Part 1. Circle the appropriate response on the answer sheet:

- Circle "N" if your response is NO, Not at all.
- Circle "O" if your response is YES, Once or Twice.
- Circle "S" if your response is YES, Sometimes.
- Circle "F" if your response is YES, Fairly often.

There are 48 items in Part 2. Remember to mark all your answers on the answer sheet. Please answer each item as accurately as you can. All your answers are strictly confidential. If you do not wish to answer an item, please circle the number of that item on the answer sheet to indicate that you have decided to skip it. If an item does not apply to you, please write NA (Not Applicable) in the box to the right of the number for that item. If you wish to change your answer, make an X through your original answer and circle the new answer. Note that answers are numbered across in rows on Part 2 of the answer sheet.

1. Did you think of different ways to deal with the problem?
2. Did you tell yourself things to make yourself feel better?
3. Did you talk with your spouse or other relative about the problem?
4. Did you make a plan of action and follow it?
5. Did you try to forget the whole thing?
6. Did you feel that time would make a difference—that the only thing to do was wait?
7. Did you try to help others deal with a similar problem?
8. Did you take it out on other people when you felt angry or depressed?
9. Did you try to step back from the situation and be more objective?
10. Did you remind yourself how much worse things could be?
11. Did you talk with a friend about the problem?
12. Did you know what had to be done and try hard to make things work?
13. Did you try not to think about the problem?
14. Did you realize that you had no control over the problem?
15. Did you get involved in new activities?
16. Did you take a chance and do something risky?
17. Did you give up in your mind what you would say or do?
18. Did you try to see the good side of the situation?
19. Did you talk with a professional person (e.g., doctor, lawyer, clergy)?
20. Did you decide what you wanted and try hard to get it?
21. Did you daydream or imagine a better time or place than the one you were in?
22. Did you think that the outcome would be decided by fate?
23. Did you try to make new friends?
24. Did you keep away from people in general?
25. Did you try to anticipate how things would turn out?
26. Did you think about how you were much better off than other people with similar problems?
27. Did you seek help from persons or groups with the same type of problem?
28. Did you try at least two different ways to solve the problem?
29. Did you try to put off thinking about the situation, even though you knew you would have to do it at some point?
30. Did you accept it: nothing could be done?
31. Did you read more often as a source of enjoyment?
32. Did you yell or shout to let off steam?
33. Did you try to find some personal meaning in the situation?
34. Did you try to tell yourself that things would get better?
35. Did you try to find out more about the situation?
36. Did you try to learn to do more things on your own?
37. Did you wish the problem would go away or somehow be over with?
38. Did you expect the worst possible outcome?
39. Did you spend more time in recreational activities?
40. Did you cry to let your feelings out?
41. Did you try to anticipate the new demands that would be placed on you?
42. Did you think about how this event could change your life in a positive way?
43. Did you pray for guidance and/or strength?
44. Did you take things a day at a time, one step at a time?
45. Did you try to deny how serious the problem really was?
46. Did you lose hope that things would ever be the same?
47. Did you turn to work or other activities to help you manage things?
48. Did you do something that you didn’t think would work, but at least you were doing something?
# APPENDIX B

**CRI-ADULT ANSWER SHEET**

**Form:** Actual   __ Ideal   __

Name ___________________________ Date ___________/ ____________ Sex _____ Age _____

Mental Status ___________ Ethnic Group ___________ Education ___________

---

**Part 1**
Describe the problem or situation

---

**Part 2**

<table>
<thead>
<tr>
<th></th>
<th>N - No, Not at all</th>
<th>O - Yes, Once or twice</th>
<th>S - Yes, Sometimes</th>
<th>F - Yes, Fairly often</th>
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Note: This form is printed on chlorinated paper. Any other version is unauthorized.
### CRI-Adult Profile

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**PAR**
Psychological Assessment Resources, Inc. P.O. Box 993/Oceanic, Fl 33354/fax-free 1-800-331-TEST
Beck Depression Inventory

APPENDIX C 71

Read the entire group of statements in each item. Then circle the number beside the statement that best describes the way you feel right now.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can’t snap out of it.
   3 I am so sad or unhappy that I can’t stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don’t enjoy things the way I used to.
   2 I don’t get real satisfaction out of anything any more.
   3 I am dissatisfied or bored with everything.

5. 0 I don’t feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don’t feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don’t feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don’t feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don’t have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don’t cry any more than usual.
     1 I cry more now than I used to.
     2 I cry all the time now.
     3 I used to be able to cry, but now I can’t cry even though I want to.
11. 0 I am no more irritated now than I ever am.
   1 I get annoyed or irritated more easily than I used to.
   2 I feel irritated all the time now.
   3 I don’t get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
   1 I am less interested in other people than I used to be.
   2 I have lost most of my interest in other people.
   3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
   1 I put off making decisions more than I used to.
   2 I have greater difficulty in making decisions than before.
   3 I can’t make decisions at all any more.

14. 0 I don’t feel I look any worse than I used to.
   1 I am worried that I am looking old or unattractive.
   2 I feel that there are permanent changes in my appearance that make me look unattractive.
   3 I believe that I look ugly.

15. 0 I can work about as well as before.
   1 It takes an extra effort to get started at doing something.
   2 I have to push myself very hard to do anything.
   3 I can’t do any work at all.

16. 0 I can sleep as well as usual.
   1 I don’t sleep as well as I used to.
   2 I wake up 1–2 hours earlier than usual and find it hard to get back to sleep.
   3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don’t get more tired than usual.
   1 I get tired more easily than I used to.
   2 I get tired from doing almost anything.
   3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
   1 My appetite is not as good as it used to be.
   2 My appetite is much worse now.
   3 I have no appetite at all any more.

19. 0 I haven’t lost much weight, if any, lately.
   1 I have lost more than 5 pounds.
   2 I have lost more than 10 pounds.
   3 I have lost more than 15 pounds.

20. 0 I am no more worried about my health than usual.
   1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
   2 I am very worried about physical problems and it’s hard to think of much else.
   3 I am so worried about my physical problems, that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
   1 I am less interested in sex than I used to be.
   2 I am much less interested in sex now.
   3 I have lost interest in sex completely.

Please circle the appropriate response.  
Please answer all questions:

1. What age group do you best fit in?  
   a. 16-20  
   b. 21-25  
   c. 26-30  
   d. 31-35  

2. What is your marital status?  
   a. Married  
   b. Single  
   c. Separated  
   d. Divorced  
   e. Living with a companion  

3. Which ethnic group best describes you?  
   a. African-American  
   b. American Indian  
   c. Hispanic-American  
   d. Caucasian  
   e. Other  

4. What level of education have you completed?  
   a. High School  
   b. 1-2 years of college  
   c. 3-4 years of college  
   d. college degree  
   e. Graduate work  

5. What category(s) best describes your situation?  
   a. Employed  
   b. Housewife  
   c. Receiving Financial Assistance  
   d. Unemployed  

6. What is the number of children born to you?  
   a. 0  
   b. 1-2  
   c. 3-5  
   d. 6-8  
   e. 9-11
7. By whom were you raised?
   a. Parent(s)
   b. Grandparent(s)
   c. Aunt/Uncle
   d. Other

8. Do you have a history of any psychiatric illnesses?
   a. yes
   b. no
   c. Parent(s) have a history of psychiatric illness
   d. Siblings have a history of psychiatric illness

9. Is religion a major influence in your life?
   a. yes
   b. no

10. Do you have a strong support network
    a. yes
    b. no

11. If you had an emotional problem and wanted to talk with someone, which of the following would you talk to?
    a. God
    b. Friend
    c. Relative
    d. Pastor or Priest
    e. Significant Other
    f. Therapist, Social Worker, Counselor,
    g. Other

12. Did you have any prenatal classes in preparation for your new baby?
    a. Yes
    b. No
Please read and sign before completing the instruments:

I agree to participate in the research entitled "An investigation of the coping responses of African-American women and Caucasian women who suffer from postpartum depression, which is conducted by Foye A. Smith, Department of Counseling and Psychological Services at Clark Atlanta University (404) 880-8516.

I understand this participation is voluntary; I can withdraw my consent at anytime without penalty.

I have been informed that I will be asked to complete three instruments: The Beck's Depression Inventory, Coping Response Inventory and a demographic survey.

I am aware that I could possibly experience some discomfort or distress in answering some of these questions.

My name cannot be matched with the result due to anonymous procedures.

I am giving my informed consent for participation in this study with the understanding that any information provided will be used confidentially and responsibly by the researcher.

_________________________  _______________________
NAME                        DATE
REFERENCES


Mitchell, J. (Ed.). (1992). *Tests in print III: An index to tests, test reviews, and the literature on specific tests.* Lincoln, NB: University of Nebraska-
Lincoln.


