Depression and Coping disposition among Mothers of Preschool children in the downtown Eastside

by

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Abstract

Mediating variables in the etiology of depression in mothers of preschool children have been the focus of numerous investigations since Brown, Brolchain, and Harris (1975) identified that women with a child under the age of six have a high prevalence of depression. The question that remains is why not all mothers suffer from depression under similar sets of social circumstances. Coping behaviors have been identified as one of the mediators between life strains and health status and the relationship of coping and depression remains to be an important concept in treatment and prevention of depression. A group of sixty-three mothers with at least one preschool child age five and under voluntarily completed a sociodemographic questionnaire, a self-report depression scale, and a coping disposition measure. Results indicated a significant negative linear relationship between depression and coping disposition. As depression scores increased coping disposition decreased, and inversely depression scores decreased as coping disposition increased. Findings suggest that a re-examination of present social policies and a renewed look at treatment and prevention strategies of depression in mothers of preschool children are in order.

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Acknowledgement

This work is dedicated to the sixty-seven mothers who made this investigation possible.

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Chapter I

Introduction

In examining social class and depression among women Brown, Bhrolchain, and Harris (1975) identified working class women with a child under the age of six have a high prevalence of depression. They isolated four vulnerability factors preceding onset of psychiatric disturbance: experience of a severe life event, lack of full- or part-time employment, having three or more children aged 14 or under at home, loss of mother by death or separation before the age of 11, and lack of an intimate relationship. Similar high rates of depression in mothers were reported in a behavior study of preschool children (Richman, Stevenson, and Graham, 1982). Mediating variables identified were: a poor marriage, behavior problems in children, housing conditions, more than three stressors, and five or more children at home (Richman, 1978). Moss and Plewis (1977) found no social effect in depression but a breakdown of distress ratings found non-married mothers suffered from higher levels of distress than their married counterparts. Research continues to focus on the correlates of maternal depression as it effects well-being of children (Rutter, 1990) but reported results indicate inconsistent outcomes (Bromet et al., 1982).

Several intermediary variables have been identified in the etiology of depression and future inquiries need to

further present understanding of why not all mothers in similar sets of social circumstances suffer from depression (Miller, 1982).

Coping behaviors have been identified as mediating factors between life strains and health (Dohrenwend and Dohrenwend, 1973).

Coping has a variety of definitions and this study uses the definition of Menaghan (1983, p. 162) who states:

> Stress may be defined as perceived mismatch between environment and self, coping embraces actions to reduce that mismatch (directly or by altering the interpretation of environment or self), to avoid or manage associated emotional distress, and to maintain or enhance the overall sense of self.

Stress is manageable when coping resources are well utilized and varied (Coyne, Aldwin, and Lazarus, 1981; Pearlin and Schooler, 1978). The need for well developed measurements of coping strategies has been documented (Holahan and Moos, 1986; Folkman and Lazarus, 1980).

Billings and Moos (1982) suggest that depression-related outcomes of stressful life circumstances are influenced by the individuals' personal and environmental resources as well as by their appraisal and coping responses.

Rotter (1966) proposes that individuals differ in how they perceive environmental reinforcers to be under their personal control. Individuals who are internals perceive these events as being under their control, and persons who

are externals see reinforcers as being the result of fate, luck, and chance.

Folkman and Lazarus (1984) have conceptualized coping as a transactional, reciprocal process between the individual and the environment that consists of appraisal and coping. Stress arises only after there has been an individual cognitive appraisal of a "lack of fit" between perceived demands and the perceived capability of meeting these. Effective coping reduces or eliminates stress whereas ineffective coping results in intensified stress (Lazarus and Folkman, 1984).

Antonovsky (1988) has focused on understanding coping in examining how individuals cope with universal stress and still do well. On the basis of this research he developed the orientation to life questionnaire based on the "sense of coherence" concept (SOC). The sense of coherence is a coping disposition orientation. The SOC or coping disposition is defined as (1) Comprehensible - that stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable, (2) Manageable - the resources are available to one to meet the demands posed by these stimuli, and (3) Meaningful - these demands are challenges worthy of investment and engagement (Antonovsky, 1988, p. 19). These three components are inextricably intertwined. Rather than identifying specific stresses he introduces a unified concept of "generalized resistance resources-resistance

deficits" (GRR-RD). In each individual "wealth, ego-strength, cultural stability, and so on are GRR-RD'S" (p. 20) and these may be ranked on a continuum. The higher on a continuum the more likely it is that one will have life experiences that are conducive to a strong SOC. In contrast those individuals with fewer GRR-RD'S are likely to have experiences that will render a weak SOC. A strong sense of coherence is essential to health maintenance.

The understanding of a relationship between coping and depression remains to be an important concept in the treatment and prevention of depression. This investigation will focus on the relationship between depression and coping disposition in mothers of preschool children.

Chapter II

Literature Review

An important observation made in the study of depression is that rates of depression in every age group of women are higher than in men (Weissmann and Klermann, 1979). In a review of the rates of depression in the United States between 1936 and 1973 the rate of depression occurring in women was twice the rate as that in men. Since rates of treated cases do not necessarily reflect the prevalence of depression in the community, Weissmann and Klermann (1979) further examined the outcomes of various community surveys. The same existing trend was identified within communities.

Several theoretical frameworks have been generated to explain the etiology of depression. The following section will provide an overview of the various theoretical explanations for the genesis of depression. According to Freud, depression is a pathological reaction to a loss. He argued that the over-involvement and ambivalence between the ego and a lost love object leads to difficulties in resolving a loss. The loss of an object then becomes an ego loss which results in a lowered self-esteem and self-regard. The ambivalence between the ego and object is transformed into an intra-psychic conflict (Corob, 1987). Psychoanalytic theory has been criticized for its limited perspective of psychological difficulties (Szasz, 1961), and for a masculine bias (Horney, 1926). The similarities that

are drawn between feminine qualities and depression are evident in psychoanalytic literature (Feldman, 1983).

Learned helplessness theory is based on investigations conducted by Seligman (1975). Seligman directed laboratory experiments in which he discovered, both in animals and humans, that if they were repeatedly exposed to unpleasant stimuli outside of their control they eventually learned that they were helpless. In later tests the subjects remained passive and did not attempt to gain control in situations. Learned helplessness results when individuals believe that the outcome of a situation is independent of their response to it. Seligman drew on the similarities between learned helplessness and depression. He proposes that individuals who are not permitted to have some control in their environment in their developmental years are more likely to react to situations with a learned helplessness in adulthood. Due to widespread criticism that this theoretical framework did not address individual differences Seligman introduced a cognitive component (Abramson et al., 1978). The reformulated hypothesis states that:

> When people find themselves helpless, they implicitly or explicitly ask why they are helpless. The causal attributions they make influence the generality and chronicity of the helplessness deficits as well as later self-esteem (Abramson, Garber, and Seligman, 1980, p. 5).

Depression results from the expectation of helplessness combined with the tendency to attribute negative events to

internal, stable, and global causes. Depression ensues when individuals believe that their helplessness is their own fault (internal attribution), that they will be helpless for a long time (stable attribution), and that they will be helpless in a wide range of situations (global attribution), (Abramson, Garber, and Seligman, 1980). Findings indicate a correlation between depression and styles of attribution but do not explain causality (Golin, Sweeney, and Shaeffer, 1981).

Aaron Beck (1967, 1976) developed a cognitive model of depression on the basis of clinical studies. Patients were found to be depressed when they acquired learned misconceptions about themselves, of the world, and the future and that this cognitive triad perpetuated depression (Beck, 1961, 1963). Cognitive structures or schemas originate in childhood and represent a person's generalization about past experiences. Consequently, schemas determine the manner in which information is perceived, remembered, and later recalled. Schemas are largely inactive during asymptomatic periods but become activated with the onset of depression. Necessary conditions need be in place for the activation of negative schema; conditions being defined as stress. It is when these schemas are evoked that they mould thought content, and lead to typical depressive feelings.

> As the depression deepens, these schemas increasingly dominate the cognitive processes, displace more appropriate schemas but also disrupt the cognitive processes that are involved in maintaining self-objectivity and reality testing (Beck, 1967, p. 290).

Beck's theory has found support in several investigations (Lewinsohn et al., 1981; Gotlieb, 1981; Hollon and Kendall, 1980). Cognitive theory does not address social influences which may assist or hinder in maintaining positive, mental health. The focus tends to be exclusively on personal adjustment and not all problems can be dealt with at a personal level. An example of a lack of social influence is a study comparing control, cognitive, and behavior therapy groups in the reduction of depression in low-income Puerto Rican women. A five-week follow-up assessment revealed that alleviation of depression had been maintained, with a slight advantage for the behavioral approach. The differences in outcome were attributed to mode of treatment. The cognitive therapy group focused on the idea that depression is caused by distorted negative cognitions/expectancies, clients were taught to challenge and modify these, and the importance of control over important outcomes was emphasized. The investigators conclude that minority individuals may face situations where they do indeed lack control over events (Comas-Diaz, 1981).

Behaviorist theory is based on a tension reduction model of human behavior. The focus is on the concept of reinforcement of behavior and environmental factors as

reinforcers are considered within the framework (Hammen, 1989). Behaviorists consider depression to be the result of a decrease of positive reinforcements in an individual's life. The reduction of reinforcers may be the result of environmental changes such as the loss of a loved one or a lack of social skills (Lazarus, 1968). Depression is predictive when there is little possibility that the individual's behavior will be followed by positive reinforcement and there is a good probability that the person will be positively reinforced when he does not exhibit the behavior. Depressed persons are lacking in social skills, and thereby do not receive positive reinforcement from others (Lewinsohn, 1974; Lewinsohn et al., 1980). Ferster (1974) proposes that it is not only the frequency of positive reinforcement but also the schedule of reinforcements that are apt to produce depression. He suggests that a young executive is less likely to be stressed due to a variable reinforcement schedule than a housewife who performing in a standard routine where reinforcements are predictable and therefore less rewarding.

The possibility of a genetic factor playing a role in developing depression has further intrigued research. Evidence indicates an:

> increased morbid risk of affects disorder in the first degree relatives of diagnosed patients as compared with the general population and a higher concordance rate for affects disorders in monozygotic and dizgotic twins (Weissmann and Klermann, 1979, p. 398).

In view of these findings there is some indication that points to a correlation between genetic disposition and depressive illness. A more specific elucidation for the high rate of occurrence of depression in women has been referred to as the X-linkage theory (Weissman and Klermann, 1979). This theory suggests that depression is located on the X chromosome and if it is dominant then females having two X chromosomes are more likely to be affected. The results of these studies have been contrary (Weissman and Klermann, 1979).

In psychiatry there has been a widespread interest in identifying a link between female sex hormones and depression. Some of the areas investigated have been pre-menstrual tension, the effect of the use of oral contraceptives, postpartum depression, and menopause. There is a lack of conclusive evidence that suggest a direct relationship between hormonal structures of women and depression (Klerman and Weissman, 1980; Penfold and Walker, 1983; Steiner, 1979).

Pharmacological research has resulted in a neurochemical theory of depression. The amine hypothesis of affects disorders proposes that there is a functional deficit of one or more brain neurotransmitter amines at specific central synapses. These synapses in specific brain areas are related to vegetative and regulatory behavior. Norepinephrine, dopamine, and serotonin are the

neurotransmitter amines regulating the flow of impulses in these brain areas. Complex processes are involved in synthesizing, storing, releasing, re-utilizing, and metabolizing the amine neurotransmitters. The neurochemical postulate has found support in research conducted with a drug called reserpine. In the treatment of hypertension with reserpine, a large number of patients became depressed and reserpine depleted sertonin and norepinephrine in the brain. Monoamine oxidase inhibitor drugs are capable of elevating brain amine levels and in animals treatment with monoamine oxidase could inhibit or reverse symptoms of depression caused by reserpine (Weissmann and Klermann, 1980).

Psychosocial explanations for depression have focused on the disadvantaged social status of women. For example, Gove (1972) in a study of mental illness among married women, single women, and married men found that mental illness was more common among married women. He concludes that depression in wives is due to role restraint. Men occupy two roles, one as a household head and the other of a wage earner, and both of these roles provide a sense of gratification. Married women on the other hand have only one source of gratification which is the role of housewife. Downey and Moen (1987) found that multiple roles promoted psychological health in women. However it was not role of employment that increased psychological well-being but the income it produced. Although this theory addresses the

social and cultural role of women in North American society it does not account for why not all unemployed, married women are depressed.

Brown and Harris (1978) in identifying a link between women's daily experiences and depression found that in 83% of women traumatic life events or major ongoing difficulties preceded depression. These "provoking events" dealt with the experience of a loss or disappointment of a person, role, object, or an idea. They propose that loss events are a deprivation of sources of value or reward. What becomes important about the loss is that it may lead to an inability to have good thoughts about oneself, and a loss of faith in one's ability to attain an important and valued goal. The immediate response to the loss of an important source of positive value is likely to be a sense of hopelessness accompanied by a range of feelings. A person's sense of mastery is crucial in determining whether the hopelessness becomes generalized. In other words, the perception of the individual's world is what eventually leads to depression. If an individuals perceives that there are alternatives available the loss will be resolved and depression will be avoided. It is only in the case of where a loss is not resolved and a specific hopelessness becomes generalized that depression occurs. Brown and Harris (1978) do not suggest that the physical basis of depression should be ignored but propose that these functions may be a dependent rather than an independent variable.

Physical, emotional, behavioral, cognitive, and social factors have been utilized to explain reason for depression. Gruber (1974) states:

> It is a serious error to suppose that the main features of a complex idea are adequately characterized by the more elementary ideas which make it up. If that were the case, the discovery of a new component idea and its introduction into a theoretical structure would always be the most prominent kind of event in the growth of the complex structure.
> In fact, however, very profound changes in the nature of a complex idea may depend mainly on the rearrangement of its components to form a new structure (p. 156).

The intricacy of constructing a complex idea is evidenced by the numerous investigations of depression in mothers of young children.

Role of Mothers

Mothers with young children have particularly high rates of depression. Brown et al. (1975) found that 42% of working-class women with children under the age of six had experienced an affective disorder where middle-class women and working-class women without young children at home had lower rates of depression. In a survey of mothers of preschool children living in London, England, 52 percent of women had moderate to severe mental distress over the previous 12 months (Moss and Plewis, 1977). In correlating parental status and self-reported symptoms of depression Radloff (1975) found that depression scores increased as

children's age decreased. Other researchers have drawn similar conclusions (Richmann, 1974, 1976, 1978; Berg et al., 1984; Brown, Harris, and Copeland, 1977; Mirowsky and Ross, 1989). What makes motherhood so depressing?

The physical and emotional work of women in the home has been termed "Motherwork" (Bernard, 1974, p. 116). This work has several qualities. Mothering rests on the emotional and physical care of infants and children through touching, soothing, feeding, diaper-changing, bathing, supervising, smiling, teaching, playing, and disciplining.

Boulton (1983) describes four factors that make mothering of preschoolers notably frustrating. Children in this age group are immature both intellectually and socially. They are limited in their ability to grasp concepts and their attention span is restricted. Children have bound ability to express themselves rationally and to understand rational explanations. They have limited capacity to anticipate danger and are in need of constant supervision. Children in this developmental stage are ego-centric and are unable to consider the needs of others. This makes parenting exceptionally demanding. As one woman describes:

> With children, they need feeding when they need feeding. Their nappies have to be washed every day. It's as simple as that. When they cry you can't say, ' Well I'll see you in an hour.' That is what hits you: the fact that it's seven days a week, twenty-four hours a day, and they make the rules (Boulton, 1983, p. 69).

Mothers often describe a loss of personal identity. Lopata (1971) addresses the limitations of activity on a woman's sense of individualism:

> The care of infants calls for repetitious action, isolation from interaction and intellectual stimulation and limitations of occasions to display a wide range of personality behaviors in a variety of social contexts which shows the uniqueness of self (p. 193).

Mothering can be very isolating in that there are no co-workers to share the workload, to confer with, and provide feedback (Blauner, 1964). She notes:

> The need for sheer activity, for social intercourse, and for some status and identity in the larger society keeps even unskilled workers on the job after they are economically free to retire (p. 31).

Research has approached isolation to some extent by drawing a comparison between mothers that are housewives and mothers that are employed. McCannell (1988) found that women at home experienced greater difficulty in the transition to motherhood as opposed to mothers who were employed on a full or part-time basis. This difference was statistically significant after a period of one year. She suggests that the rewards experienced through employment may minimize the difficulties associated with parenting. Another possible explanation may be "that women who work are not continuously exposed to the stress of child rearing and therefore rate difficulties as being lower" (p. 102). Other

investigations have reported similar findings (Kessler and McRae, 1982; Ferree, 1976, 1984; Downey and Moen, 1987).

Preschool children may restrict their mother's social and emotional support network because of their own emotional needs (Belle, 1980). Marital satisfaction decreases as the number of young children in a family increase (Pleck, 1983), and husbands are less likely to be a confidante (Brown and Harris, 1978).

The traditional role of housewife and mother who is not employed outside the home is stressful (Gove and Tudor, 1973). A mother with two preschool children spends 38 hours on housework and 70 hours on childcare tasks. Overall her working hours are 98 hours a week (Kome, 1982; Mitchelson, 1985) and the connection between housework and mental well-being has been examined (Oakley, 1974; Nairne and Smith, 1984; Rosenberg, 1987; Boulton, 1983). Mothers still bear most of the day-to-day responsibility for their children (Nye, 1976; Luxton, 1983; Bernardo, Shehan, and Leslie, 1987).

In identifying the various aspects of mothering the reoccurring theme is one of loss. There may be a loss of financial independence, a loss of control, a loss of social contact, and a loss of personal identity. Parenting is also very stressful and stress within this context may be defined as a loss of control. If one considers the aspects of motherhood and the losses that are incurred by becoming a mother then it is of little surprise that women suffer from

depression more than men but these deprivations do not explain why all mothers do not suffer from depression. Shehan (1984) for example, found no significant differences between employed wives and housewives in rates of depression, health anxiety, or life satisfaction.

Depression Studies

Poverty has long been associated with poor mental health (Hollingshead and Redlich, 1958; Liem and Liem, 1978; Canadian Mental Health Association, 1987) and generates stress in other areas of life (Daniel, Hampton, and Newberger, 1983). Women who live alone with children and who are disadvantaged by being poor are at increased risk of depression (Orr and James, 1984; Pearlin and Johnson, 1977; Guttentag, Salasin, and Belle, 1980). In comparing psychiatric as well as social-economic functioning of single versus married mothers Weissmann, Leaf, and Livingston (1987) found a higher rate of dysthymia among single-parent families. Single parent women lacked the financial resources to meet basic needs and were more likely to receive welfare. Mothers on welfare report that they do not have an adequate amount of money to spend on food (Baxter, 1988; National Council of Welfare, 1990; Ross and Shillington, 1989).

Mothers suffering from depression are young (Berg et al., 1984; Reis, 1989; Cox et al., 1987). Coletta (1983) studying symptoms of depression in young mothers found that

59% of adolescent mothers were rated as depressed as compared to 21% of the individuals in the general population, and 48% of low-income mothers.

Mothers with the least education suffer from higher rates of depression (Weissman, Leaf, and Livingston, 1987; Coletta, 1983). This in turn supports that mothers have difficulty finding employment that enables them to become self-sufficient (Moore, 1978).

Mothers that are poor live in inadequate housing (Richmann, 1978; Hall, Williams, and Greenberg, 1985). Medical and non-medical staff in a London teaching hospital rated housing as the most frequent problem for women around the time of childbirth (Puckering, 1989). Similarly in Canada "the majority of low-income women live in some of the worst accommodation: the oldest dwellings, and the least adequate in terms of size and amenities" (Wekerle, 1988, p. 104).

Depressed women suffer from poor physical health (Berkmen, 1969; Richmann, Stevenson, and Graham, 1982; Weissman, Leaf, and Bruce, 1987). Belle (1982) found in a sample of 43 women 42% reported a physical problem that required regular treatment, and 22% had two or more problems that required the regular attention of a physician.

Maternal responsiveness and nurturing behaviors deteriorate as stress increases, particularly in mothers that are depressed (Belle, 1982). Depression in mothers has been positively correlated with punitive attitudes toward

childrearing (Susman et al., 1985), lack of knowledge of child development (Reis, 1988), and poor quality of parenting (Goodman and Brumley, 1990). Behavioral problems are more common in preschool children (Williams and Carmichael, 1985; Richman, Stevenson, and Graham, 1982; Cox et al., 1987).

The role that social networks play in mediating depression in mothers remains unclear (Thoits, 1982). Network size for non-working mothers is associated with social class and network size is drastically lower for non-working mothers in the lowest social class (Hammer, Gutwirth, and Phillips, 1982). A strong supporting network, especially by the father is significant in preventing depression (Williams and Carmichael, 1985). The support of a spouse acts as a buffer to depression in mothers of preschool children (D'Arcy and Siddique, 1984) which in turn supports that depressed mothers report poor marital relationships (Bromet and Cornely, 1984; Birtchnell, 1988; Hall, Williams, and Greenberg, 1985). Individuals as sources of support may also increase levels of stress (Belle, 1982). Social support may also have no effect on individuals' well-being. A three year long study examining the relationship between stressful life events, social supports, and psychological functiong in mothers of preschool children found that although depressed mothers reported more problems they also reported more resources. The number of resources did not effect the health status of

depressed mothers when compared to well mothers with fewer resources (Goodman and Johnson, 1986).

Employed mothers appear to be in better mental health (Weissman and Paykel, 1974; Warr and Parry, 1982) but employment may only act as a buffer when it is appraised as being meaningful by the individual (Hock and DeMeis, 1990). Mirowsky and Ross (1989) using data of 680 husbands and wives found that nonemployed wives with young children had significantly higher levels of depression than those without children. For employed wives difficulty in arranging child care and husband's participation in parenting affected psychological well-being. The optimal combination was found to be employment and motherhood where the care for the young children was shared by the husband. Findings in this study indicated that "When the social roles of husbands and wives are similar, their depression levels are similar" (p. 106).

Cultural factors play a significant role in the manifestation of depression. Williams and Carmichael (1985) identified that immigrant mothers who were unable to speak the English language and lacked a supporting social network had significantly higher rates of depression than Australian-born mothers.

Chronic depression has been noted in longitudinal studies of mothers (Wolkind et al., 1980; Belle, 1982).

Several models of depression have attributed that depressed individuals differ in how they cope with environmental factors (Billings and Moos, 1982).

The development of Rotter's scale of internal-external control (Rotter, 1966) which measures personal control over environmental events has led researchers to investigate the relationship of control and depression. Johnson and Sarason (1978) examined the link of depression and locus of control, and found students with an external locus of control were more depressed and experienced more negative life changes. The study supported that those individuals who experience high levels of change but feel that they have no control over events are most subject to depression. In a group intervention for unipolar depression Steinmetz, Lewinson, and Antonuccio (1983) found that those individuals with greater perceived control at pretreatment had a positive treatment outcome whereas locus of control was not significant in explaining outcome variance in posttreatment scores.

Further analyses have focused on two general categories of coping reactions: those that are problem focused and those that are emotion focused. Problem focused are those efforts made to deal with sources of stress by changing one's personal behavior or the environment, and emotion focused coping refers to efforts utilized to reduce emotional distress (Folkman and Lazarus, 1984). In identifying coping responses Pearlin and Schooler (1978) found severe depression was associated with emotion coping responses, and that this style of coping was more often utilized by women. In comparison those with less severe

dysfunction employed problem solving coping. Billings and Moos (1984) in a study of depressed men and women further support these findings.

In linking the role of social environmental factors to unipolar depression Billings and Moos (1983) found that depressed persons experienced more lifestrains with personal health, family relationships, home, and work situations as compared to controls. Subsequent evidence implied that specific aspects of social support and coping processes influenced adjustment among depressed individuals. In a longitudinal study of 380 clinically depressed individuals Fondacro and Moos (1987) found that increased support of family members was related to problem-solving coping among women. Conversely, a decrease of family support was correlated to a decrease in problem-solving strategies. Efforts to control stress-related emotions, verbal expression of unpleasant emotions, and more indirect efforts to reduce tension such as smoking were not significantly related to family support among women.

Coyne, Lazarus, and Aldwin (1981) in an analysis of how depressed men and women coped with stresses in everyday life found that depressed individuals scored higher on "wishful thinking", emotional support-seeking but that they did not differ from non-depressed controls in the amount of problem focused coping or self-blame they utilized.

Post-treatment studies have focused on the relationship between coping and depression in remitted and non-remitted

patients. For example, Billings and Moos (1985) in a twelve-month follow-up study of 424 patients examined the post-treatment phase of remitted, partially remitted and non-remitted patients. The non-remitted group was lower on self-esteem and used alcohol as a form of emotional coping. Patients whose depressive symptoms remitted reported increases in the quality of significant relationships, family support, and fewer negative events. In contrast non-remitted patients continued to lack in each domain. "Such patients participated less actively in family and social roles, were less likely to be employed, and earned less money" (p. 323). Non-remitted patients were more likely to have problems associated with alcohol and this indicates that emotion focused coping may further complicate a already troublesome situation.

Barth, Schinke, and Maxwell, (1984/1985) utilized a coping skills training program for school-age mothers and indicate that cognitive and interpersonal skills of mothers increased but mental health status remained the same.

The strength of the relationship between coping and depression remains obscure. Although findings indicate depressed individuals utilize more emotion focused coping and lack internal control outcomes have not been consistent. The definitions and measurements of depression and coping vary, mediating psychosocial factors are assessed by disparate scales and frequently are not all encompassing.

Methodology employed has salient influence on research outcome (Surtees and Rennie, 1983).

Theoretical perspectives on depression have dealt with ego loss, learned helplessness, learned misconceptions, genetic factors, neurochemical reactions, social-environmental elements, and behavioral reinforcers.

Behavioral reinforcers may also play a role in the development of coping disposition. Bandura (1977) identified that individuals can learn not only through reinforcement contingencies but also through social learning. Social learning occurs through the imitation and observation of others. Coping disposition as described by Antonovsky (1988) is learned through the observation and imitation of individuals and through reinforcement of behaviors (Bandura, 1977).

The sense of coherence questionnaire has not yet been utilized with a population that may be at risk of depression and this investigation will seek to answer the ensuing question: Is there a relationship between depression and coping disposition in mothers of preschool children?

Chapter III

Method

Introduction

A descriptive survey, employing three instruments, was utilized with a disadvantaged urban core sample of 67 mothers of preschool children in the downtown east-side of Vancouver.

Sampling design

The survey was based on a non-random design and mothers with at least one preschool child age five and under voluntarily participated in the study.

Data collection procedures

Mothers were approached individually and requested to complete three questionnaires. In the socio-demographic questionnaire a number was entered into the name category as to identify the number of the questionnaire but also to provide anonymity for mothers. All participants were informed that given information remain confidential.

Data were collected for a two and a half week period, three times a week, beginning February 12 to March 26, 1991.

Sites

Crabtree Corner is a short-term and emergency daycare center and 90 to 100 children use this service on a monthly basis (Crabtree Corner-Monthly Statistical Report, 1991).

The Vancouver foodbank was selected as a second site for data collection. The foodbank has designated Tuesdays

as a foodbank day for single parents with children age five and under and as it had been noted that a large majority of single mothers utilized the daycare center the selection of this site was deemed appropriate in that it would not influence outcome of results. Data were gathered for 67 mothers of preschool children.

Measures

Three instruments were used for data collection, a socio-demographic questionnaire, the center for epidemiologic studies depressed mood scale, and the sense of coherence questionnaire.

(a) Sociodemographic questionnaire

The sociodemographic variables were identified on the basis of the review of literature dealing with depression in mothers. It has face validity but was not pretested for concurrent validity. Each subject was requested to provide information about: age, marital status, ethnic origin, first language spoken, number of children, number of preschool children, expecting another child, education, full- or part-time employment, monthly income, and monthly income on welfare when applicable (See Appendix A).

(b) The Center for Epidemiologic Studies Depressed Mood Scale (CES-D) (Refer to Appendix B)

The CES-D scale is a short self-report scale that has been utilized to measure depressive symptomology in the general population and is widely used for research purposes. The CES-D has a good internal consistency with alphas of .85

for the general population. It has demonstrated stability with test-retest correlations that range from .51 to .67 (Radloff, 1977). It has excellent concurrent validity and correlates significantly with a number of depression and mood scales.

The theoretical range of scores is 0-60, four questions being reverse scored. Radloff, (1977) suggests a score of 16 be employed as cutoff to indicate "case" depression. Group rates are to interpreted in terms of level of symptoms which accompany depression and not in terms of rates of illness. A group with a high average score may be at risk of depression or in need of treatment (Devins and Orme, 1985).

(c) The Sense of Coherence Questionnaire

This scale measures a sense of coherence or coping disposition. The questionnaire is based on 29 questions of which thirteen are reverse scored (See Appendix C). Although questions can be identified that address comprehensibility, manageability, and meaningfulness it does not measure interrelationship of components. The components have been identified separately for theoretical purposes only. The notation to the left of each question on the questionnaire identifies whether the question deals with the category of meaningfulness, comprehensibility, or manageability. The theoretical range is 0-203 and a higher score indicates stronger coping disposition.

The SOC has been utilized with several populations and mean coping scores reported have ranged from 132 to 160. Higher mean scores were reported for homogenous groups of Israeli army officers and lower mean scores for more diverse populations (Antonovsky, 1988, p. 80). For purpose of comparison the mean coping score of New York state productions workers was utilized in this study as this population was similar to the sample of mothers in terms of absence of higher education. The mean coping disposition score reported for workers was 133.

The SOC has high reliability, Cronbach's alpha ranges from .84 to .93. The questionnaire has convergent validity with the Internal-External Locus of Control Scale and results indicate a significant positive correlation of .385. Discriminant validity has been suggested by a significant negative correlation of -.212 between the SOC questionnaire and the Sarason Test Anxiety Scale. Criterion validity has not been established (Antonovsky, 1988).

Data Analysis

The social-demographic questionnaire was coded. The CES-D scores were computed reversing questions 4, 8, 12, and 16. The orientation to life questionnaire was scored by adding the numeric answers for each of the twenty-nine questions, reverse scoring thirteen of these questions. The SPSS/PC+4 statistical analysis computer program was utilized for statistical analysis. Frequencies were run for all

data. Statistics were calculated for interval data and missing data were excluded from calculations.

A multivariate analysis was utilized to identify predictor variables for depression. Depression was entered as the dependent variable, and coping disposition, age, income, total number children, and number of preschool children act as independent variables.

Limitations of study

As sampling is purposive findings cannot be generalized to the population at large. The coping disposition scale has not been utilized with a population that is at risk of depression and investigations with similar populations need to further test presented results. This investigation is an initial step in conceptualizing the relationship between symptoms of depression and coping disposition.

Chapter IV

Results

Sixty-seven mothers of at least one preschool child age five and under voluntarily completed three questionnaires. Questionnaires were not included in data analysis where the depression scale was incomplete or completed incorrectly and four questionnaires were exluded. The same criteria was utilized for the coping disposition measure. Four questionnaires were exluded all together from the study and two of these same four incomplete questionnaires were accidentally destroyed. There were no missing cases for depression and coping measurements. Missing information for the sociodemographic questionnaires was identified and excluded in data analysis. The total sample size was n=63.

The age of the population was close to being normally distributed with a mean of 28.45, mode and median being 28, a range of 26, and a standard deviation of 6.

Population Profile

The population ranged in age 17 to 43 and 28 was the mean age. Thirty mothers are Caucasian, and 27 are Native Indian. The equal representation of races in this investigation is dissimilar from reports in the literature which often report a higher incidence of one minority group (Weissmann, Leaf, and Bruce, 1987). English was the first spoken language for the majority of women.

The majority of mothers were single. Only fourteen women reported being separated or divorced. Single-parent families headed by women are the poorest among all family types (National Council of Welfare, 1990).

Fifty mothers out of a sample of 63 were unemployed and received social assistance. Monthly income ranged from $564 to $1600, with a mean monthly income of $1005. Twenty-three percent of the respondents failed to report income as the wording of the questionnaire led women to believe that if they were on welfare income was not of interest. In order to obtain a more accurate figure for income, questionnaires where women indicated being on social assistance, total number of children, and failed to report income, base welfare rates in effect during the time of the study were entered into fourteen questionnaires.

The large number of mothers receiving welfare comes as no surprise. The Ontario Social Assistance Review Committee, stated "Despite the inadequacy of social assistance benefits, most single-parent families are better off financially receiving assistance than they would be working for minimum wages" (National Council of Welfare, 1990, p. 63). The mean monthly income of $1005 falls well below the established low-income cut off for a family of two in Canada for 1989. The income cut off is $1516 a month (Ross and Shillington, 1989, p. 6).

The total number of children for women ranged from one to seven. Nearly one-half of the population had one child

and 27% reported two children. The number of preschool children per family ranged from one to four, one being the norm. One-tenth of the population were expecting another child. The age and number of children are an important consideration in labour force participation (National Council of Welfare, 1990) as income not only needs to cover daily living expenses but also the cost of daycare for preschool children (National Council of Welfare, 1990).

Education ranged from grade six to university level. The level of education most frequently cited was grade ten. Fifty-seven percent of the mothers had not completed high-school. Mothers with less than grade 11 are less likely to be employed full-time (National Coouncil of Welfare, 1990) as minimum wages are not adequate to meet the living expenses of a family (Ross and Shillington, 1989).

Depression scores ranged from 0 to 47 and the mean score was 22. Thirty-five percent of the sample scored below 16 indicating an absence of symptoms of depression. In contrast 65% of the population have scores that indicate symptoms that accompany depression. The CES-D does not measure the presence of the clinical syndrome of depression thus scores of 16 or above indicate high depressive symptoms but are not intended to connote a diagnosis of clinical depression. The mean rate of symptoms of depression is not startling as studies with similar impoverished groups have reported high rates of symptoms of depression (Hall, Williams and Greenberg, 1985; Belle 1982).

Cox et al. (1987), identified that mothers at risk of depression were under the age of 21 when they had their first child. In this study six women were under the age of 21. The majority of mothers reported having one preschool child, and mean age being 28 would have given birth to their first child around age 23. These data indicate that a more mature population of mothers may be just as much at risk of depression as adolescent teenage mothers.

Coping disposition scores ranged from 57 to 174, the average mean score being 124. A mean coping disposition score of 133 was reported for 111 New York State productions workers with a range of 62 to 189 (Antonosky, 1988). This score was chosen as a score for comparison as the workers were similar to the mothers in terms of absence of higher education. The mean coping score of 124 is lower than the score of comparison of 133 of the New York production workers and the need for further investigations with mothers of preschool children at risk of depression may allow for a more accurate comparison of coping disposition scores in the future.

Table 1 provides a summary of selected findings.

TABLE 1

Means and Standard Deviations of Selected Characteristics of Mothers

Variable	Mean	Standard deviation	n=
Age	28.45	6.03	59
Monthly Income	1005.26	192.24	60
Depression Score	21.88	12.13	63
Coping Disposition Score	124.20	23.70	63
No. of Preschool Children	1.47	.09	63

TN= 63

Cross-tabulation utilizing the chi-square statistic were utilized for the recoded ordinal variables of education, ethnic origin, with recoded interval level variables of age, income, and symptoms of depression. There were no significant results noted for either the native or caucasian group of mothers. Similar results have been reported in a study by Pearlin and Johnson (1977) who

examined marital status, life strains, and depression and found that "economic strain is the pertinent condition, not race, sex, or age" (p. 709).

A simple regression was utilized to identify existing linear relationships for predictor variables of depression. Depression was entered into the ordinary least squares equation as the dependent variable, and coping disposition, age, income, total number of children, and number of preschool children are the independent variables. Table 2 summarizes the results of the equation.

TABLE 2

Results of Ordinary Least Squares Equation for Predictor Variables of Depression

Variable	B	SE B	Beta	T	Sig T
Coping	.3669	.0466	-.7440	-7.868	.0000
Pre-school	-1.0869	2.5667	-.0685	-.423	.6738
Age	.0567	.2088	.0277	.272	.7870
Income	2.0602	.0088	.0032	.023	.9815
No.of children	-.9338	1.4156	-.1132	-.660	.5125

R^2 =.5854
Adjusted R^2 =.5440
R =.7651

The only significant variable contributing to depression is coping disposition p> .00001 and the relationship was negative. In other words, depression scores decreased as coping disposition scores increased, and depression scores increased as coping scores decreased. A Pearson correlation coefficient of .77 was computed and the square of the coefficient indicates that approximately 59% of the variation of depression scores can be explained by the equation. The adjusted R square indicates that 54% of the variation is due to the independent variables entered into the ordinary least squares regression.

The Pearson correlation coefficient of .77 is unusually high and this high correlation may be attributed to several factors. The sample of mothers is a very homogenous group and this results in a lack of variance within the defined variables. The lack of variance may contribute to a high correlation. Another critical factor may be that the depressed mood scale and the coping disposition are measuring the same or similar feelings. Auto correlation between measures will increase the Pearson correlation coefficient. The Sense of Coherence questionnaire has demonstrated discriminant validity with the Sarason Test Anxiety Scale and a significant negative correlation of -.212 has been reported (Antonovsky, 1988).

Chapter V

Discussion

Findings indicate a significant negative linear relationship between rates of depression and coping disposition. As depression increases sense of coherence decreases, and as depression decreases the ability to cope increases. Six out of every ten mothers displayed symptoms of depression and a corresponding or lack thereof sense of coherence. What is of considerable interest is that thirty-five percent of mothers had no symptoms of depression and a strong sense of coherence. For example, one single mother of seven children, in receipt of social assistance, had no symptoms of depression, and a high coping disposition score. Results support that a strong sense of coherence serves as a mediator between life strains and mental health.

How does one explain the differences in symptoms of depression and sense of coherence in a group of individuals that are poor and single parents of at least one preschool child? Several paths may lead to developing a strong sense of coherence (Antonovsky, 1988).

Understanding the genesis of the mothers lack of coping skills indicates that childhood experiences may affect their ability as adults. A sense of coherence is developed from early infancy onward to early adulthood. Children, like adults need to comprehend their world, make meaning out of it, and be able manage it (Antonovsky, 1988). Children

learn to cope within their environment very early on in life (Gunnar, 1980; Seligman & Peterson, 1986) and over time the infant and child learns that his or her physical and social environment are predictable. In other words stable family routines provide a "harmonious sense of continuity" (Antonovsky, p. 129, 1988). The young child is primarily affected by the perceived evaluations of the parent (Rosenberg, 1979). Parents who have:

> an orientation that is one of complexity and flexibility, alternatives and self-direction, meaning, consistency, choice, and a sense that problems are manageable and solvable (Antonosky, 1979, p. 147).

are likely to address the needs of the child. In each individual, wealth, ego-stregth, and cultural stabiliy contribute to a strong sense of coherence. The stronger the sense of coherence of the parent "the more likely they are to shape the set of life experiences of the child so that it leads in the same direction" (Antonovsky, 1988, p. 100).

The development of coping disposition may in essence be rather cyclical. The stronger a sense of coherence in the parent the more presumable that the child will achieve a solid coping disposition. For example, Margalit (1985) utilized the sense of coherence questionnaire with thirty-two children that were selected from grades four to six. She compared one group of school children that were identified as being hyperactive with a control group and substantiated that the group of hyperactive students had

significantly lower sense of coherence scores, which "reflected that their environment seemed less ordered and predictable; expected (age-appropriate) tasks seemed less manageable, and to a large extent seemed meaningless" (pp. 361-362). A predictable environment in childhood may have led to a secure coping disposition for the mothers of this sample.

Antonovsky (1988) reasons that social support may be another mode of achieving a strong sense of coherence. In a longitudinal study Werner and Smith (1982) examined a group of children in Kauai that lived in chronic poverty and experienced a series of stressful life events. The focus of the study was to identify a set of predictors that discriminated between high-risk resilient children compared to peers that had developed serious coping problems by ages ten and eighteen.

> Yet there were others, also *vulnerable*-exposed to poverty, biological risks, and family instablility, and reared by parents with little education or serious mental health problems who remained *invincible* and developed into competent and autonomous young adults....This report is an account of our search for the roots of their resilience, for the sources of their strength (Werner and Smith, 1982, p. 3).

Seventeen years later the findings indicated that resilient children exhibited:

> ...a more internal locus of control, a more positive self-concept, and a more nurturant, responsible, and achievement-oriented attitude toward life...developed a sense of coherence in their lives and were able to draw on a number of informal sources of support (p. 154).

Antonovsky (1988) cautions that although informal networks were available to the children it is the characteristics of the networks that are imperative:

> One of Werner's key phrases is *structure and rules* ...her emphasis on exposure of the child to extensive networks, all of whose members hold similar values and beliefs, likewise suggests a dynamic but stable environment, with good feedback, which provides the basis for seeing the world as predictable (p. 50).

This may be an alternate description of how mothers in this particular group achieved a strong coping disposition, not only were informal networks available but they also possessed the crucial properties necessary to effect a strong sense of coherence.

Forty-one mothers of the sample of 63 mothers suffered from symptoms of depression and comparative coping dispositions. Nearly 60% of the women had not completed high-school, grade ten being the most frequent response. The reported mean monthly income of $1005 falls well below established poverty lines (National Council of Welfare, 1990). Eighty percent of mother were welfare recipients. Data generally support the literature in that mothers suffering from symptoms of depression are likely to be poor and have low levels of education although this population

differs in that the majority of women were not in the category of "high risk" i.e. teen mothers as the mean age was 28 years. Findings support the notion that those with fewer resources are likely to develop symptoms of depression. A lack of high-school education reduces the likelihood of becoming self-sufficient. Low income may be a barrier to obtaining resources, and individual experiences are less conducive to strengthening coping disposition.

Antonovsky (1988) suggests, based on statistical predictions that by the time one is thirty, one has attained a given location on the sense of coherence continuum.

> For the person with a weak SOC in early adulthood, life becomes a vicious circle. General resistance resources deficits play an increasingly prominent role, as encounter after encounter debilitates the SOC ever more. The 'loser' continues to lose, and life becomes more and more chaotic, unmanageable, and meaningless (p. 122).

Certainly the coping disposition can be strengthened temporarily but soon the individual returns to the mean (Antonovsky, 1988). Antonovsky (1988) does not identify on how he arrived at these statistical predictions and one needs to interprete this statement with some care.

For this group of mothers that are at a disadvantage in terms of coping disposition and depressive symptoms there are implications for helping professionals. The paramount factor appears to be one of treatment and prevention both for mothers and children.

In all societies one's social class is one of the key variables that determine daily living (Antonovsky, 1979). Mothers with the least resources are least likely to have a strong sense of coherence and least likely to generate a solid coping disposition in children. One may take this a step further and define resources as options. For this population options appear limited. For example, although mothers in this population had access to daycare the mandate of this center was short-term care, and the hours of operation did not address the needs of working mothers. In this specific instance the lack of options to increase financial resources exists. Mothers with fewer resources will continue to lack options unless social policies address the needs of all family members.

Antonovsky (1988) warns against focusing on the cognitive aspect of a sense of coherence but refers to the importance of involvement "as a participant in the processes shaping one's destiny as well as one's daily experience" (p. 18). Social work practitioners need to identify if clients are indeed participating in their own lives, and to encourage active involvement in what is indeed meaningful for the individual.

The infant usually has one caretaker but increasingly with age the child's social environment becomes much broader (Feiring and Lewis, 1989). Relatively little is known about the impact of the social environment on young children (Belle, 1989). Parents who provide social environments that

are responsive to children promote their children's development of internal control beliefs (Skinner, 1985) but if depression affects the mother's ability to provide a responsive environment, children will have few opportunities to develop a strong sense of coherence. It becomes crucial to intervene at this level but "little is known on the extent to which good relationships outside the home can serve a similar protective function" (Rutter, 1990 p. 64).

Although findings proved to be significant, one must caution that a relationship does not imply causality between two variables. Findings cannot be generalized to the population at large as sampling was purposive.

Summary

Findings indicate that mothers who are likely to suffer from symptoms of depression are poor and have low levels of education. A lack of high-school education leads to a low income which creates a barrier to obtaining resources. Individual experiences are less conducive to strenghtening coping disposition when resources are unavailable. Women with fewer resources are less likely to develop a strong sense of coherence. Coping behaviors of mothers at risk of depression influence how children learn to cope.

Social workers need to take an active approach toward identifying the needs that are meaningful for the client, and to encourage client participation in changing present social policies at the grass-roots level. Organizations

such as anti-poverty groups may offer mothers opportunities to voice concerns and influence political decision-making.

Social work treatment will need to identify and utilize resources that are conducive to strengthening coping disposition so that the client's world may be comprehensible, meaningful, and manageable.

The need for the prevention of a low sense of coherence in children lies in creating predictability in the childrens' lives. The importance of routine may be emphasized in social work contact with the client and through parenting courses. Community resources may also be utilized to meet childrens' need for stability. These resources may range from support of the grandparents to preschool children programs.

The link of a lack of education and poverty is evident. Social workers need to advocate for comprehensive social policies that address the needs of all family members if mothers and children are to cope better in the future.

Coping behaviors are recognized as having influence on health and well-being. Findings in this study indicated a significant negative linear relationship between depression and coping disposition. Thirty-five percent of mothers reported absence of symptoms of depression, and strong coping dispositions despite existing life strains, such as low income, and lack of education. Over half of the sample was at risk of depression as indicated by a weak sense of coherence.

The complex nature of this relationship warrants further systematic analysis. The high correlation between coping disposition and symptoms of depression may be explained by a lack of range as a result of a homogenous sample and thereof a lack of variance within defined variables. Another critical, contributing factor may be that the depressed mood scale and the sense of coherence questionnaire are measuring corresponding feelings. The possible auto correlation between the two measures requires further investigation. It is essential that this issue be addressed before researchers can continue to investigate the relationship between symptoms of depression and coping disposition as defined by the sense of coherence concept.

Findings tentatively support social work intervention to strengthen individual coping resources through education, income, and increasing positive social support networks.

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Appendix A

Sociodemographic Questionnaire

DEMOGRAPHICS QUESTIONNAIRE

Name:

Age:_____

Ethnic origin:_____

First language spoken:_____

Last grade of education completed_____

Total number of children:_____

Number of children age five and under:_____

Are you pregnant right now?:_____

Marital status: single_____
common-law_____
married_____
divorced_____
partner/live-out_____

Are you employed: Yes_____
No_____

If yes, full-time or part/time_____

What is your monthly income?:_____

Do you presently receive social assistance: No_____
Yes_____

Appendix B

The Center for Epidemiologic Studies Depressed Mood Scale

Table 1. CES-D Scale

INSTRUCTIONS FOR QUESTIONS: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. HAND CARD A.

Rarely or None of the Time (Less than 1 Day)
Some or a Little of the Time (1-2 Days)
Occasionally or a Moderate Amount of Time (3-4 Days)
Most or All of the Time (5-7 Days)

During the past week:

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
14. I felt lonely.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people dislike me.
20. I could not get "going."

Appendix C

The Sense of Coherence Questionnaire

Appendix: The Sense of Coherence Questionnaire

The notation to the left of each item represents the profile structure of the item, derived from the mapping sentence used in questionnaire construction (see p. 77). C = comprehensibility, MA = manageability, ME = meaningfulness. The four numerals represent the elements in facets A, B, C, and D, respectively.

A high score represents a strong SOC. Before calculating the total score, the thirteen items marked R should be reversed.

For those interested in using a short form of the SOC, the thirteen items marked * are recommended.

These notations, obviously, are to be omitted when the questionnaire is used.

ORIENTATION TO LIFE QUESTIONNAIRE

Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number which expresses your answer, with numbers 1 and 7 being the extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

C R 1312 1. When you talk to people, do you have the feeling that they don't understand you?

1	2	3	4	5	6	7
never have this feeling						always have this feeling

MA 1111 2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:

1	2	3	4	5	6	7
surely wouldn't get done						surely would get done

C 1322 3. Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?

1	2	3	4	5	6	7
you feel that they're strangers						you know them very well

ME R 1222 *4. Do you have the feeling that you don't really care about what goes on around you?

1	2	3	4	5	6	7
very seldom or never						very often

C R 1221 *5. Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?

1	2	3	4	5	6	7
never happened						always happened

MA R 1221 *6. Has it happened that people whom you counted on disappointed you?

1	2	3	4	5	6	7
never happened						always happened

ME R 2332 7. Life is:

1	2	3	4	5	6	7
full of interest						completely routine

ME 2331 *8. Until now your life has had:

1	2	3	4	5	6	7
no clear goals or purpose at all						very clear goals and purpose

MA 1222 *9. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
very often						very seldom or never

C 2331 10. In the past ten years your life has been:

1	2	3	4	5	6	7
full of changes without your knowing what will happen next						completely consistent and clear

ME R 1313 11. Most of the things you do in the future will probably be:

1	2	3	4	5	6	7
completely fascinating						deadly boring

C 2232 *12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1	2	3	4	5	6	7
very often						very seldom or never

MA R 2332 13. What best describes how you see life:

1	2	3	4	5	6	7
one can always find a solution to painful things in life						there is no solution to painful things in life

ME R 2132 14. When you think about your life, you very often:

1	2	3	4	5	6	7
feel how good it is to be alive						ask yourself why you exist at all

C 1112 15. When you face a difficult problem, the choice of a solution is:

1	2	3	4	5	6	7
always confusing and hard to find						always completely clear

ME R 1312 *16. Doing the things you do every day is:

1	2	3	4	5	6	7
a source of deep pleasure and satisfaction						a source of pain and boredom

C 2333 17. Your life in the future will probably be:

1	2	3	4	5	6	7
full of changes without your knowing what will happen next						completely consistent and clear

MA 3211 18. When something unpleasant happened in the past your tendency was:

1	2	3	4	5	6	7
"to eat yourself up" about it						to say "ok, that's that, I have to live with it," and go on

C 2122 *19. Do you have very mixed-up feelings and ideas?

1	2	3	4	5	6	7
very often						very seldom or never

MA R 1113 20. When you do something that gives you a good feeling:

1	2	3	4	5	6	7
it's certain that you'll go on feeling good						it's certain that something will happen to spoil the feeling

C 3122 *21. Does it happen that you have feelings inside you would rather not feel?

1	2	3	4	5	6	7
very often						very seldom or never

ME 2333 22. You anticipate that your personal life in the future will be:

1	2	3	4	5	6	7
totally without meaning or purpose						full of meaning and purpose

MA R 1223 23. Do you think that there will *always* be people whom you'll be able to count on in the future?

1	2	3	4	5	6	7
you're certain there will be						you doubt there will be

C 2233 24. Does it happen that you have the feeling that you don't know exactly what's about to happen?

1	2	3	4	5	6	7
very often						very seldom or never

MA R 3131 *25. Many people—even those with a strong character—sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1	2	3	4	5	6	7
never						very often

C 1211 *26. When something happened, have you generally found that:

1	2	3	4	5	6	7
you overesti-mated or under-estimated its importance						you saw things in the right proportion

MA R 1313 27. When you think of difficulties you are likely to face in important aspects of your life, do you have the feeling that:

1	2	3	4	5	6	7
you will always succeed in over-coming the difficulties						you won't succeed in over-coming the difficulties

ME 1212 *28. How often do you have the feeling that there's little meaning in the things you do in your daily life?

1	2	3	4	5	6	7
very often						very seldom or never

MA 3122 *29. How often do you have feelings that you're not sure you can keep under control?

1	2	3	4	5	6	7
very often						very seldom or never

Appendix D

Subject Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

School of Social Work
6201 Cecil Green Park Road
Vancouver, B.C. Canada V6T 1Z1

Depression and Coping in Mothers of Preschool Children

My name is Ute Holley and I am a social work student at the University of British Columbia. I am presently enrolled in the graduate program and my area of research is depression in mothers of preschool children and how they cope. The reason I chose this area of research is that I hope to find out what services mothers need in order to cope better. I do not work at Crabtree Corner Daycare and if you do not wish to participate in this study this will have no effect on your use of the daycare center. You do not have to answer any of the questionnaires if you do not wish to.

I have attached three questionnaires. Each questionnaire has a number in place for a name. This is to make certain that no one will know who filled it out. One questionnaire will ask you about your age, number of children, income, and education. These questions can be answered by checks or short answers. The second questionnaire is a measure of depression. The questions will ask you about your feelings over the last week. There are 20 questions that you fill in with a number. The third questionnaire is a measure of coping. There are 29 questions and each can be answered by drawing a circle around the number that you choose.

THE UNIVERSITY OF BRITISH COLUMBIA

School of Social Work
6201 Cecil Green Park Road
Vancouver, B.C. Canada V6T 1Z1

Each questionnaire will take 20 minutes to fill out and altogether the three questionnaires will take 60 minutes to complete. When you have started to fill out the questions but find you do not want to go on answering - don't. It is okay to stop if you do not want to continue. Once you have filled out the questionnaires it will also mean that you have given me permission to use these questionnaires for research. All given information will remain confidential. When you have completed the questionnaires please return these to me in the reception area. If you have any more questions about the study please call me at 325-8979. If you do not understand certain questions please let me know. I can help you with these.

Thank you,

Ute Holley

Research is conducted under Dr. S. Manson-Willms who may be contacted at the School of Social Work at 822-2255.

Appendix E

Agency Consent Letter

101 East Cordova Street
Vancouver, British Columbia
V6A 1K7
(604) 689-2808

February 28, 1991

I, Betty MacPhee, authorize Ute Holley to have access to our program, Crabtree Corner Emergency Daycare, which is administered by the Young Women's Christian Association, to conduct research on mothers of preschool children, depression and coping style as part of her thesis of the Masters of Social Work Program at the University of British Columbia.

Betty MacPhee
Manager

Appendix F

UBC Behavioral Sciences Screening Committee Approval Certificate

The University of British Columbia
Office of Research Services

B92-089

BEHAVIOURAL SCIENCES SCREENING COMMITTEE FOR RESEARCH AND OTHER STUDIES INVOLVING HUMAN SUBJECTS

C E R T I F I C A T E of A P P R O V A L

INVESTIGATOR:	Manson Willms, S.
UBC DEPT:	Social Work
INSTITUTION:	Crabtree Corner Daycare
TITLE:	Depression and coping disposition among mothers of preschool children in the downtown eastside
NUMBER:	B92-089
CO-INVEST:	Holley, U.
APPROVED:	APR 9 1992

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Dr. R.D. Spratley
Director, Research Services
and Acting Chairman

THIS CERTIFICATE OF APPROVAL IS VALID FOR THREE YEARS FROM THE ABOVE APPROVAL DATE PROVIDED THERE IS NO CHANGE IN THE EXPERIMENTAL PROCEDURES