# Gestation Dominant, Stages of the Spouse Holon Development and Signs of Sibling Disorder

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## Abstract

The present study investigated the association between spouse holon development and onset of sibling rivalry among girls. As to the knowledge of the researcher, it is the first study devoted to this issue in Kyrgyzstan. Many scientists tried to explain the phenomenon of sibling rivalry, but such concepts as spousal holon and gestation dominant were not considered as factors that can be associated with onset of sibling rivalry. Therefore, this

research aimed to explore the relationships between spouse holon, gestation dominant and development of sibling rivalry. This research was based upon mixed methodology. It included a self-made questionnaire, projective testing, Psychological Component of Gestation Dominant (PCGD) testing, and interviewing. This research used purposive sampling. The participants were taken ten ethnically Kyrgyz families with at least two daughters, where the age of the older one being not older than ten years old. “The participants included in this study consisted of ten ethically Kyrgyz families…” It is expected that there is a relationship between the Spouse Holon and the development of sibling rivalry, moreover, it is hypothesized that daughters born during the negative holons are less likely to develop sibling rivalry than those who were born during the positive holon.

*Keywords:* Spouse holon, sibling rivalry disorder, siblings, family, gestation dominant, Psychological Component of Gestation Dominant.

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*“As a rule there is only one person an England girl hated more that she hates her mother, and that’s her elder sister”*

-Freud, 1916-1917, p. 205

In the process of theory analysis the author organized three major scientific discourses: the relationship between siblings, stages of spousal holon development, and psychological component of gestation dominant.

Presumably, the problem of “brothers and sisters” is as old as the problem of “Fathers and Sons”. There are a lot of examples that demonstrate the complexity and ambiguity of such a relationship: they can be found in the ancient myths and legends, folk tales and fiction, in children's fairy tales and stories that have been inherited to us from family and friends. Even in the Bible there is a story of Cain and Abel, an example of tragic sibling relationships. These kinds of stories are countless, and they once again prove the existence of the brother - sister relationship problem, and its continued relevance to people at all times. Throughout the history, this topic has been exciting, and will excite people because it is inseparable from family relations in general and probably because it simply cannot be ultimately solved.

Taking into account the complex nature of sibling relationships, the author attempts to analyze the scientific data revealing the impact of the conception situation on the further development of the child and his relationships with other family members. Many psychologists, psychiatrists, and anthropologists such as Francis Galton, Alfred Adler, Erik Bern, and David Graham tried to explain this phenomenon through different factors such as birth order, Oedipus complex, or lack of parental attention toward the older child, etc. All of these scientists made a great contribution to the issue of sibling rivalry, but such concepts as spousal holon and gestation dominant were not considered as factors that can be associated with the onset of sibling rivalry.

Psychologists have investigated the consequences of birth order ever since Charles Darwin’s cousin Francis Galton (1874) reported that eldest sons were overrepresented as members of the Royal Society. Sir Francis Galton was the first to pay attention to the sibling rivalry issue. In his work “The People of English science” in 1874, he wrote about the importance of the phenomena of the birth order and its impact on personality development of a child. Another studies devoted to the issue of development of sibling rivalry are the works of Alfred Adler (Adler, 1997, 1998). After breaking away from Sigmund Freud in 1910 to

found a variant school of psychoanalysis, Alfred Adler (1927) focused on birth order in his own attempt to emphasize the importance of social factors in personality development. A. Adler was first who formulated the development of the child, depending on the birth order in the family. He identified sibling positions: only child, the eldest child (the firstborn), the middle child, and youngest child. A. Adler also singled out the personal characteristics of children and the specificity of the relationship between brothers and sisters, according to birth order. He believed that birth order may also explain many features of interfamily relationships. The second child is born in the family, which is fundamentally different from that in which the first child was born. These families are different in a number of family members and parental experiences. The motivations for conceiving the first and second child are different. However, studying the influence of birth order on personality development of a child and further onset sibling rivalry, neither Francis Galton nor Alfred Adler did not consider gestation dominant and spousal holons as factors which might be the cause of onset of sibling rivalry.

In 1949 Sigmund Freud theorized that the aspect of sibling relationships was a key to subsequent personality differences. He wrote “a child who has been put into second place by the birth of a brother or sister, and who is now for the first time almost isolated from his mother, does not easily forgive her this loss of place; feelings…arise in him and are often the basis of a permanent estrangement” (Freud, 1916-17, p. 34). This estrangement may lead to further disturbance in relationships between siblings.

E. Bern believed that "the situation of human conceiving can greatly influence his future destiny" (Bern, 1972). The situation of conceiving, he proposed to call "embryo installation" (Bern, 1972) and recommended, regardless of whether it was "the result of chance, passion, love, violence, deceit, cunning, or indifference ... to analyze any of these options to find out what were the circumstances and how this event was prepared. Was it

planned? If planned, as "coolly and meticulously, with temperament, conversations and discussions, or with the tacit consent of passionate? “In the life scenario of a future child all these qualities can be reflected” as well as parental attitudes toward intimate life is reflected in their relationship to the child (Bern, 1972, p. 193). David Graham believed that “the time of conceiving, fetal life and especially the time of birth and the first few hours after, and the experience of a person is unique and therefore, capturing, it generates a behavioral model” (Grahame, 1985, p. 21).

We can see the development of the sibling relationships issue over time, generations, and centuries, till nowadays. Our contemporaries, Edmond Eidemiller and Irina Nikolsyaya in 2003 also devoted one of their studies to the issue of constructive and destructive models of conceiving, and its influence on a child’s further behavior.

In 1966 the *Family systems theory* was introduced by Dr. Murray Bowen that suggests that individuals cannot be understood in isolation from one another, but rather as a part of their family, and as the family as an emotional unit. Families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system. Further, E.M. Duvall in 1957 and J. Zibach in 1986 determine the development of the family as a natural sequence of changes. They believed that the operation or organization of the family at one stage, determines the quality of the subsequent stage. This means that everything that happens within this system directly impacts all its members.

Murray Bowen theorized that family is an emotional unit, and claimed that it is the nature of a family that its members are intensely connected emotionally. According to Murray, the emotional interdependence is a natural phenomenon, evolved to promote cohesiveness and cooperation among family members in order to protect it. However, according to Bowen Theory, if the tension is heightened it can intensify these processes that promote unity and teamwork, and this can lead to problems. Eight major theoretical

constructs are essential to understanding Bowen's approach. These concepts are differentiation, emotional systems, multigenerational transmission, emotional triangle, nuclear family, family projection process, sibling position, and social regression. These constructs are interconnected. One is unable to understand each of the terms without understanding the other terms (Bowen, M., 1994).

1. Differentiation concept. "Group thinking" is mostly applying to families and social groups as their influence has an impact on how people feel, act and think. As to the individuals, it will depend on their predisposition to group thinking. A person's "self" and its development will affect his or her functioning and dependence on others pressure for conformity. The variety in functioning became possible to measure with the scale of measuring differentiation of self that was developed by Bowen.

2. The nuclear family concept specifies the mechanisms of how families deal with anxiety by offering four relationship patterns to manage it: 1) marital conflict, 2) dysfunction in one spouse, 3) impairment of one or more children, and 4) emotional distance. They are triggered when stress and anxiety intensify.

3. Family projection process concept is dealing with parents' transmission of their emotional problems to a child. For parents, it is often difficult to make realistic appraisal of their child and as they project their anxiety about self onto child, that leads to children acceptation of the parents' projection and acting according to them.

4. Multigenerational transmission process concept proposes that small differences in the levels of differentiation between parents and their children may affect many generations functioning among the members of a multigenerational family. The stories of people relations and reactions to the behaviors can affect parents' expectations and projections on their children and the ability of children to develop their own identity.

5. Sibling position Bowen's theory demonstrates to us that the position of an elder brother or the eldest man has the status of the most responsible and most meaningful person in the family. Usually the eldest children try to become leaders, and others try to follow them. For example, if I had an eldest brother, my wife should obey him as well as me, and the conflict based on this fact even may lead to divorce, because the status of my eldest brother is higher in my family than my wife's one. The status of the most eldest is not only about the authority and importance, but also about being responsible for welfare and security of the whole family, does not matter how big it is. The status comes from on eldest to next eldest person in family.

6. Triangle principle is relationship among three people. Huge systems are based on such little triangles. The triangle works if in the conflict of two the third takes the side of the first or second. Two of three angles may evaluate, give comments or even exclude the third one. But the triangle works when in the argument there are just two answers, instead of three. Marital therapy uses the triangle to provide a neutral third party capable of relating well to both sides of a conflict.

7. Emotional cut off: While keeping unresolved emotional issue with family members and parents as well, an individual can reach the point of reducing of cutting entirely any emotional contacts with them. This is called the "Emotional cut off". This may even work in a short-term, but will have its negative effects on the flexibility of the relations. In many cases this can be caused by an intense blame, the unwillingness or even inability to see one's part in a problem. Without having any resolutions, the anger gets accumulated and frozen in time, increasing relationships sensitivity, which reduces the emotional flexibility and raises the requirements of other relations to be "perfect" on a higher level. Those unresolved emotional issues caused by cut-offs get carried forward into one's family of origin into future nuclear families.

8. Societal Emotional Process. The concept of societal emotional process implies the idea that the behavior of the societal level is being controlled by the emotional system. This system can induce progressive or regressive periods in the society, as well as it does in a family. The explanation is that under stress, family members may act in a too mean or too nice manner towards each other. Parents that tend to be too nice with their children begin to elicit short-term solutions for the chronic problems. In a similar manner, leaders of the social groups are having difficulties identifying the roots of the problems, and consequently the regression starts through the leaders' tendencies to give the short-term solutions for the problems that require greater efforts. Mechanisms give us ready-to-go solutions to the rising anxiety: distance, conflict, illness and reciprocal functioning devour the rising anxiety, postponing the process of solving the problems. As people's anxiety increases and becomes more tolerant to the short-term solutions given before, the society starts to need more and more of those in order to feel better. A regression is a return to an earlier stage of development, which is characterized by the less principle-driven rules of behavior, the less degree of comfort-seeking and giving in, and lesser abilities to work in team and respect the authorities. And as many new problems occur, demanding new ways of solution, they force us into the zone of discomfort.

In 2003 contemporary scientists Edmond Eidemiller, Irina and Igor Nicholas Dobryakov accented scientific attention on the motives that determine the conception of a child. They developed the concept of spouse holon. From the perspective of prenatal therapy, they allocate stages of family cycle, basing upon relationships between spouses and the manner of how they attempt to resolve the conflicts that arise.

As a rule, there are several motives that guide couples, deciding to conceive a child, but only one of them is essential (Eidemiller et al., 2003). These motives of men and women may be different, and it is difficult to identify them. It is very important to distinguish

between constructive motives that contribute to the strengthening of the family, personal growth of the spouses, prosperous birth and development of the child, and destructive motives which contribute to the opposite results (Eidemiller et al., 2003).

Constructive motives are associated with the feelings of love (Eidemiller et al., 2003). Examples of the hidden and unconscious motives, associated with this conception are the desire to immortalize one's self in creating a child, an expression of gratitude for the happiness that your beloved one is bringing to you, the desire for creation (to birth and upbringing of such a person, that did not exist yet) (Eidemiller et al., 2003). The following conceiving objectives have destructive impacts on family relationships and on the child's upbringing and development: to strengthen family relationships (to "link" the husband, to return the husband or to prevent his leaving, etc.); force the partner to marry; to give birth, “in order to have at least one close person” , in order to have someone to care about; to improve the living space; to show parents that you became a mature person; to force parents to accept the marriage; “to be like everyone else”; to give birth for “health”; to obtain material benefits; to change the social status and many other things (Eidemiller et al., 2003).

Taking into consideration the motives of conception, it is important to ascertain in what stage of family formation process was the couple during pregnancy. Edmond Eidemiller developed a theory according to which family formation (spousal holon) is a process which is divided into 6 stages. Thus, the stages of development of spousal holon: the stage of pre-marital relations, confrontation stage, the stage of compromises, the stage of mature spousal holon, the stage of experimentation with independence, and stage revival.

Figuring out in what stage of the family formation was the family during pregnancy of the woman, helps to clarify many issues. There are many options for dividing the family life cycle on stages and periods (Eidemiller et al., 2003). Scientists of Saint Petersburg school of psychology developed the theory where he claimed that family formation is a process, which

divides into six stages. He called them holons. The word “holon” comes from the greek *holos*, which means whole, entire, complete in all its parts. He allocated the stages of life cycle of a family, basing on the relationship between the spouses, the manner in which they are trying to resolve the conflicts and he identified six stages of the development of spousal holon: the stage of pre-marital relations, the stage of confrontation, the stage of compromises, the stage of mature spouse holon, the stage of experimenting with independence and the stage of renaissance.

The first stage described by Eidemiller is the phase of pre-marital relations. This phase continues to average about 9-12 months, and is characterized by a state of euphoria, sometimes overvalued love content ideas, and increased sex drive. Everything seems “in pink glasses”, the shortcomings of the partner ignored. By the end of this stage, the shortcomings that have not been highlighted before becoming noticed, and the relation to each other becomes more critical. Very often, the couple decides to break up during this phase. However, if during that time people became really close to each other, the couple decides to get married, in order to strengthen their relations. Unplanned, accidental pregnancy can serve as a catalyst for the development of relations. Quite often, the marriage is directly related to pregnancy. But in this situation, the child himself is not holding a value in himself, but serves as a “tool” for resolving personal problems. In this case, there are difficulties in forming an early dialogue of mother and an infant. They are significantly exacerbated if the child does not justify the hopes assigned to him. As a rule, his upbringing is carried out by type hypoprotection, characterized by unconscious or conscious rejection of a baby. Also, the lack of development of parental feelings and educational uncertainty appear (Eidemiller et al., 2003).

The second phase is called the stage of confrontations. It is described as the stage which occurs when the couple moves in together. Each of them has certain habits, attitudes

and stereotypes about the responsibilities and the relationship of husband and wife. Creating a family, each of the spouses based on their own experience in the families of the parents. “The couple creates a family together, bringing each of their experiences from their own families” Often, these ideas are contradictory, which leads to conflicts. After starting living together, the couple is surprised to note that his or her beloved one is very different from the image that he/she has created. The degree of divergence of expectations and reality determines the level of conflict in relationships. Parents of newlyweds of both sides often trespass the borders of the immature holon, convincing their children that the only family is exemplary is their own. The confrontation increases. As a rule, pregnancy and birth of a child in this situation, does not strengthen but undermines the family. The hopes that the birth of a child will help to improve the relationship, usually do not come true.

C. Whitaker (1989) notes that during pregnancy the mother reduces the relationship with the child’s father, and becomes more and more concerned with a new life, which is growing in her womb. And the “unattached” father finds another attachment – to money, a secretary, a new car or to his own mother. When the child is born, the mother is getting attached to him even more. When the child is about half a year, the mother “turns to the husband” but he is not already there. She begins to feel loneliness (Whitaker, 1989, p. 30). In this situation the early dialogue with the child is characterized by sufficient depth and understanding, however, unresolved conflicts with the husband, his compensatory behavior makes a woman anxious, emotionally unstable, which affects the mother -infant relations as well. It can further be expressed in neurotic unfounded fears for the health of the child. Moreover, if the child is very much like his father, with whom the mother is in a state of conflict, she is likely to develop emotional rejection (Eidemiller et al., 2003).

The third phase of family formation according to Edmond Eidemiller is the stage of compromises, which marks the end of confrontations. Sometimes it occurs gradually,

sometimes fast. In the second case, after a serious conflict which led them to the break, they suddenly realize the impossibility of existence without each other. Fear of losing a spouse forces them to make concessions, to accept the spouse as he/she is with all faults and virtues. Trying to improve the relationship, both of the partners are not so much trying to change the other one, but to change themselves. During this period, they begin to understand, to respect each other more. Their relationships are gradually becoming more and more constructive. Conscious or unconscious unsuccessful attempts to create a copy of the parental family, which caused so many problems, are finally gone.

Here, the construction and maturing of a truly new family with its traditions, rituals and customs starts. Since joint work unites more, a mutual desire to have a child can appear. A newborn is wanted and loved in such a family. The child is a separate value for parents, but not a "tool" for manipulations, which can help in resolving personal problems. (Eidemiller, et. al., 2003)

The fourth stage is the phase of mature marital holon. It is characterized by stability and absence of all the features of the previous stage. After the birth of a baby in the previous phase, which brought so much joy, after a while, the couple has a desire to have another child. Birth of a child at the stage of a mature family is a favorable situation for the formation of harmonious psychological conditions for a child (Eidemiller et al., 2003).

The fifth stage of family development is called "experiment with independence". This period often coincides with a period of midlife crisis of one or both of spouses. By this time the children already grew up and the relationship between spouses have become commonplace, a routine, and has lost its sharpness. Unconscious fear that the remaining half of life will be entirely made up of family and work responsibilities, which seem rather boring, leads to an attempt to make radical changes. The person often tries to go beyond its life scenario by changing job, family, place, and even the country of residence.

The important thing is that, if the family life was smooth before and the spouse was quite attentive to his partner, he/she will promptly realize that something is going wrong with his/her beloved one and helps him/her to cope with the crisis. Otherwise, there is a real risk for breaking up. Trying to prevent this through pregnancy and childbirth, which is sometimes taken by one of the spouses (usually the woman) or (rarely) by mutual consent, is almost never successful.

The sixth stage ("Renaissance") - the final stage of the development of family relationships in which a child can be born. If the crisis was successfully overcome, sometimes the relationship between husband and wife become even closer and more trusting than they were before. In this situation very often spouses have a desire to have another child. Newborns are loved, they are coming into the world pleases everyone, including sisters and brothers (Eidemiller et al., 2003).

The following scientific discourse is devoted to the study of psychological component of gestation dominant. Thus, all the holons, which are listed above were divided into two groups. The first is the so called “negatively influencing group”, which included such phases of family formation as “the stage of confrontations”, “the stage of pre-marital relations” and “the stage of experimenting with independence”. The second group is a “positively influencing group”, which included the following stages of family development: compromises, mature relations, and renaissance. Thus, children who were born at different stages develop under different conditions that affect their personality formation, relationships with parents, siblings and other family members.

The principle of dominant as one of the basic principles of the central nervous system has been formulated in the thirties by A.A Ukhtomskii (1932). Ukhtomskii’s theory is capable to explain some of the fundamental aspects of behavior and mental processes of the man. According to this principle, the dominant focus of excitation (dominant) is formed

under the influence of an excitation caused by external or internal stimuli. This focus of excitement provides activity of the body in a certain direction, and helps to provide an inhibitory effect on the work of other nerve centers. (Batuev, A. S., & Pavlova, L. P., 1986)

The main principle of the dominant is a mechanism of our brain, which chooses just one focus of excitation. At this time all other needs and wishes are not taken into account by the brain. They get reoriented under the dominant submission. In other words, the center of excitation in the brain (the dominant) suppresses all other desires and needs, ignore any resistance. Actually, resistance to the dominant is the way of redistributing power from one need to other ones in the dominant direction.

Dominant principle described in his work "The dominant operating principle as the nerve centers". Under the concept of “dominant” Ukhtomsky and his followers implied a “more or less stable nidus of increased excitability of neural centers, whatever the cause of this excitability is. Incoming signals in such case increase excitability in the nidus, while inhibitory processes prevail in other components of the Central Nervous System”.

A. Ukhtomsky wrote, “The dominant is not a theory and not a hypothesis, but it is a very strong principle, empirical law, like the law of gravity, for example. We use it always and everywhere, so it is impossible to ignore it.” (Ukhtomsky, 1932).

Based on the Ukhtomsky’s principle of dominant I.A Arshavskii suggested the term "gestational dominant" (from the Latin. Gestatio - pregnancy, do-minans - ruling). It mostly reflects the features of the occurrence of physiological and neuro-psychological processes in the body of a pregnant woman (Arshavskii I.A, 1967). Gestation dominant represents complex of psychic self-regulation mechanisms that occur at the period of occurrence of pregnancy. From the moment of pregnancy the increasing flows of impulses deliver in the central nervous system of the future mother. This causes the appearance of increased excitability in the cerebral cortex gestational dominant. (Arshavskii, 1967). These

mechanisms aimed to preserve gestation and create conditions for the development of the unborn child, forming a woman's attitude to her pregnancy, and her behavioral patterns. After studying of anamnesis data, clinical and psychological observations of pregnant women and conversations with them, it has been allocated five types PCGD (psychological component of gestation dominant): optimal, hypogestognozic, euphoric, anxious and depressed (I. Dobryakov in E.Eidemiller “Family Diagnosis and Family Psychotherapy, 2003”).

The “optimal” type PCGD characterizes women, who perceive their pregnancy responsibly, but without undue anxiety. In these cases, as a rule, marital holon is mature, and there are harmonious family relationships, pregnancy is desirable for both of spouses. The woman continues to lead an active lifestyle, but promptly gets registered at the prenatal clinic, following the recommendations of doctors, monitor their health, happy and successfully engaged in pas antenatal preparation courses. Optimal” type contributes to formation of harmonious conditions for a baby (I. Dobryakov, 2001). This stage is also characterized by the rational and adequate attitude of pregnant women to changes occurring with her, to the upcoming challenges, as well as high degree of responsibility as future mother of her child.

Hypogestognozic PCGD type (from the Greek . Hypo - a prefix meaning weak intensity; Lat. Gestatio - pregnancy, Greek . Gnosis - knowledge). This type of PCGD often occurs in women who have not completed their studies or who are passionate about the work. Among them are as young students, and those women who will soon be or already turned thirty. Firstly, they did not want to take an academic leave, they continued to take exams, attended discos, sports, hiking. Often, the pregnancy was unplanned (I. Dobryakov, 2001). This type of PCGD is characterized by underestimating the importance and seriousness of the situation. Women with this type of PCGD not inclined to change their life style. After birth, they develop hypogalactition (reduced function of the mammary glands.).

The second subgroup of women, as a rule, has a profession, passionate about the work, often holding leadership positions. They are planning a pregnancy, because of the fear that getting older heightens risks of complications. On the other hand, these women are not inclined to change their life style, they have “not enough time” to get registered in the antenatal clinic, to attend physicians and to perform their appointment. Women with this type the hypogestognozic PCGD are often skeptical about antenatal preparation courses, and neglect classes. Childcare tends to confide to others (grandparents, babysitters), since mother herself is "very busy." This type of PCGD is common in mothers who were raised in large families. Most often it is accompanied by such types of family education as hypo protection, emotional rejection, and poor parental feelings (I. Dobryakov, 2001).

The next type psychological component of gestation dominant is euphoric (from the greek eu - well ; phero - transfer ). Euphoric type is characterized by a predominance of high spirits, confidence in the successful pregnancy, and misunderstanding of her new role now and in the close future. Pregnancy can be a very desired, however, being convinced that conception has occurred, "careless woman" put on "pink" glasses. If any complications occur during pregnancy, they take her unawares, its severity exaggerated. This PCGD type is observed among women with hysterical personality traits, as well as among those, who had undergone a long-term infertility treatment. Often their pregnancy becomes a means of manipulation, a way to change the relationship with her husband. At the same time excessive love of the unborn child is demonstrated, and the difficulties encountered during ailments are exaggerated. Those women become pretentious; they require special attention (I. Dobryakov, 2001).

Anxious PCGD type characterized by high levels of anxiety during the pregnancy and this affects her somatic state. Gestational dominant suppressed by the dominant of unresolved social problems. Furthermore, “ ... each wave of maternal hormones dramatically displays the

child from his normal state and provokes him to exacerbations susceptibility. He begins to feel that there was something unusual and disturbing, he tries to understand what exactly ...”- Thomas Verny writes in his book “The secret life of the unborn child”. So, being an anxious or worried mother may harm her baby.

In anxious type of PCGD, the reason of increased anxiety, which determines the behavior of women at that period, can be quite explicable. They can be related to family problems, health status (in case of presence of acute or chronic diseases), household difficulties, disharmonious family relationships, poor material or living conditions, etc. But in some cases, a pregnant woman either overestimates the problems or cannot explain what her anxiety is associated with. Often the anxiety accompanied with hypochondria. Most of pregnant women with this type PCGD need a psychotherapeutic help. High level of moral responsibility is the main characteristic of these women, when they just become mothers. There are also the features such as lack of confidence in their own abilities, and abilities to raise a child (I. Dobryakov, 2001).

Depressive type of PCGD assumes maximum severity of anxiety, which can lead to the development of neurotic reactions. A woman, who dreamed about a child some time before, can claim that she now does not want it, and does not believe in her ability to carry and give a healthy birth to a child, and that she is afraid of dying during childbirth. Often she has thoughts of her own ugliness. It leads to dismorphic ideas. Women believe that pregnancy “disfigures them”, and they start to experience a fear of being abandoned by their husband, and often cry. In severe cases overvalued and sometimes delusional hypochondriacal ideas, ideas of self-destruction, found suicidal tendencies appear.

Type of PCGD reflects, above all, personality changing and reactions of women during pregnancy. Determining the type of PCGD can help to understand the situation in

which the child was born and nurtured, to understand how relations were in the family due to his birth.

Disadaptive maternal organism has great importance in the pathogenesis of violations of fetal development (N.L.Garmasheva, N.N Konstantinova, *Pathophysiological basis of protection of human fetal development*, 1985, p. 147-157). Since the emergence of organism in the form of zygote, at the same time appears the mechanism (the principle of the dominant), which provides not only the processes of regulation, but also its integration as a holistic system (I.A.Arshavskii "*Physiological mechanisms and patterns of individual development,"* 1982, p. 270)

In the period from 2008 to 2009 in one of Russia's prenatal center 418 women during pregnancy and after births were surveyed to determine the type of psychological component of gestation dominant. The "Psychological Components of gestation Dominant" test developed by I. Dobryakov was used within the study of N.V Startseva, L.V Yushkova, M.V Shvetsov L. V. Yushkova, N. V. Startseva "*Peculiarities of adaptive reactions and emotional status in women with premature labour."* The following results were obtained:

1) There is a direct correlation between the quality of gestational dominant, pregnancy and its outcomes. Less favorable the PCGD was, at an earlier term of pregnancy the abortion occurred. In cases when women were with an optimal, euphoric and even hypogestognozic type of gestation dominant, in 55-60% of cases the birth occurred at week 36. In case when women was with anxious-depressive type of gestation dominant in 80% of cases the pregnancy interrupted before the 33rd week, and 50% of children born with extremely low birth weight less than 1000 g. (N.V Startseva et al., 2013)

2) Gestation dominant type determines the ability of pregnant women to adapt.

3) The weight of the newborn, frequency and term of premature termination of pregnancy directly depends on the gestation dominant type.

4) There are marked differences in the adaptive reactions of infants according to mode of delivery. Indicators significantly better in spontaneous preterm labor compared with induced births.

5) Observing pregnant women in prenatal clinics, women with anxious-depressive type of gestational dominant (PCGD) require most attention. These pregnant women need for a special prenatal preparation and providing them psychotherapeutic help. They are 3-4 times more likely to occur in premature termination of pregnancy in early dates: from 25 to 32 weeks; in 80% of cases premature rupture of membranes.

6) Children prematurely born by mothers with anxiety-depressive type of gestational dominant have a significantly lower (200gramm) body weight. These children are prone to hypoxia, and are not adapted for survival. Early mortality in this group is 2-3 times higher.

Within this research it was found that pregnancy period and its outcome depends on the type of gestational dominant, which forms during pregnancy. Temporary inhibition of gestational dominant in the earliest stages of pregnancy may occur due to the necessity of adaptive adjustment mother to unfavorable environmental conditions. The least favorable (pathological) type of gestational dominant (GD), according to the research of N.V Startseva, L.V Yushkova, and M.V Shvetsov, is anxious-depressive GD. (N.V Startseva et al., 2013)

Another research study concerning the issue of gestation dominant was conducted by Robavlyuk Lubov in 2012, which was devoted to the "Valued orientation of pregnant woman dependence on type of psychological component of gestation dominant." 154 pregnant women in different trimesters of pregnancy attended in this research. Analyzing the results of the study revealed significant differences in the valued orientations in pregnant women with different types of PCGD. Valued orientation on a "happy family life" was significantly lower in women from "risk group" with euphoric and hypogestagnozic type PCGD than in women

with predominantly optimal type PCGD. Even more important significant differences of this valued orientation were identified between the first group of women with optimal type of PCGD and the third group, which included women with major depressive and anxious types PCGD, combined with hypogestognozic type. Thus, women who are focused on family, implemented in the family tend to have an optimal type of gestational dominant; they are in psychological comfort and less conflict with her pregnancy.

According to the author of the research, valued orientation on "health, both physical and psychological" significantly lower in the group of women with mainly optimal type PCGD than women from "risk group", which was not found between the first and third group, between the second and third groups of the sample. Valued orientation is "to independence, as a way to act on their own" in women from "risk group" and a third group (women with anxious-depressive type PCGD) higher than in women with predominantly optimal type PCGD (Robavlyuk, L.N., 2012).

The conducted theoretical analysis of the literature study has allowed the author to build a system of possible factors affecting the establishment and development of relations between siblings. These factors: stage of development and spousal holon gestation dominant.

It is important to note that besides the tendency towards independence, women in the third group demonstrated greater significance valued orientation to "materially prosperous life", than women with optimal type PKGD. Most likely, anxiety and depression in women of the third group is the result of presence of financial difficulties. Probably, this valued orientation is relevant and unsatisfied, and therefore more important for this group of pregnant women (Robavlyuk, L.N., 2012).

Women from the “risk group” significantly more focused on "self-confidence", which implies the inner harmony, freedom from internal contradictions, and doubts (Robavlyuk, L.N., 2012).

According to the results of empirical research devoted to the topic “Valued orientation of pregnant woman dependence on type of psychological component of gestation dominant”, the authors made the following conclusions: 1) Valuable orientations of pregnant women significantly differ depending on the PCGD type. 2) In a sample of women, predominantly optimal type of PCGD identified in 14.28 % of cases. 3) “Risk Group” basing upon PCGD type, was detected in 63.64 % of the respondents. 4) The more optimal type of PCGD, the less important the valued orientation of “materially prosperous life” and more important “happy family life." 5) Women at “risk group” and the third group are more valued as independence, decisiveness, and self-confident than women in the first group (Robavlyuk, L.N., 2012).

The present study investigates the association between Gestation Dominant, Stage of the Spouse Holon in which the child was born and development of sibling rivalry. The goal of this research was to establish the relationship between the Stage of the Spouse Holon, in which the child was born and its influence on the development of sibling rivalry.

The problem of sibling relationships seems relevant to the author for several reasons. First, it is traditional for Kyrgyz families to have more than one child. Thus, as the number of members of the family increases, the relationship between its members, including children, changes. Second, the anomalies of social interaction between siblings, including intentional infliction of physical harm to youngest child by the older children, are becoming a common case in many societies.

The establishing of relationship will allow family psychologists, family doctors, gynecologists and to families themselves planning the birth of children minimizing the risk of onset of sibling rivalry, and most importantly it will help to prepare corrective techniques to relationships normalization between children in a family.

The present study focused on the study of spousal holon (stages of family development process), where the birth of an older daughter was expected. This factor (spouse holon) was measured by using a self-made questionnaire (developed by the author), semi formal interview for both parents and PCGD (psychological component of gestation dominate) test for a woman (wife).

Spouse holon has two levels: negatively influence holons, and positively influencing holons. Sibling rivalry between daughters were assessed based on the information that parents provided the researcher with while filling the questionnaires in, and based upon the projective paintings of the family members (mother, father and an older daughter). This variable contains 2 levels: the first level is absence of any sign of sibling rivalry. The second level is presence of sibling rivalry, but this rivalry tendency is not over exaggerated.

With increased family dynamic more needs to be known about relationships among siblings. Nowadays, the situation where some degree of emotional disturbance that usually follows the birth of an immediately younger sibling develops into something more serious occurs more often, for example into abnormalities of social interaction and intentional infliction of physical harm.

As to the knowledge of the researcher no studies have been conducted to date in Kyrgyzstan that would investigate the relationship between the Stages of the Spouse Holon, its influence the development of sibling rivalry in children. Given that a lack of information about factors that might predispose sibling rivalry reduces the chances of minimizing the risk of onset of sibling rivalry in children while planning the family. And moreover, it limits health professionals in understanding, explaining and finding the core of a problem in the relationships between two siblings.

Mixed methodology was used within this research: qualitative and quantitative. The present study was focused on Spouse holon while expecting an older daughter. It was

measured with the help of self-made questioners and semi-formal interviews for both parents and PCGD (Psychological Components of Gestation Dominant) test for the wife.

Basing upon the listed literature review, it is hypothesized that there is a relationship between the Spouse Holon and the development of sibling rivalry. In addition, it is expected that children conceived during the positively influencing holons will be less likely to develop sibling rivalry than those conceived during the negative holons.

There are many studies and research which prove that «human life scenario largely determines by the motives and the conditions of his conceiving, especially pregnancy, childbirth, how and under what conditions the child developed in the early stages of ontogenesis» (Eidemiller, Dobryakov & Nikolskaya, 2003). Symbiotic relationship between mother and baby during the pregnancy forms strong interconnection; everything that mother experiences influences the baby. Thus, the baby affected by mother's feelings, mood and any other psychological or physiological changing. Proceeding from this information it is also hypothesizes that there is a relationship between gestation dominant, conditions during pregnancy and sibling rivalry. Namely, that participants born by mothers with adaptive gestation dominant are less likely to develop sibling rivalry. It has also been hypothesized that participants born by mothers in conditions favorable to pregnancy, are less likely to develop sibling rivalry than those who were born in unfavorable conditions.

## Method

### *Participants*

The participants were ten ethnically Kyrgyz families where both parents raised at least two daughters, with the elder one not older than ten years old. Overall, ten families participated in the research. 20 parents and 10 daughters were examined. This study used a purposive sampling technique by which participants were selected. All participated families

were selected in different districts of Bishkek. The mean age of wives was 34.5. The mean age of husbands was 37.6. The mean age of the older sister was 8.4. The time was spent for all the procedure was about 1 hour.

***Materials***

This study was based upon mixed methodology which comprises self-made questionnaire (Appendix B), projective testing, Psychological Component of Gestation Dominant (PCGD) testing (Appendix C) and interviewing (Appendix D).

For measuring sibling rivalry between daughters, the self-made questionnaire (Appendix B) for parents was used. Establishment of scales and making a list of questions was based upon the criteria for sibling rivalry disorder which described in DSM-IV (code V61.8). In DSM-V, under this code is Sibling Relational Problem.

According to $4^{th}$ Diagnostic and Statistical Manual of Mental Disorders Sibling Rivalry Disorder may occur in families where there is conflict between brothers and sisters which is so severe that it leads to marital problems, creates a real danger of physical harm to one or more family members, is damaging to the self-esteem or psychological well-being of one or more family members and requires the intervention of psychologist, psychiatrist, or other mental health professional. The main symptoms of this disorder are:

- Some degree of emotional disturbance usually following the birth of an immediately younger sibling is shown by a majority of young children.
- A sibling rivalry disorder should be diagnosed only if the degree or persistence of the disturbance is both statistically unusual and associated with abnormalities of social interaction.
- Sibling jealousy.
- Is not related to another psychiatric disorder, such as depression or drug abuse.

The most common symptom of sibling rivalry according to DSM-IV TR is frequent or continuous demands for attention: the older child may want to be held and carried about, especially when the parent is involved with the newborn sibling. Other symptoms may also include; acting like a baby again (regressive behavior), thumb sucking, wetting, or soiling. Aggressive behavior, may take the form of handling the newborn.

The Cronbach's alpha (Table 13) of self-made questionnaire with N=45 is equal to 0.9, which shows a high internal consistency of the test.

The self-made questionnaire consisted of forty five questions, which were combined into the following 4 scales: jealousy and rivalry, tendency to infant behavior (regressive behavior), protest, and anxiety. All the statements were oriented on children's relationships. It is important to note that this test is only valid when the respondent (parent) spends a lot of time with the child. Usually it is the mother.

For answering the rating the Likert scale was used, from 0 to 5, where 0-absolutely disagree, 1-disagree, 2- rather disagree, 3-rather agree, 4-agree, 5-absolutely agree.

In association with similar – structured inventories (Zung Depression Scale, Taylor Anxiety Scale, etc.) in order to make a conclusion about presence or absence of sibling rivalry the following meanings were suggested: 0-10 – no signs of sibling rivalry; 11-45 – a few signs of sibling rivalry, 46-60 – mild sibling rivalry; 61-100 moderate sibling rivalry, 101 and above – severe sibling rivalry.

Other tool which was used within current study is projective drawing (Appendix E). The use family drawings as assessment instrument has been described and advocated by a number of writers (DiLeo, 1970; Hammer, 1958; Koppitz, 1968), and several early empirical studies of the family drawing technique exist in the literature (Lorand, 1957; Martin, 1955; Reznikoff & Reznikoff, 1956).

Our contemporary, Zoltan Vass in his work “A psychological interpretation of drawings and paintings/ The SSCA Methods: A Systems Analysis Approach” says that phrase “projective drawing” indicates that, within the limits set by the instruction, the picture is prepared freely, without direct influences by the examiner. The examiner does not interfere with the picture, does not help to in painting even if subject asks to help in painting some details, or even give the cue in what way to portray this or that element (Z. Vass, 2012). Vass also provided another, more scientific definition of “projective drawings”. In general sense, a projective drawing (painting, scribble etc.) is an externalization (Sehringer, 1983, 1999; Vass, 1999, 2003) of a cognitive-emotional structure.

However, a major change in approach was taken in 1970 when Burns and Kaufman introduced action instructions to the task of drawing a family. Rather than ask the child to “draw a family” or to “draw your family”, as others (Hulse, 1951, 1952; Reznikoff & Reznikoff, 1956) has done, Burns asked children to “draw your family doing something”; he specifically asked to child to draw “some kind of action.” This change in the instructions led to surprising results, namely, revealing clearer data concerning family dynamics, as well as clearer picture of interpersonal interactions and emotional relationships among family members.

Test “Kinetic family drawing” test of R.S. Burns and S.X. Kaufman gives information about the child's subjective perception of family situation. It helps to identify the relationships in the family, which causes anxiety. It also shows how the child perceives other members of the family and his place among them. According to Burns, it is very important to pay attention to who painted the picture and what each family member does in the picture. Not always children draw the whole family. Usually they do not draw the one, with whom he or she is in a conflict. Location of family members in the picture often tells about their relationships. For example, an important indicator of psychological proximity is a distance

between the individual and family member. Sometimes children draw some additional objects between family members, which are like a barrier between them. So, quite often you can see father, hidden behind a newspaper, or near a TV, which segregate him from the rest of the family. Mother is often portrayed near the plate. Presence of mutual activity when all family members are involved usually is an evidence of good and favorable family relations. Sometimes, family members are divided into groups. This may indicate the internal grouping in the family. Drawing the family, some children paint all the figures in a very small size and locate them on the bottom of the sheet. This may indicate the presence of depression in a child, as well as feeling of inferiority in the family situation. Sometimes, not people, but subjects dominate in the painting. It also reflects emotional concern about family situation, it worries the child, and he or she postpones drawing the members of the family and draws subject, which do not have such strong emotional importance.

One more tool which was used in the study is the PCGD test (psychological component of gestational dominant), which was developed by Igor Dobryakov (Appendix C). This test helped the researcher to identify the features of the occurrence of physiological and neuropsychological processes of pregnant women. This test was standardized in Kyrgyzstan by Kanikey Latipova in 2009 within the study of anxiety and depression in expecting women. A study revealed that PCGD test as a whole and the separate components of its scales have sufficient internal consistency. Constructive validation method (contrast groups method and divergent and convergent validation) demonstrated high quality of the diagnostic tool, high criterion validity. Repeated measurements showed sufficient reliability of the test. The data consisted of rural and urban Kyrgyz women N=82, whose mean age was 22.66.

The PCGD test is a 4-page A4 format booklet which consists 3 blocks of statements which reflected the following: the attitude of a pregnant woman toward herself, the attitude of a pregnant woman toward the forming system of “mother-baby”, and the attitude of a

pregnant woman toward the attitude of others to her pregnancy. Each of the blocks included 3 subgroups with 5 statements, where the woman should have chosen the one, which was most expressed of her state during the pregnancy. Block A, the first subgroup consisted of 5 statements which were focusing on the attitude of a pregnant woman toward her pregnancy. The questions of a second subgroup were about the attitude of the pregnant woman toward the life style during the pregnancy. The questions of the third subgroup were about the attitude of a pregnant woman to the upcoming birth.

The next block is B. It is one page with 3 subgroups, with 5 statements in each of them. Statements in the first block were directed to identification of the attitude of a pregnant woman to herself being pregnant. The next subgroup was focused on the attitude of a pregnant woman to her baby. The last subgroup consisted of the questions oriented to the attitude of a pregnant woman to breast-feeding.

The last block of PCGD test consisted of the following subgroups: the attitude of a husband towards her being pregnant, the attitude of the relatives to her being pregnant, the attitude of foreigners towards her being pregnant. It is 1 page block, with 3 subgroups included 5 statements in each of them.

The final method that was used in this research to collect data about the spouse holon, in which the couple was while expecting the older daughter was a semi-formal interview (Appendix D) with each of the spouses. The interview consisted of 11 open questions directed to the relationships between the spouses at the time of expecting for the older daughter. Not only were the answers recorded, but also, the pauses which were made by the participant while replying.

***Design***

The design of the study was mixed and included qualitative and quantitative technologies. The present study was focused on Spouse honon (stages of family development) in which the couple was while expecting an older daughter. The identification of it was made with the help of the self-made questioners and semi-formal interviews for both of parents and psychological components of gestation dominant test for the wife.

The presence of sibling rivalry was assessed basing on the information that parents provided the researcher with while filling the questionnaires in, and basing upon the projective paintings of the family members (mother, father and an older daughter).

The first variable, which is spouse holon has 2 levels: negatively influence holons, and positively influencing holons. The second variable is sibling rivalry, which contains 4 levels. The first level is absence of any sign of sibling rivalry. The second level is presence of sibling rivalry, but this rivalry tendency is not over exaggerated.

***Procedure***

All participants were volunteers and were informed that all data obtained in the test were strictly confidential and could only be used within research, and that further, the answers were going to be analyzed only in conjunction with the answers of other respondents. The researcher also informed the participants about the opportunity to interrupt/stop the procedure at any time. Before working with children the permission from parents was granted in written form (Appedix A).

The tests, which were provided by the researcher, were directed to each of the participants. The questionnaires, surveys and other data were coded in order to prevent any possible future loss of confidentiality and the subjectivity of a researcher while analyzing the results. The names of participants were deleted from the forms and were written down in the excel program, in order to have a possibility to use contact information if it necessary.

The wife/mother was taking the following tests: the PCGD (psychological component of gestation dominant), the sibling rivalry questioner, projective test, and an interview. The husband was given the sibling rivalry questioner, projective test and an interview. The oldest daughter was asked to draw the family (projective test). Older daughters were tested by means of projective tests only.

PCGD test consisted of several blocks. The task of this test was to choose in each of the blocks the statement in accordance with woman's state during the pregnancy. After that, all the answers were transferred into the special table, which showed the type of psychological components of gestation dominant of the woman.

When sibling rivalry questioner was given to spouses, and they were asked to assess the statements using 5-point Likert scale from 0 (strongly disagree) to 5 (strongly agree). All the statements were devoted to the behavior of their children (two girls).

For projective test, family members were provided with a pencil and A4 forma paper (one per person) and were asked to draw their family. Use of colored pencils was not offered, but if respondents expressed such desire they were not restricted by the examiner.

While taking an interview, not only the answers were recorded, but also the pauses which were made while answering. The procedure was held in separate room, where no one else (except the researcher and the respondent) was there. Then the researcher started asking question in Russian. Overall there were 11 questions. But, if during the interview the additional information was needed, or the respondent provided poor answers, the researcher asked additional question, which helped to understand the respondent's answers deeply.

The process was held at the same time, and all the family members who were taking part in the study were sitting in the different rooms. All the procedure took about one hour.

## Results and Discussion

The results of the current study revealed that there is no association between stage of spouse holon and development of sibling rivalry in children. But it is important to notice that this research requires a larger sample size to make any definitive conclusions regarding this hypothesis. However, this hypothesis can be supported when the sample will be much larger. This issue is to be revised in the future research.

Regarding the first sub hypothesis, there was not found any significant differences between sibling rivalry in daughters who were born during positive and negative holon stages as it was expected. But there is a difference of means. Means of sibling rivalry in positive spouse holon= 56, 42 and in negative spouse holon=60, 50 (Table 1). A small difference is seen, but this result is insignificant (Sig. >0.05) (Table 7).

Comparing means of anxiety in positive and negative spouse holons, the following results were obtained: mean of anxiety score in case where parent were in positive spouse holon while expecting a child =17,37 , and in case of negative holon mean score is equal to 14, 83. Even there was found a difference between means, the results were not significant (p>0.05) (Table 2).

The author can assume that first hypothesis was not supported due to several reasons: the first reason is due to the fact, that stage of spouse holon was identified based on the interview, and moreover, majority of spouses already do not remember details concerning their past relationships during the pregnancy period, which took place several years ago. Another presumed cause is that the study was rather retrospective, than longitudinal: in order to obtain more precise information concerning spouse holon the in-depth interview had to be conducted, however it would require more time, which is a strong limitation for a senior student.

Despite that first hypothesis was not supported by quantitative methods some support was found through projective techniques. Analyzing the painting of an older daughter (Figure 1, F1) the following conclusion was made: we can see hidden hands in the draw of the older daughter. According to R. Berns, it tells about lack of contact with all family members, including her younger sister. Also, a broad distance among all family members is seen in the draw of an older daughter. Stage of family formation process during pregnancy was determined as confrontation. The family is composed of 6 members: 4 children, the father of 43 years and a mother of 40 years. According to father, elder daughter pregnancy was planned, however according to mother this child was sudden. Conditions of conceiving the child were described by mother as unfavorable. Sibling rivalry score evaluated by mother in this family = 77. Sibling rivalry score evaluated by father = 42. The mean of both scores = 59. According to the author's scale, such result indicates mild sibling rivalry.

Mother from this family (F1) describes her drawing (Figure 1) in the following way:
*"We woke up early in the morning. Girls went to school and I stood with my son at home.*
*In the picture we are all at home. I'm cooking a dinner, children are playing, and my husband is at work.*
*When Daddy comes, we have a dinner. And then the night comes, we will go to sleep."*

The elder daughter tells about her drawing (Figure 2) the following:
*"Before we were on the way for a long time and really wanted to eat. We are now at the Issyk Kul, relaxing in the summer. After that we go home, and then to grandmother, we will have a rest there."*
Younger daughter from this family describes her drawing (Figure 3) in the following way:
*"It is our house. Before I was sleeping. Now I am awake and playing with my little brother. Dad will come soon and he himself will play with my brother."*

Father from this family denied drawing.

The family member of family number 6 described their drawings in the following way:

Mother (F6) (Figure 16): *"Before this we were preparing, dressed nicely, made nice hairstyle and we were planning to visit our grandmother in the village. Now we are all as a family visiting grandmother. We eat delicious food, talk…"*

*After we will go home, clean the house, cook and other housework."*

Father (F6) (Figure 17)*: "I have a big family and I'm surrounded by girls. I have a son as well. Before we were all going to make a family photo. In the picture is a photograph of us. After that we will go for a walk."*

Older daughter (F6): *"I'm the eldest in the family and the most beautiful. (laughing) Also, I have two sisters…Oh, and a brother. But he did not fit in the picture. My youngest sister also did not fit partially"*

*"In my drawing we are waiting for guests. Now I meet guests. And afterwards, we are going to celebrate my dad's birthday."*

Second hypothesis and first sub hypothesis were not supported, which means that there was not found any relationship or correlation between Gestation dominant and signs of sibling rivalry. The researcher can assume that this hypothesis was not supported because again, a self-made questionnaire was used in order to identify sibling rivalry, which for the first time was applied. The assessment of the situation between daughters was very broad. In some cases their assessment was very contradictory. The author tends to suppose that the reason for that could be defense mechanism of parents. Therefore, it requires the researcher

himself to spent time with the kids and the whole family to get reliable data on family relations.

Second sub-hypothesis of the second hypothesis was supported. Sibling rivalry scores in families with favorable and unfavorable conditions of conceiving are the following: sibling rivalry means score in families with favorable conditions = 42, 45. Sibling rivalry mean score in families with unfavorable conditions = 67.00 (Table 3). This result is significant (Sig. = 0, 00) (Table 10).

Mean scores of the scale “tendency to a childish behavior” in families with favorable conditions of conceiving = 6, 71, and the same scale’s mean score in unfavorable conditions of conceiving = 16, 53 (Table 4). Significance level of this result is equal to 0,00 (Table 11).

Mean scores of the scale “opposition toward parents” in families with favorable of conceiving is equal to 5, and mean scores of the same scale in unfavorable conditions of conceiving = 9, 38 (Table 5). A significance level of this result is equal to 0,05 (Table 12).

The mean score of anxiety in children from families with favorable conditions of conceiving = 9, 42, and anxiety in children from families with unfavorable conditions of conceiving = 19, 30 (Table 6). A significance level of this result is equal to 0,00 (Table 9).

Based on the conducted research the following main conclusions were made by the researcher: 1) No signs of sibling rivalry (0-10) was indicated in 0 families. 2) A few signs of sibling rivalry (11-45) were found in 3 out of 10 families (F4; F8; F9). 3) Mild sibling rivalry (46-60) was explored in 3 out of 10 families (F1; F2; F7). 4) Moderate sibling rivalry (61-100) was identified in 4 out of 10 families (F3; F5; F6; F10). 5) Severe sibling rivalry (101 and above) was not revealed in any family.

## Additional findings

Based on the received results, it is found that 9 out of 10 men who participated in the research demonstrated the tendency to "ignore" the first pregnancy of the woman. The following answers were given to the questions regarding the period of expecting the older daughter:

Husband from family number 1 says*:*

*"What a stupid questions! I hardly remember the period while expecting Milana" (Milana is the older daughter).*

Husband from family number 2 says:

*"Ohh…I do not remember that time… I know that until now did not even know that she experienced toxicosis"*

*F4 "What a strange questions! Honestly I do not remember very well that time"*

*F5 "I do not remember such things….it was 5 years ago…"*

*F6 "to be honest, I do not know how to answer your question…it is already difficult to remember"*

*F7 "Ooohh…..i hardly remember how it was…."*

*F8 "I do not remember much from that time…"*

*F9 "Are you kidding? I do not remember already that time…give me some time to think …"*

*F10 "do you have easier questions?? From the period that I will be able to memorize…" (laughing)*

Basing upon the received information, namely the fact that 9 out of 10 men did not remember the first pregnancy of their wives, the researcher tends to explain this phenomenon by means of pure defense mechanism called repression.

Basing upon this information the next conclusion can be made: the first pregnancy is very stressful life event for men, and they had a hard time adjusting to this change, and it has serious consequences.

Next, is that in the situation of pregnancy these man demonstrated clear defensive behavior. It can be explained by means of defense mechanism called repression. This finding can indicate the presence of adjustment disorder in those men.

Based on the conducted research the following main conclusions were made by the researcher: 1) No signs of sibling rivalry (0-10) was indicated in 0 families. 2) A few signs of sibling rivalry, (11-45) were found in 3 out of 10 families (F4; F8; F9). 3) Mild sibling rivalry (46-60) was explored in 3 out of 10 families (F1; F2; F7). 4) Moderate sibling rivalry (61-100) was identified in 4 out of 10 families (F3; F5; F6; F10). 5) Severe sibling rivalry (101 and above) was not revealed in any family.

Another finding that was discovered within this research is that if parents were in a positive stage of family formation process (positive holon), there is a slight difference in the scores of the questionnaire which is focused on child's behavior. And in those cases, where parents were in a negative stage, this difference is very big. This means that the contact between children and parents is much better if parents were in a positive stage of family formation while expecting their child.

6 out of 10 families demonstrated a big difference (from 50 and above) of mother's and father's perception of the situation of their child's behavior. The mean of this difference is equal to 42, 2. This can be explained: 1) by the fact that usually one of the parents spends more time with children, and it is logically that this parent knows more about the

relationships between children. Therefore, the other one, who spend much less time with children, is tends to underestimate the situation. 2) There are families where fathers indicate the presence of rivalry behavior between children, but mother of these children did not. Again, this can be explained by means of psychological defense mechanisms, namely denial and rationalization. As an example, the family number 2 was taken. Here, the score of sibling rivalry scale according to mother is equal to 21, but father's scores indicate the presence of rivalry behavior much clearer, namely 74, which is 3.5 times more than mothers'.

Based on the conducted research the following main conclusion was made: Neither gestational dominant nor spouse holon did not show any association with onset of sibling rivalry between daughters.

Initially, the interview was used as an additional tool to help determine the stage of family formation (holon), but the obtained results showed that respondents gave answers related more to the conditions in which they were during pregnancy. Summing up all the obtained information, for the convenience of statistical analysis, the concept of conceiving was divided into 3 factors: psychological, physiological, and social. Psychological factor implies emotional distress, negative thoughts or fears that occurred during pregnancy. By physiological factor means the assessment (by pregnant woman) of physiological changes during pregnancy; physiological discomfort or presence of diseases that accompany pregnancy. Social factor implies discomfort coming from the outside, influence of close environment, or strangers, stress associated with the interaction with others.

The current result showed that the only factor which was found within this research associated with the onset of rivalry between children is conditions, under which the pregnancy proceeded. The following results regarding the quality of conditions were obtained: F1, F2, F3, F5, F6, F7, 10 described their psychological, physiological or social conditions during the time of expecting older daughters as negative.

F1. "*We were living together with his (husband's) parents and we often quarreled". Also, she mentioned about pressure from her husband and eldest son. "My Husband and eldest son insisted to birth a girl. They wanted a daughter / sister."* – This information identifies presence of psychological and social distress at the period of expecting of an older daughter. According to this, the researcher determines conditions of conceiving as negative.

F2. *"I did not have any diseases… I was feeling nauseated but did not vomit." "Wanted to go back studying, but the status of married women did not allowed"* – Mother form family number two describes her physiological state and social factors during pregnancy, as stressful ones.

F3. Mother from the third family mentions the social distress occurred during the pregnancy period. She said: *"We were living and studying abroad, and did not plan to give a birth in a foreign country*".

F5. *"I was not ready for having a baby so early."* Also, she mentioned *"A few months after marriage I started working in the place I liked a lot. But after a week I discovered that I was pregnant. And I should have left my job. Relative insisted on that."* – Respondent from family number 5 pointed out the existed psychological and social distress occurred during the pregnancy.

F6. In the case of family number 5 the psychological distress was described by mother in the following way: *"Throughout the pregnancy I was afraid that I will not be able to give birth, or some difficulties as it happened to my acquaintance." "Also I missed my husband. He is a doctor, was often on duty."*

F7. *"At that time we were living with his (husband's) parents. I was a younger daughter-in-law in the family, so I was responsible for all household duties."*

*"There were frequent quarrels with husband's sister, who tried to teach me how to live."* – According to the interview of mother from family number 7, it is seen that she experienced strong social distress.

F10. *"Oh I suffered this pregnancy. I had toxicosis for several months. And I had lack of iron in the organism. It was just a horror"* – in this case, woman describes her physiological state as a stressful. Basing upon this information conditions were identified as unfavorable.

There are three families out of ten who characterized their condition as positive and favorable. They are family number 4, 8, and 9.

F4. *"I wanted to self-actualize myself as a mother ... And I was excited to expect a baby." "We were constantly supported by our parents and relatives during my pregnancy period."* – It is seen from the interview that mother describes her psychological state and social situation during pregnancy as positive.

F8. *"At that time we already had our son, so was not afraid to give a birth. And we decided to have one more child." I often felt dizziness, but overall I felt good throughout all pregnancy period."*- Participated woman from family number eight described the condition under which the child was developed as favorable.

F9. Mother from family number 9 mentions: *"At the period of my pregnancy my husband was always beside me, protecting, supporting me and even indulging". "My physiological state was normal. Neither toxicosis nor threats appeared. I was active till the last."* – Participant from ninth family described both social and physiological state as positive.

There are several limitations in this study. The study was primarily limited by ethnical criteria for participants. Selection of ethnically Kyrgyz families limited the sample, that affected on data collection and led to difficulty to access relevant data.  In most cases fathers

refused to participate, but sometimes both of parents rejected. Often family structure is closed system with impermeable boundaries, so family system is not easy available for research. In our case, difficulties occur with fathers, most of them refused to participate, in spite of the mother's consent. Research could be more effective if the questionnaires and other research methods were translated into the Kyrgyz language (native language of participants). This would provide an opportunity to respond on their native language and reduce misunderstandings and stress factors. The same with the fact that boys (sons) did not participate in the study due to their special status in the ethnical group (Kyrgyz families) so the participated children were female (daughters) only. Moreover, the presence more than two children who were close in age range. Scattered age gap between girls is large. The study took place in urban areas only and was not applied to the whole ethnic group. Also it should be noted that the problem of sibling relationships is very few researched. Subject is not enough developed in both the theoretical and practical frameworks.

Another very important limitation of this study is that Psychological Component of Gestation Dominant was identified a few years after that. In some cases, between the pregnancy period and the time when mother was interviewed 10 years passed. In this case, women tend to give answers which do not reflect the period of pregnancy, since during these years the situation was reassessed.

For future research the following recommendations are suggested: to take into consideration both daughters and sons in order to get a clear picture of sibling rivalry problem not only among girls; to expand ethnical background, not focusing on the one ethnical group only; to involve participants from both urban and rural areas, to take into consideration presence of other children in families, to take into account age difference between girls, to avoid the gap of the age, to provide all the materials in the native language of the participants, to avoid the age gap among participated parents. Aside the listed

limitations, it is important to note that self-made questionnaire which was developed in the course of research should be yet validated, moreover it was the first time it was used. And if the score of sibling rivalry will be 101 and higher, there is a risk of sibling disorder formation. In such case it is recommended to examine the situation in more detail and it might be suggested to meet a specialist. Eliminating all of the listed limitations will help to provide the researcher with more accurate and best results.

## Conclusion

A study involving 10 Kyrgyz families with two daughters, had not found any relationship between retrospectively evaluated stage of spousal holon and sibling jealousy. The relationship between psychological component of gestation dominant and sibling rivalry was also not identified. As previously stated, this work was based on the mothers' recollections of memories on PCGD, the stage of spousal holon was determined based on the results of semiformal interviews – a tool, which is also vulnerable to data distortion.

The correlations between women's memories of conditions under which the pregnancy flowed (emotional climate, well-being, and family's financial situation) and severity of sibling rivalry of the older girls can be found as the most significant finding of the study. We believe that these memories (conditions in which pregnancy progressed) tie together psychological component of gestation dominant and development of stage of spouse holon. If conception was planned, parents happily expected the birth of a child, grandparents treated well the pregnant daughter in law/daughter, then memories of how pregnancy proceeded are joyful for women.

This work not only confirmed the typical memory distortions, but also determined the undesirability of using quantitative research methods in retrospective study of identified variables such as spouse holon and gestation dominant. Questionnaire designed to assess the

sibling rivalry between children can be used as a screening tool, indicating the possible existence of a problem.

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Table 1

*Mean Scores and Standard Deviations of Sibling Rivalry in children born during positive and negative spouse holons.*

| | Spouse holon |
| --- | --- |

Sibling Rivalry

| | Positive holon | Negative holon |
|---|---|---|
| All families | | |
| M | 56,42 | 60,50 |
| SD | 23,701 | 2.223 |

Table 2

*Mean Scores and Standard Deviations of the anxiety scores in children born in positive and negative spouse holons.*

| | Spouse holon | |
|---|---|---|
| Anxiety | | |
| | Positive holon | Negative holon |
| All families | | |
| M | 14,83 | 17,35 |
| SD | 7,94 | 5,57 |

Table 3

*Mean Scores and Standard Deviations of Sibling rivalry in families with favorable and unfavorable conditions of conception.*

| | Conditions | |
|---|---|---|
| Sibling Rivalry | | |
| | Favorable | Unfavorable |
| All families | | |
| M | 42,45 | 67,00 |
| SD | 14,41 | 20,97 |

Table 4

*Mean Scores and Standard Deviations of "tendency to a childish behavior" scale in families with favorable and unfavorable conditions of conception.*

| | Conditions | |
|---|---|---|
| Tendency to a childish behavior | | |
| | Favorable | Unfavorable |
| All families | | |
| M | 6,71 | 16,53 |
| SD | 5,93 | 8,67 |

Table 5

*Mean Scores and Standard Deviations of "opposition toward parents" scale in families with favorable and unfavorable conditions of conception.*

| | Conditions | |
|---|---|---|
| Opposition toward parents | | |
| | Favorable | Unfavorable |
| All families | | |
| M | 5,00 | 9,38 |
| SD | 4,28 | 5,04 |

Table 6

*Mean Scores and Standard Deviations of "anxiety" scale in families with favorable and unfavorable conditions of conception.*

| | Conditions | |
|---|---|---|
| Anxiety | | |
| | Favorable | Unfavorable |
| All families | | |
| M | 9,42 | 19,30 |
| SD | 5,38 | 5,20 |

Table 7

*T-test on Sibling Rivalry in children born during positive and negative spouse holons.*

| | Spouse Holons | | | |
|---|---|---|---|---|
| | Positive holon | Negative holon | *t* | *df* |
| Scale | | | | |
| Sibling rivalry | 26,07 | 23,70 | -,355 | 18 |

Table 8

*T-test on anxiety in children born during positive and negative spouse holons.*

| | Spouse holons | | | |
|---|---|---|---|---|
| Scale | Positive | Negative | *t* | *df* |
| Anxiety | 7,94 | 5,57 | -,783 | 18 |

Table 9

*T-test on anxiety in families with favorable and unfavorable conditions of conception.*

| | Condition | | | |
|---|---|---|---|---|
| Scale | Favorable | Unfavorable | *t* | *df* |
| Anxiety | 9,42 | 19,30 | -4,004* | 18 |

*Note*. * = $p < .05$. Standard Deviations appear in parentheses below means.

Table 10

*T-test on Sibling rivalry in families with favorable and unfavorable conditions of conception.*

| | Conditions | | | |
|---|---|---|---|---|
| | Favorable | Unfavorable | *t* | *Df* |
| Scale | | | | |
| Sibling rivalry | 14,41 | 20,97 | -3.42* | 18 |

*Note*. * = $p < .05$. Standard Deviations appear in parentheses below means.

Table 11

*T-test on tendency to a childish behavior in families with favorable and unfavorable conditions of conception.*

| Scale | Conditions | | | |
|---|---|---|---|---|
| | Favorable | Unfavorable | *t* | *Df* |
| Tendency to a childish behavior | 5,93 | 8,67 | -2.66* | 18 |

*Note*. * = $p < .05$. Standard Deviations appear in parentheses below means.

Table 12

*T-test on tendency to opposition toward parents in families with favorable and unfavorable conditions of conception.*

| | Conditions | | | |
|---|---|---|---|---|
| | Favorable | Unfavorable | *t* | *df* |
| Scale | | | | |
| Opposition toward parents | 4,28 | 5,04 | -1.94* | 18 |

*Note*. * = $p < .05$. Standard Deviations appear in parentheses below means.

Table 13

*Reliability statistics for self-made questionnaire*

*Reliability Statistics*

| Cronbach's Alpha | N of Items |
|---|---|
| ,908 | 45 |

Appendix A

Код участника:____________

**Информированное согласие**
на участие в исследовании

Выпускница кафедры психологии Американского Университета в Центральной Азии государственного университета приглашает Вас принять участие в психологическом исследовании, целью которого является изучение взаимодействий детей (девочек) в семье.

Прежде чем Вы примите решение об участии в этом исследовании, мы бы хотели ознакомить Вас с условиями проведения данного исследования.

**Условия участия в исследовании.**

В данном исследовании принимаю участия следующие члены семьи: отец, мать и две дочери.

**Добровольность участия.**

1. Ваше участие в исследовании исключительно добровольно.
2. Вы можете принять решение **не** участвовать в исследовании сейчас или отказаться продолжать участвовать на любом этапе без каких-либо негативных последствий.

**Конфиденциальность.**

Ваше имя, фамилия и должность не будут упомянуты где-либо в связи с теми сведениями, которые вы сообщите.

**Процедура исследования.**

Родителям будет предложено заполнить несколько анкет. Взаимодействие с детьми будет ограничено рисунком и рассказом о том, что изображено на рисунке.

У Вас будет возможность ознакомиться с результатами исследования, как только они будут готовы.

Правильных и неправильных ответов нет. Ваши полные и правдивые ответы очень важны и ценны для этого исследования.

**Возможные неудобства.**

Некоторые вопросы интервью, возможно, затрагивают личные и/или эмоционально тяжёлые темы. Помните, что Вы можете отказаться от участия в исследовании на любом этапе.

**Выгоды.**

Участие в исследовании не предполагает получение респондентом денежной или материальной компенсации, или какой-либо другой прямой выгоды. Однако, информация, полученная в ходе этого исследования, может в будущем принести пользу и Вам, и другим людям.

Если у Вас возникнут вопросы, касающиеся исследования, Вы можете позвонить координатору исследования по телефону 0556350600 или написать письмо на электронный адрес: alina2105@mail.ru

**ПОДТВЕРЖДЕНИЕ ИНФОРМИРОВАННОГО СОГЛАСИЯ НА УЧАСТИЕ В ИССЛЕДОВАНИИ**

*Подписывая данную форму информированного согласия, я подтверждаю, что прочитал(а) и понял(а) цели, процедуру, методы исследования. У меня была возможность задать все интересующие меня вопросы. Я получил(а) удовлетворительные ответы и уточнения по всем вопросам, интересовавшим меня в связи с данным исследованием. Я даю свое согласие на участие в исследовании и вовлечение моих детей ________________ и ___________________.*

| Подпись участника исследования | Дата: «_____»____________________ 2011 |
|---|---|

*Я объяснил(а) респонденту предложенную выше форму информированного согласия, а также ответил(а) на все вопросы респондента относительно участия в исследовании. Его(ее) решение принять участие в исследовании не навязано кем-то, а является осознанным и добровольным, о чем получено согласие.*

| Ф.И.О. и подпись интервьюера | Дата: «____»_____________________ 2011 |
|---|---|

Appendix B

Self-made questionnaire

**ИНСТРУКЦИЯ:**

**Уважаемый родитель, просим Вас оценить по 5тибальной шкале, насколько данное утверждение соответствует вам:**

1. **Полностью не согласен**
2. **Не согласен**
3. **Затрудняюсь ответить**
4. **Согласен**
5. **Полностью согласен.**

ФИО: ___________________________________________________________________

*Возраст: ____________

*Укажите, о какой по счету беременности идет речь:________

1. Каждый раз, когда мне нужно перепеленать/накормить _____________________*, ___________________ находит повод отвлечь меня.
   0 1 2 3 4 5

2. ______________________ помогает мне в уходе за младшей сестренкой.
   0 1 2 3 4 5

3. В последнее время, в ответ на обычные распоряжения, ______________________ стремится сделать все наоборот
   0 1 2 3 4 5

4. После рождения ______________________ , ______________________ стала вести себя взрослее.
   0 1 2 3 4 5

5. В секции, (садик, школа, курсы) воспитатели сообщают об изменениях в поведении ______________________.
   0 1 2 3 4 5

6. В последнее время я замечаю за ______________________ привычку кусаться.
   0 1 2 3 4 5

7. После рождения ______________________, у ______________________ стали замечаться проблемы со сном.
   0 1 2 3 4 5

8. После рождения ______________________, у ______________________ стали замечаться проблемы с ранее сформированными навыками, такими как: контроль функции кишечника и мочевого пузыря, появление искажённой речи.
   0 1 2 3 4 5

9. Случалось, что ______________________ случайно причиняла _____________ физическую травму
   0 1 2 3 4 5

10. Я замечаю, что после рождения ______________________, _____________________ стала более непослушной.
    0 1 2 3 4 5

11. ______________________ активна как в школе (в садике, и д.р), так и дома
    0 1 2 3 4 5

12. Я замечаю, что после рождения ______________________, __________________ стала менее активна.
    0 1 2 3 4 5

13. После рождения _______________ _, поведение_______________ не изменилось.
    0 1 2 3 4 5
14. ______________________ стала конфликтовать со сверстниками в последнее время (после рождения младшей)
    0 1 2 3 4 5

15. В последнее время я замечаю, что ______________________ стала ломать, разбивать, портить вещи
    0 1 2 3 4 5

16. ______________________ стала отказываться от любой помощи со стороны родителей.
    0 1 2 3 4 5

17. В последнее время я замечаю частые перемены настроения у ______________________
    0 1 2 3 4 5

18. Старшая дочь жалуется, что я провожу больше времени с младшей дочерью.
    0 1 2 3 4 5

19. Я замечаю за ______________________ тенденцию к младенческому поведению (просит дать ей соску, запеленать, одеть).
    0 1 2 3 4 5

20. Между ______________________ и ______________________ дружеские (теплые) отношения
    0 1 2 3 4 5

21. Характеризую свою старшую дочь как очень послушную девочку.
    0 1 2 3 4 5

22. ______________________ часто повышает голос на_ ______________________.
    0 1 2 3 4 5

23. ______________________ с удовольствием проводит время с младшей сестренкой.
    0 1 2 3 4 5

24. ______________________ часто отказывается от приема пищи в последнее время.
    0 1 2 3 4 5

25. ______________________ перестала заниматься домашними обязательствами, которыми занималась до этого.
    0 1 2 3 4 5

26. Я часто замечаю, что _____________________ плачет после общения с _________________.
    0 1 2 3 4 5

27. ______________________ копирует поведение младшей дочери.
    0 1 2 3 4 5

28. Я замечаю, что после рождения _____________________, ______________________ стала более тревожной.
    0 1 2 3 4 5

29. Я замечаю, что после рождения _____________________, ______________________ перестала самостоятельно одеваться, и просит о помощи родителей.
    0 1 2 3 4 5

30. Между ______________________ и ______________________ отсутствуют дружеские отношения.
    0 1 2 3 4 5

31. ______________________ портит мои вещи (порвала платье, изрисовала туфли, делает негодной к употреблению мою косметику)
    0 1 2 3 4 5

32. У ______________________ хороший аппетит.
    0 1 2 3 4 5

33. ______________________ пытается заполучить мое внимание любыми способами.
    0 1 2 3 4 5

34. После рождения____________________, я замечаю спад настроения у ______________________.
    0 1 2 3 4 5

35. Я замечаю, что ______________________, после того, когда появилась ______________________, капризничает больше, и успокоить ее труднее.
    0 1 2 3 4 5

36. Я замечаю, что ______________________ стала более импульсивной, часто кидается в слезы.
    0 1 2 3 4 5

37. ______________________ перестала самостоятельно ходить в туалет, и просит о помощи родителей.

0 1 2 3 4 5

38. Были случаи, когда ______________________ случайно роняла младшую сестренку.
    0 1 2 3 4 5

39. В последнее время, ______________________ часто отказывается выполнять правила
    0 1 2 3 4 5

40. Были случаи, когда ______________________ толкала______________________.
    0 1 2 3 4 5

41. Я замечаю, что в последнее время ______________________ легко ссорится, начинает драку.
    0 1 2 3 4 5

42. Я замечаю частую усталость у ______________________ в последнее время.
    0 1 2 3 4 5

43. Старшая дочь неохотно проводит время с младшей.
    0 1 2 3 4 5

44. Я замечаю, что ______________________ стала немного замкнутой после рождения ______________________.
    0 1 2 3 4 5

45. У ______________________ крепкий здоровый сон.
    0 1 2 3 4 5

*Note:* instead of dashes, names of the daughters were inscribed.*

Appendix C

## Инструкция

Уважаемый участник!

Просим вас из пяти утверждений, представленных в блоках, выбрать одно, наиболее полно отражающее общее ваше состояние во время беременности.

**Все полученные данные в ходе теста являются строго конфиденциальной информацией и могут быть использованы только в рамках научной работы.**

**Пожалуйста, ответьте на все вопросы как можно точнее и не размышляйте слишком долго, поскольку это может изменить качество результатов.**

**Спасибо за участие.**

Ваши ФИО: ___________________________________________________________________

*Ваш возраст: _________

*Какая по счету беременность: _________

*Возраст ребенка на сегодняшний день: ____________

**А**

| I | 1 | Во время беременности я была счастлива, как никогда | |
|---|---|---|---|
| | 2 | Во время беременности я не испытывала никаких особых эмоций | |
| | 3 | Во время беременности я была в постоянном напряжении, испытывала больше тревог, чем радости | |
| | 4 | В основном, мне было приятно сознавать, что я беременна, особой тревоги я не испытывала | |
| | 5 | Во время беременности настроение у меня постоянно было сниженным | |

| | | | |
|---|---|---|---|
| **II** | **1** | Во время беременности, тревожась за свое здоровье и здоровье ребенка, я полностью изменила образ жизни | |
| | **2** | Во время беременности я существенно не меняла образ жизни, но стала относиться к себе бережнее | |
| | **3** | Во время беременности я не считала нужным что-либо менять в образе жизни | |
| | **4** | Во время беременности моя жизнь чудесно переменилась | |
| | **5** | Во время беременности моя жизнь значительно изменилась к худшему | |
| **III** | **1** | Во время беременности я почти не думала о ней и предстоящих родах | |
| | **2** | Во время беременности я часто думала о родах, очень их боялась, сомневалась в благополучном исходе | |
| | **3** | Во время беременности я иногда думала о родах, но не испытывала особого страха, была уверена, что все пройдет нормально | |
| | **4** | Во время беременности я все время думала о предстоящих родах и почти не сомневалась в их плохом исходе | |
| | **5** | Во время беременности я думала о родах как о предстоящем празднике | |

**Б**

| | | | |
|---|---|---|---|
| **I** | **1** | Во время беременности я часто беспокоилась о том, что не смогу справиться с обязанностями матери | |
| | **2** | Во время беременности я полагала, что хорошая мать из меня не получится | |
| | **3** | Во время беременности я не задумывалась о предстоящем материнстве | |

| | | | |
|---|---|---|---|
| | **4** | Во время беременности я была уверена, что стану прекрасной мамой | |
| | **5** | Во время беременности я полагала, что если постараюсь, то смогу стать хорошей мамой | |
| **II** | **1** | Во время беременности я часто с удовольствием представляла себе ребенка, разговаривала с ним | |
| | **2** | Во время беременности я понимала ребенка, которого вынашиваю, и восхищалась им | |
| | **3** | Во время беременности я постоянно беспокоилась о состоянии здоровья ребенка, которого вынашиваю, старалась его почувствовать | |
| | **4** | Во время беременности я не думала о том, каким будет ребенок, которого вынашиваю | |
| | **5** | Во время беременности я часто думала о том, что ребенок, которого вынашиваю, будет каким-нибудь неполноценным, и очень боялась этого | |
| **III** | **1** | Во время беременности я не думала о том, как буду кормить ребенка грудью | |
| | **2** | Во время беременности я с восторгом представляла себе, как буду кормить ребенка грудью | |
| | **3** | Во время беременности я полагала, что буду кормить ребенка грудью | |
| | **4** | Во время беременности я беспокоилась о том, что у меня будут проблемы с кормлением грудью | |
| | **5** | Во время беременности я была почти уверена, что вряд ли смогу кормить ребенка грудью | |

**B**

| | | | |
|---|---|---|---|
| **I** | **1** | Во время беременности я считала, что беременность сделала меня еще прекрасней в глазах отца моего ребенка | |
| | **2** | Во время беременности отношение ко мне со стороны отца моего ребенка не изменилось | |

| | | | |
|---|---|---|---|
| | **3** | Во время беременности отец моего ребенка стал внимательнее и теплее относиться ко мне | |
| | **4** | Во время беременности я считала, что стала некрасивой, и отец моего ребенка стал холоднее относиться ко мне | |
| | **5** | Во время беременности я опасалась, что изменения, связанные с ней, могут ухудшить отношение ко мне отца моего ребенка | |
| **II** | **1** | Когда я была беременной, большинство близких мне людей разделяли мою радость, и мне было хорошо с ними | |
| | **2** | Когда я была беременной, не все близкие мне люди достаточно радовались этому, не все понимали, что я нуждалась в особом отношении | |
| | **3** | Когда я была беременной, большинство близких мне людей не одобряли этого, мои отношения с ними ухудшились | |
| | **4** | Когда я была беременной, меня мало интересовало отношение к этому даже близких мне людей | |
| | **5** | Когда я была беременной, некоторые близкие мне люди относились к моей беременности неоднозначно, и это меня тревожило | |
| **III** | **1** | Во время беременности я всегда мучительно стеснялась, если кто-либо замечал, что я «в положении» | |
| | **2** | Во время беременности мне было немного не по себе, когда окружающие замечали, что я «в положении» | |
| | **3** | Во время беременности мне было приятно, когда окружающие замечали, что я «в положении» | |
| | **4** | Во время беременности мне было наплевать, замечают окружающие или нет, что я «в положении» | |
| | **5** | Во время беременности я не испытывала особой неловкости, если окружающие замечали, что я «в положении» | |

В данной секции нужно перенести результаты в следующую таблицу, отметив соответствующую утверждению цифру.

| **Блоки** | **Разделы** | **О** | **Г** | **Э** | **Т** | **Д** |
|---|---|---|---|---|---|---|
| **А** | **I** | 4 | 2 | 1 | 3 | 5 |
| | **II** | 2 | 3 | 4 | 1 | 5 |
| | **III** | 3 | 1 | 5 | 2 | 4 |
| **Б** | **I** | 5 | 3 | 4 | 1 | 2 |
| | **II** | 1 | 4 | 2 | 3 | 5 |
| | **III** | 3 | 1 | 2 | 5 | 4 |
| **В** | **I** | 3 | 2 | 1 | 5 | 4 |
| | **II** | 1 | 4 | 5 | 2 | 3 |
| | **III** | 5 | 4 | 3 | 2 | 1 |
| | **Всего (количество ответов/ НЕ их сумма)** | | | | | |

# Appendix D

ФИО: ____________________________________________________________________

*Ваш возраст: ___________

*Укажите возраст старшей дочери: __________

*Укажите, какой по счету ребенок: __________

1. Состояли ли вы в браке на момент рождения старшей дочери? Если да, то как долго? ____________________
2. Как долго вы были знакомы со своим супругом/супругой на момент зачатия старшей девочки? __________________________
3. Как бы вы охарактеризовали Ваши отношения с супругом/супругой, на момент ожидания рождения старшей дочери?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______
4. Вам казалось, что модель вашей семьи более правильная, чем модель семьи, где был/а воспитан/а Ваш супруг/а? (Пожалуйста, поясните ответ)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______
5. После того, как Вы с супругом/супругой приняли решение строить семью и жить вместе, Вы стали замечать, что избранник/избранница сильно отличается от того образа, который Вы себе создали? (Пожалуйста, поясните ответ)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______
6. На момент ожидания рождения старшей дочки, Вы с супругом/супругой старались улучшить отношения. Уже не столько пытались изменить другого, сколько меняли себя?
______________________________________________________________________
______________________________________________________________________

______________________________________________________________________
______

7. Как часто между Вами и Вашим супругом/супругой происходили ссоры, в период беременности старшей дочерью?

______________________________________________________________________
__

8. Какая была мотивация в принятии решение о беременности младшей дочерью? Как принималось решение о зачатии старшей дочери?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______

9. Планировалась ли беременность? (старшей дочерью)

_________________________
______________________________________________________________________
__

10. В период беременности старшей дочкой, возникало ли желание что-то изменить в вашей жизни? (сменить работу, страну, семью, обзавестись хобби) (пожалуйста, поясните ответ)

______________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
________

11. Опишите ваше общее состояние во время беременности (старшей дочкой)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Figure 1.

F1. The drawing of mother.

Figure 2.

F1. The drawing of an older daughter.

The first figure from the left was marked as little brother, next is mother, than an older brother, after him is a little sister, than the author of the drawing (older daughter), and father.

Figure 3

F1. The drawing of a younger daughter.

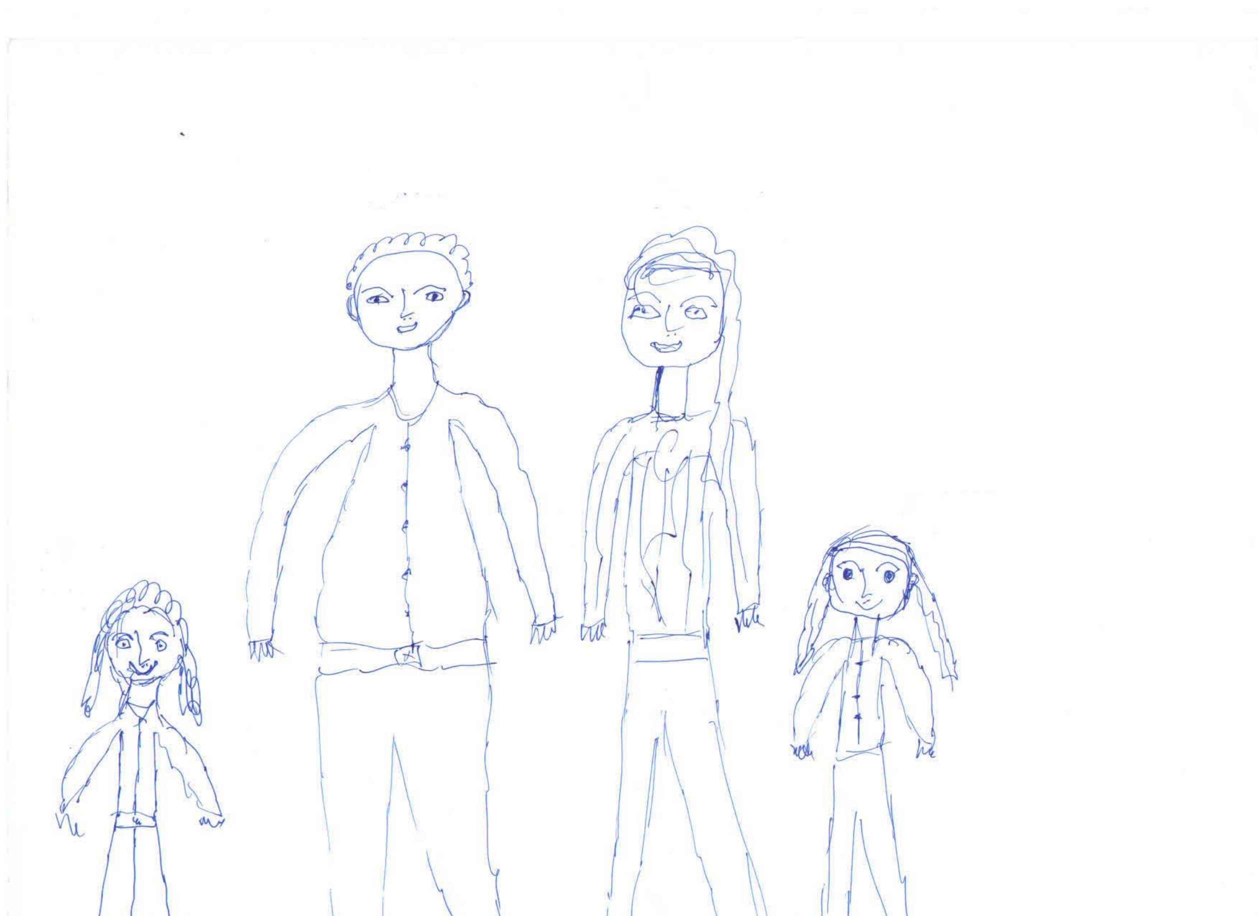
Figure 4

F2. The drawing of mother.

The first figure from the left was marked as father, next is mother (the author), than an older daughter and then the younger daughter.

Figure 4.

F2. The drawing of father.



The first figure from the left was marked as a younger daughter, next is father (the author), than is mother, and an older daughter.

Figure 5.

F2. The drawing of an older daughter.

The first figure from the left was marked as father, next is mother, then a younger daughter, and then the older daughter (the author).

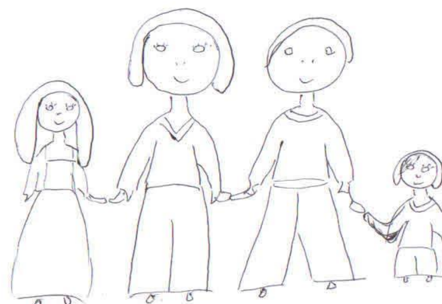
Figure 6.

F2. The drawing of a younger daughter.

The first figure from the left was marked as father, next is mother, then a younger daughter (the author), and then the older daughter.

Figure 7.

F3. The drawing of mother.



The first figure from the left was marked as older daughter, next is mother (the author), then the father, and a younger daughter.

Figure 8.

F3. The drawing of father.

The first figure from the left was marked as older daughter, next is father (the author), then is mother, a younger daughter.

Figure 9.

F3. The drawing of the older daughter.

The first figure from the left was marked father, next is mother, than is older daughter (the author), and a younger daughter.

Figure 10.

F4. The drawing of mother.

The first figure from the left was marked father, next are older daughter, younger daughter, younger brother, and mother (the author).

Figure 11.

F4. The drawing of father.

Figure 12.

F4. The drawing of older daughter.

The first figure from the left was marked little brother, next are mother, father, older daughter (the author), and a younger daughter.

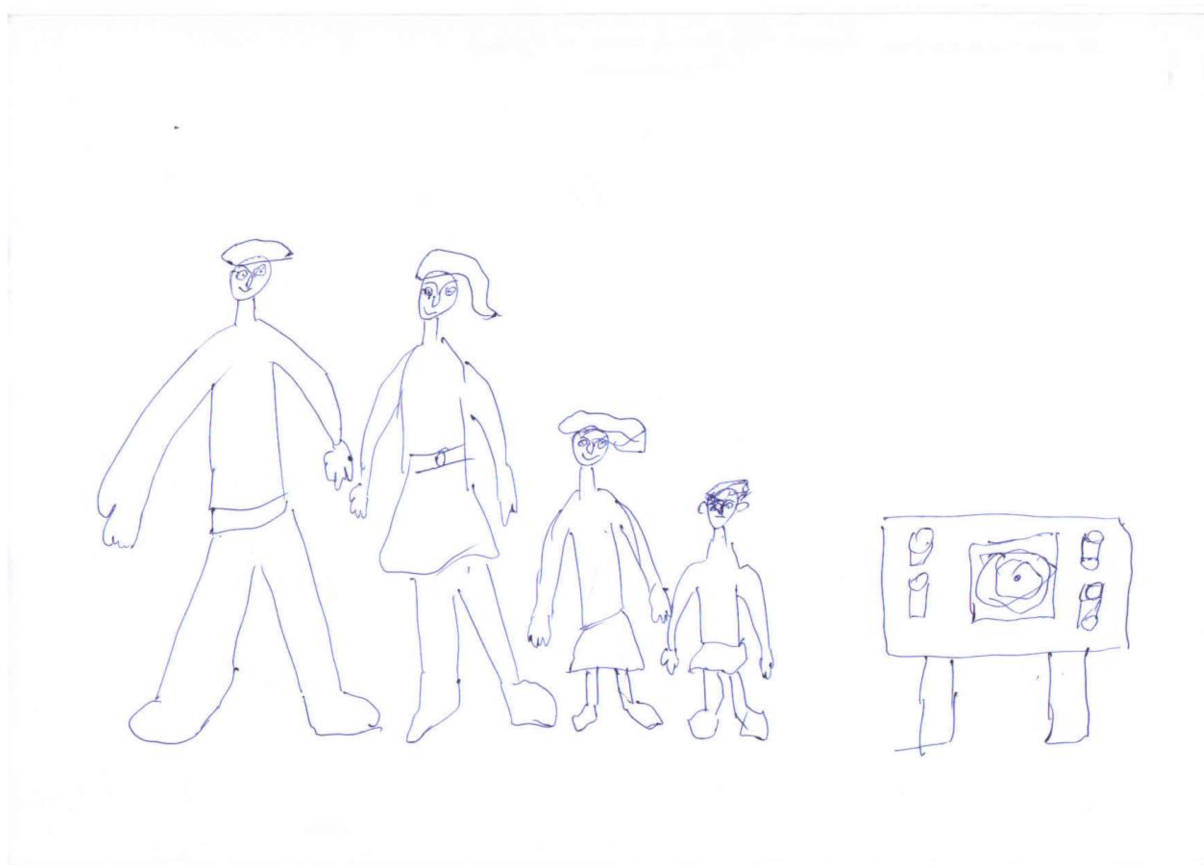
Figure 13.

F5. The drawing of mother.

The first figure from the left was marked mother (the author), next is father, then an older daughter, and a younger daughter.

Figure 14.

F5. The drawing of father.



The first figure from the left was marked father (the author), next is mother, than is older daughter and a younger daughter.

Figure 15.

F5. The drawing of an older daughter.

The first figure from the left was marked mother, next is a younger daughter, than is older daughter (the author) and father.

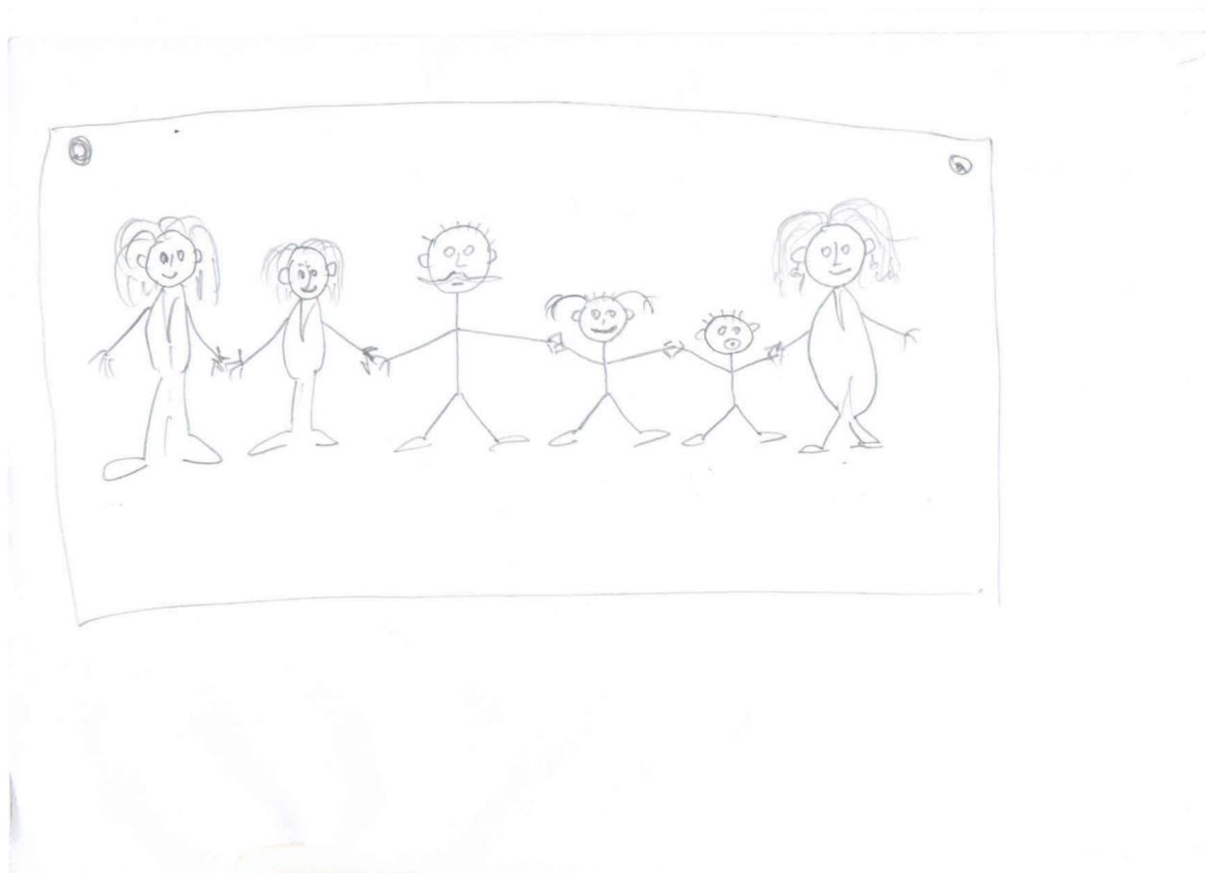
Figure 16.

F6. The drawing of mother.

The first figure from the left was marked as younger daughter, then the older daughter next is father and mother, after them is grandmother, then middle daughter and the youngest son.

Figure 17.

F6. The drawing of father.



The first figure from the left was marked as older daughter, then a younger daughter next is father (the author), after is middle daughter, then the youngest son and mother.

Figure 17.

F6. The drawing of an older daughter.

The first figure from the left was marked as younger daughter, then mother and father, next is older daughter (the author) and then middle daughter.

Figure 17.

F7. The drawing of father.

The first figure from the left was marked as older son, then father (the author) and mother, next is older daughter. In front of father is youngest daughter and in from of mother is youngest son.

Fogure 18.

F8. The drawing of an older daughter.

The first figure from the left was marked as father, then older daughter (the author) and younger daughter, next is older mother and little brother.

Figure 19.

F8. The drawing of mother.

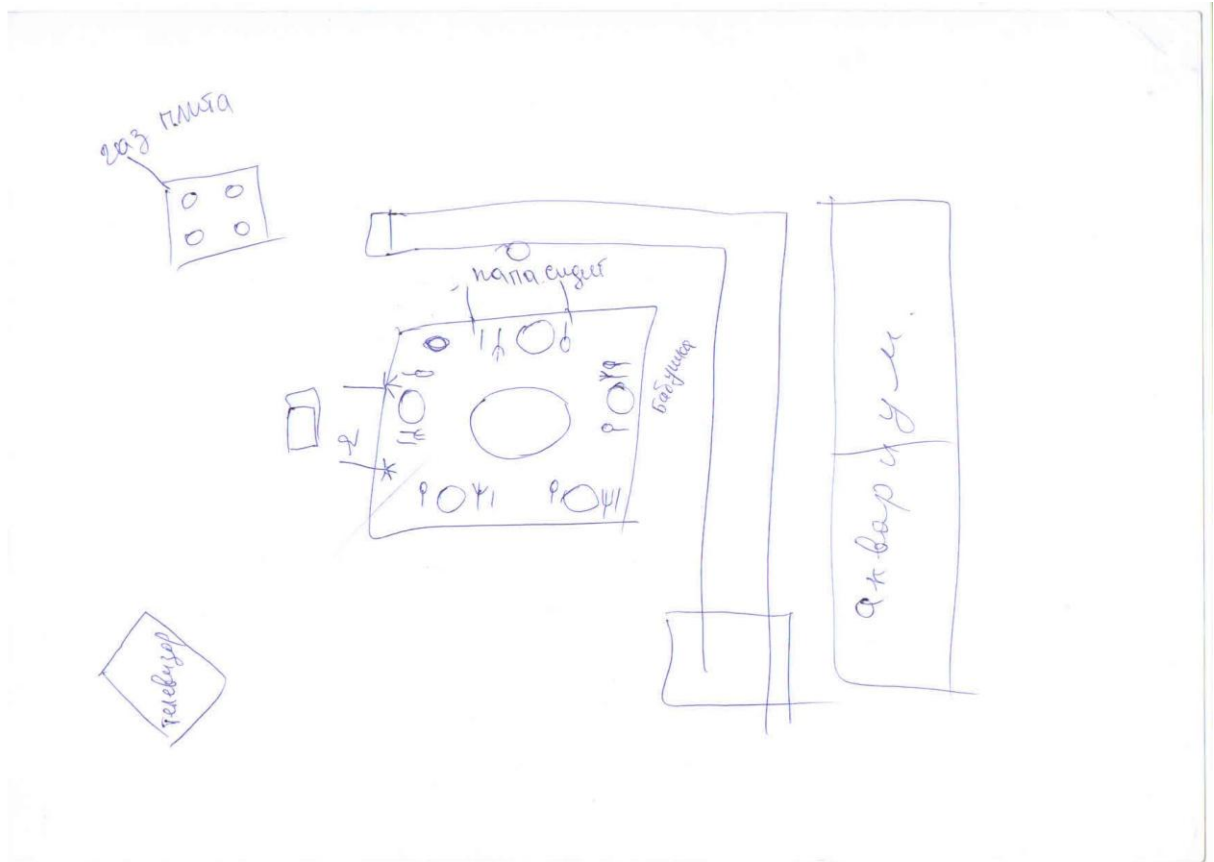



Figure 20.

F8. The drawing of father.

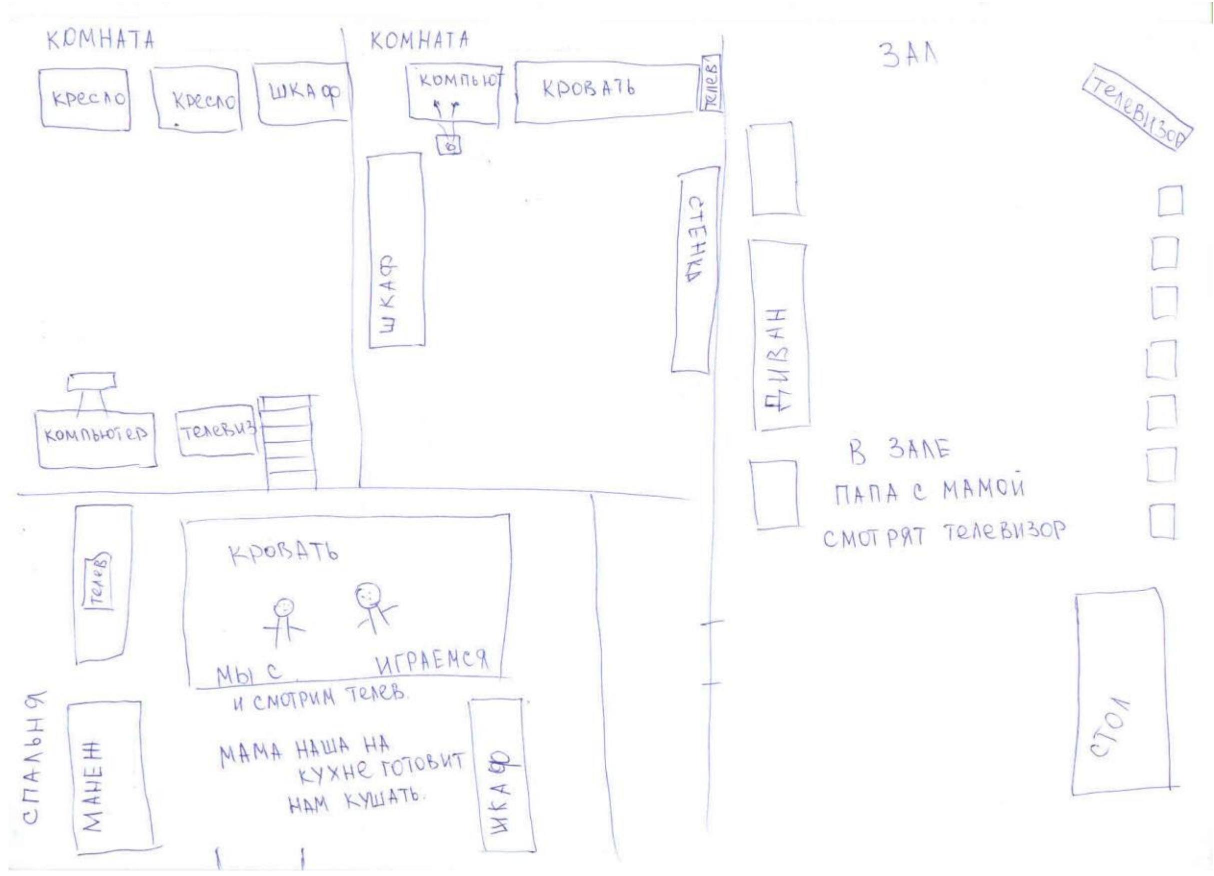
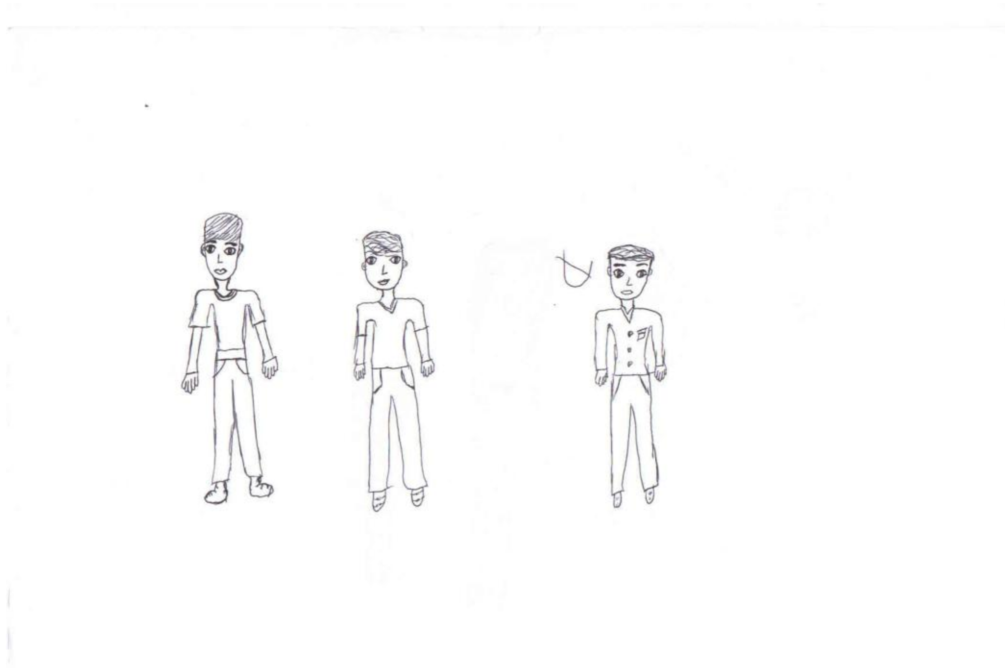



Figure 21.

F8. The drawing of an older



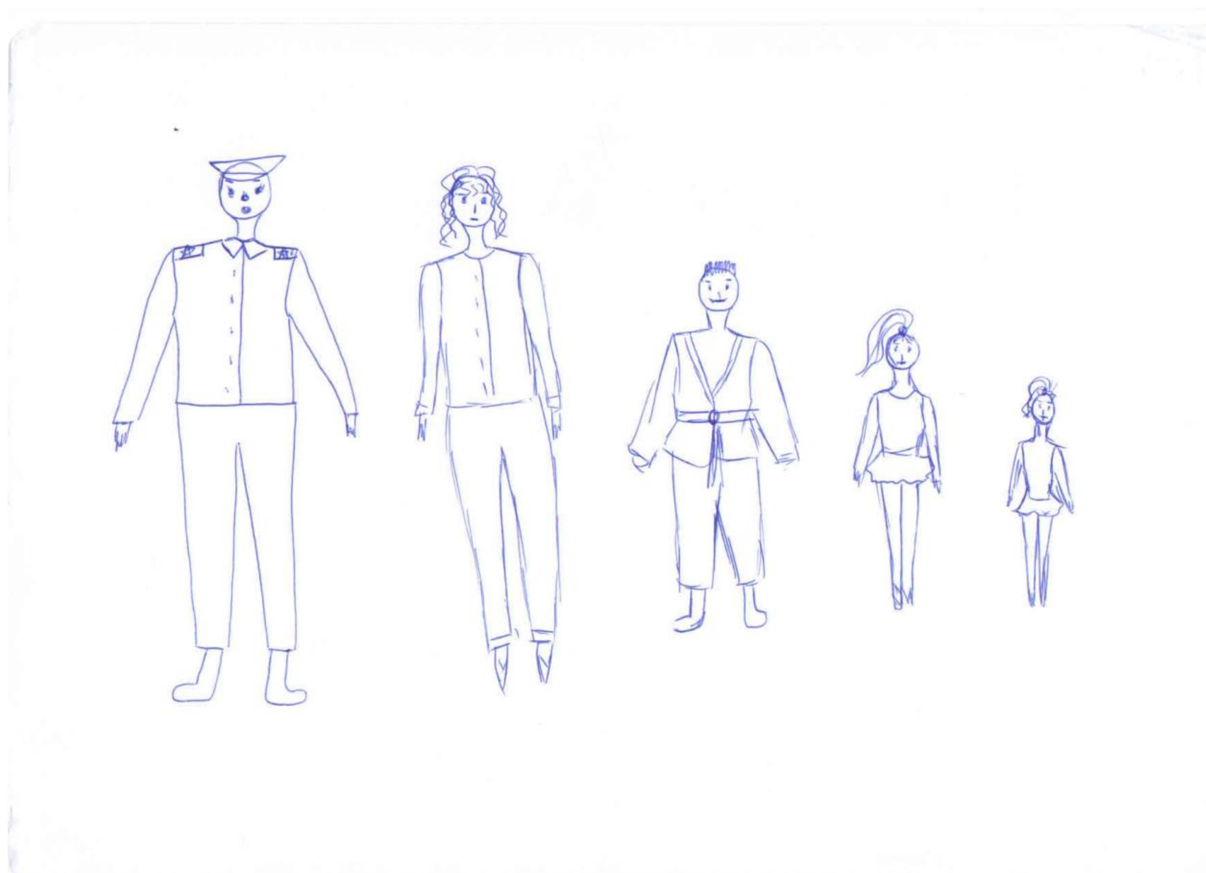
daughter.

Here is one side of the paper, where the author portrayed brother (from the left), father (in the middle) and grandfather (in the right).

On the other side the author portrayed grandmother (from the left), older daughter (the author), mother and the younger sister.

Figure 22.

F9. The drawing of mother.



The first figure from the left was marked as father, then mother, next is older son (the author), after is middle daughter, then the youngest son and mother.

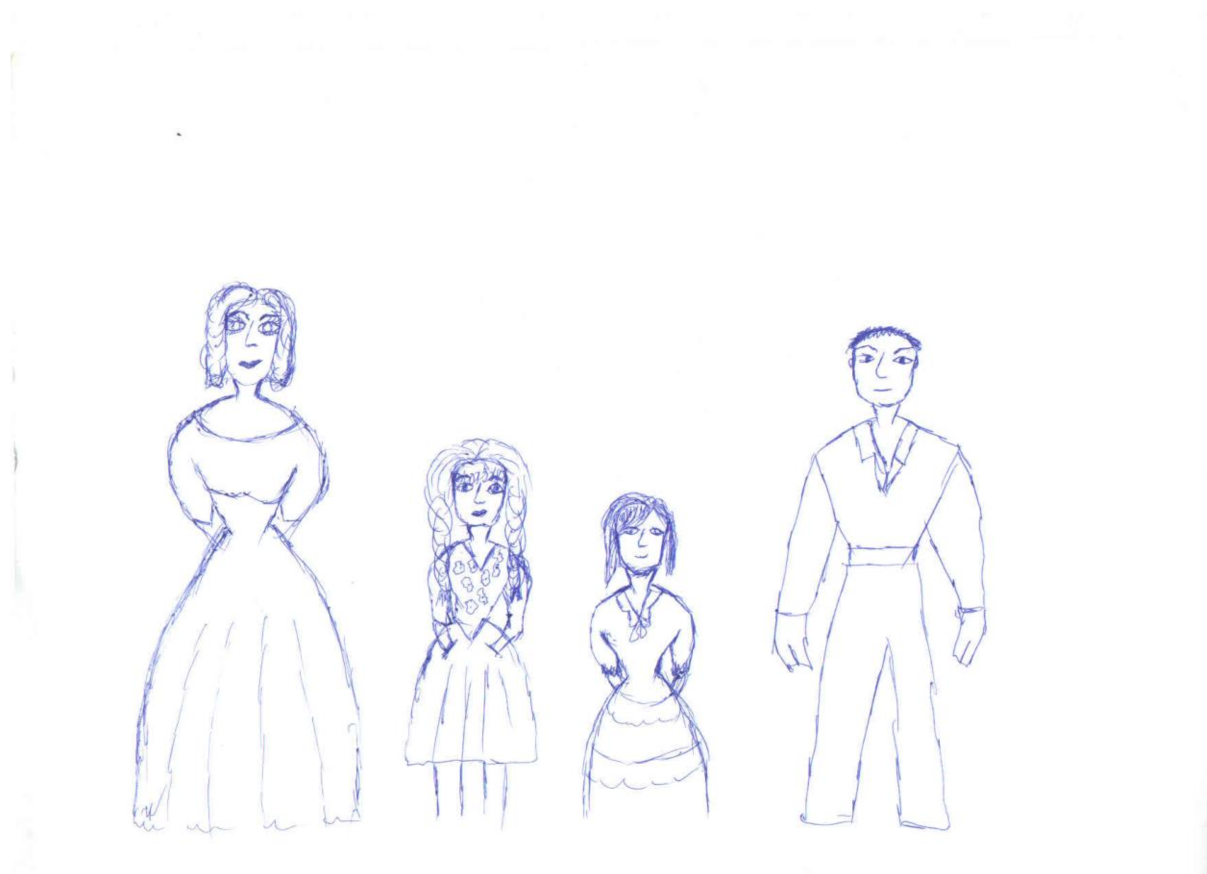
Figure 23.

F9. The drawing of older daughter.

The first figure from the left was marked as younger daughter, next is older daughter (the author), then mother, father and younger son.

Figure 23.

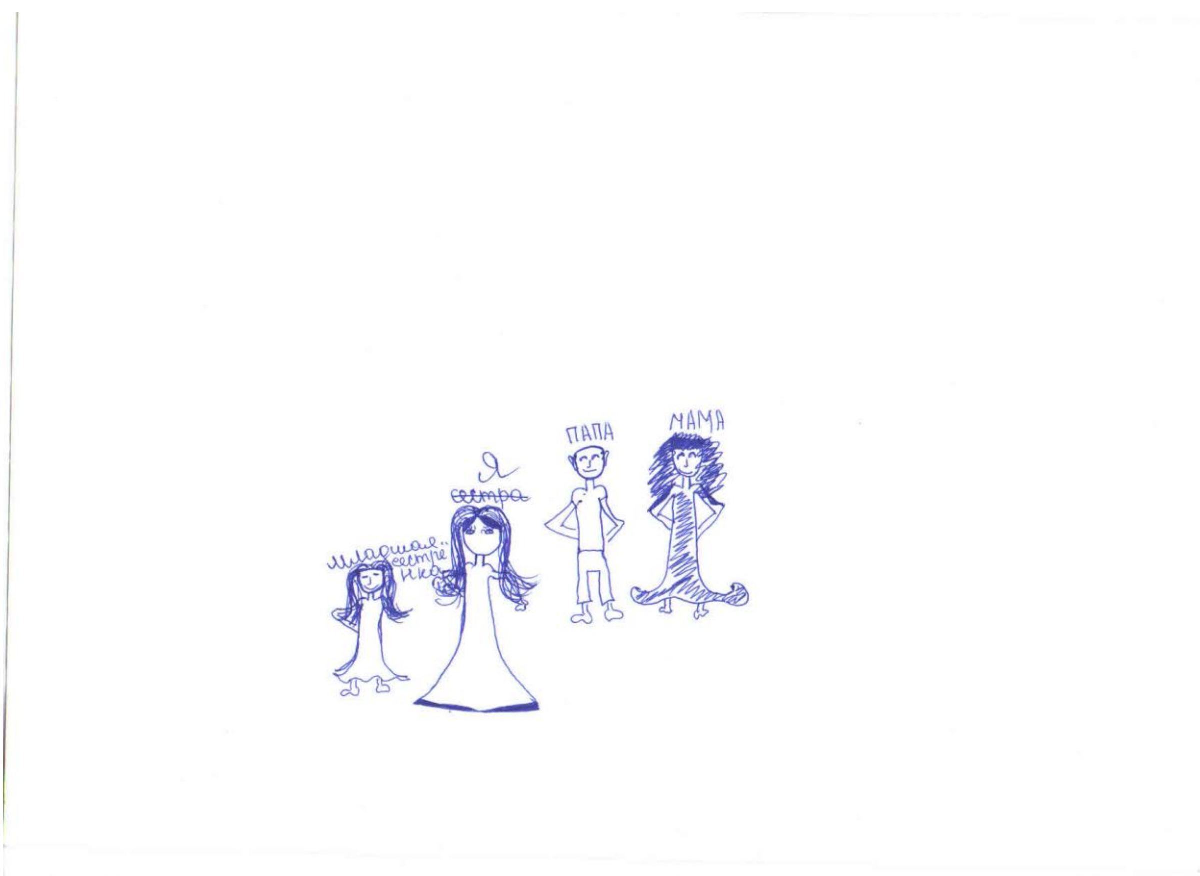
F10. The drawing of mother.



The first figure from the left was marked as mother (the author), next is older daughter, then father.

Figure 24.

F10. The drawing of older daughter.




The first figure from the left was marked younger daughter, next is older daughter,(the author),then father and mother.