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THE EFFECT OF PLANNED NURSING INTERVENTION
ON PRIMIPARA POSTPARTUM ROLE STRAIN

By

Elizabeth I. Price

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ABSTRACT

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New mothers experience role strain. Family supports no longer assist new mothers. A role socialization program administered by nurses can reduce role strain.

The experimental design used a small narrowly defined sample of new mothers, one half serving as control. The program consisted of three components: social self, role language, and role performance administered on the day of discharge.

At term, mothers completed a basic profile and Ideal Mother Index. At three weeks postpartum, mothers repeated the Ideal Mother Index and a Self Mother Index, both scored on a six-point response scale, the difference between scores revealing role strain. Role strain was evident and decreased through planned nursing intervention. Of the three components, only role performance showed a significant trend. The trends for social self and role language were less pronounced. The ideal self data supports theories concerning ideal self stability.

To my friend, Chris

ACKNOWLEDGMENTS

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CHAPTER I

INTRODUCTION

The first pregnancy is a time when a woman anticipates the role of mother and begins to realize within herself what behavioral changes the adoption of this role will bring. The cultural image of motherhood is ideal surrounded with myth and fantasy. New mothers have little time to ease into the behaviors and responsibilities of their new roles; they must perform as mothers immediately. In the past, extended families provided role models, support, and guidance for the new mother and assisted her to perform the new role. However, in a society where one of five families moves each year (1970 census), these strong role models are no longer available to young mothers. Because of this change in the traditional extended family structure, support systems are removed which could help new mothers learn to perform mothering behaviors and ease the acquisition of the maternal role (Gruis 1977).

Role strain, the difficulty of fulfilling role demands, occurs normally during any role acquisition (Goode 1960). The time of greatest role strain in maternal role acquisition is when the formal, or ideal, role behaviors

of the position are tested in reality (Thornton and Nardi 1975).

In my experience, both as a maternity nurse and a mother, I have observed the difficulties mothers have adjusting to first babies in the weeks immediately after delivery. Too often they lack family and peer support to guide them in those early days, and in general the health care system does not intervene until the sixth week postpartum.

The purpose of this study is to determine if a selected program of role socialization provided for new mothers during the informal stage of maternal role acquisition will reduce role strain. By recognizing the role strain involved in becoming a new mother, the health care system can provide support and guidance during the postpartum period, in addition to the customary re-entry examination six weeks postpartum.

Statement of the Problem

What is the effect of a selected role socialization program provided new mothers during the informal stage of maternal role acquisition on role strain at three weeks postpartum?

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Hypothesis 1

New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly lower scores on a measure of role strain than those mothers who did not receive the program.

A. New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of social self than those mothers who did not receive the program.

B. New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of role language than those mothers who did not receive the program.

C. New mothers who receive a program of role socialization during the informal stage of role acquisition will have no significantly different scores on a measure of role performance than those mothers who did not receive the program.

Hypothesis 2

There is no significant difference on the ideal mother measure between the pre and post-test scores for the new mothers who received a program of role socialization during the informal stage of role acquisition.

Operational Definitions

Social Self: a set of descriptions held by an actor for himself developed out of interaction between the organism and stimulus, objects and events, and projected in his role behavior (Biddle and Thomas 1966); a set of reflected appraisals (Mead 1934). Social self, for the purpose of this study, is defined by the following items on the Ideal Mother Index. A mother:

- . . . is happy
- . . . is concerned about her family
- . . . is consistent and dependable
- . . . is also a woman separate from her baby
- . . . is strong
- . . . feels good about herself
- . . . is important

Role Language: "Linguistic devices are the tools which aid in the further development of the social self." The learning of language, both verbal and body, particularly that which has social referents, and aids in the perceiving, identifying, and conceptualizing of roles and role expectations (Sarbin 1954, pp. 242-243). Role language, for the purpose of this study, is defined by the following items in the Ideal Mother Index.

A mother:

- . . . talks to her baby
- . . . understands her baby's different cries
- . . . touches her baby gently
- . . . communicates with her baby through looks
and gestures
- . . . cuddles her baby tenderly
- . . . is able to interpret what her baby wants
and needs
- . . . listens to her baby when her baby talks to her

Role Performance: Overt activity, including gross skeletal movements, verbal and motoric gestures, posture, styles of speech and accent, the wearing of certain forms of dress and the use of material objects (Sarbin 1954, p. 232). Role performance, for the purpose of this study, is defined by the following items on the Ideal Mother Index. A mother:

- . . . is skillful in feeding and burping her baby
- . . . is competent with tasks of bathing and
dressing her baby
- . . . protects her baby
- . . . holds and rocks her baby
- . . . changes her baby's diaper with ease
- . . . provides physical care for her baby
- . . . adapts to change

Note: The Self Mother Index contains all the items designed to define social self, role language, role performance; however, they are worded slightly differently to reflect the reader "I." For clarification, refer to the instrument section where both tools are included.

Role Socialization: (1) the process of learning the realistic limits of role behaviors, and qualities which are congruent with the internalized set of norms; (2) the process of a) identifying the ideal internalized actions and qualities of a given role, b) cognitively establishing self in relation to the standard. The Role Socialization Program is designed to provide support and education for new mothers; to assist in the acquisition of the maternal role based on the following role concepts: social self, role language, and role performance.

Role Strain: the felt difficulty in carrying out the rights and obligations of a given role in reality, balanced against internalized standards and the ideal used to evaluate action.

Role Acquisition: a developmental process in the adapting of a new role encompassing four stages: (1) anticipatory, (2) formal, (3) informal, and (4) personal. Time has been used to mark the stages in the acquisition of the maternal role.

- (1) Anticipatory--from early childhood through pregnancy.

- (2) Formal--hospital confinement post-delivery, 3-4 days.
- (3) Informal--includes the time from hospital discharge to three weeks postpartum.
- (4) Personal--is ongoing, as the tasks of the mother change and continually require testing the formal expectation against the informal reality, striving for a comfortable medium.

Limitations of the Study

The limitations of the study are as follows:

- (1) The sample size is small, and therefore the findings of this study may not be generally applicable to a large population, only to the population under study.
- (2) The same researcher was both teacher and evaluator of the program. This may affect the research outcome. Replication of the research using at least two researchers, one as teacher and one as evaluator, should eliminate any effects.
- (3) The use of office staff for the initial client contact may have affected the sample population.
- (4) Clients who agreed to cooperate in the study may be different from those who did not. Therefore, it is possible they would have had different outcomes.

- (5) The limited time and small number of contacts may not have covered the time role strain occurred.
- (6) Rubin's theory related to "binding in" is untested, so no research correlations are possible.

Assumptions

Assumptions of the study are as follows:

- (1) The relationship between the ideal self and the real self is one that can be measured.
- (2) The testing instrument is sensitive enough to pick up differences between subjects and within the time frame identified.
- (3) The period of time studied is representative of the time role strain occurs.
- (4) Clients who seek medical care from a specialty group of obstetricians are basically the same as those found in other health care settings offering maternity care.
- (5) Unplanned assistance provided the mother postpartum by family and friends would be distributed randomly in both the program and non-program groups. Therefore, the outcome would not be affected.

This study is organized into six chapters. Chapter I provides an introduction, a statement of the problem, hypotheses, limitations, assumptions, and definitions of terms underlying this study.

Chapter II presents a theoretical framework for this study, drawing on related theory from sociology and nursing.

Chapter III provides a review of the literature pertaining to this investigation and supporting the need for this study.

Chapter IV presents the methodology, design, and procedures used in this study, a discussion of the research sample, a delineation of the procedures for collection of the research data, and an explanation of the method of data analysis.

Chapter V contains all of the data collected in response to the research hypotheses.

Chapter VI provides a summary of the findings and conclusions drawn from the study, as well as recommendations for further research.

CHAPTER II

THEORETICAL FRAMEWORK

The theoretical framework for this investigation draws from both the sciences of sociology and nursing.

Role theorists assume that role performance or behaviors are learned either by intentional instruction or by incidental learning (Heiss 1976). The family and greater kinship network play a vital part in socializing individuals into various role behaviors both intentionally and incidentally (Elkin 1958). Therefore, the absence of this support when assuming a new role may place some individuals at risk due to the stress of change (Hrobsky 1977). Role acquisition is a developmental process, one which requires individual adaptation, and is often accompanied by difficulty in fulfilling the obligations of the new role. Difficulties may result in role strain or an incongruency between what the individual ideally believes to be the role rights and obligations and how comfortable he is actually performing the role (Goode 1960). This study focuses on the acquired role of mother.

To better understand how maternal role acquisition might be accomplished, the developmental approach model of role acquisition described by Thornton and Nardi (1975), incorporating both social and psychological dimensions, seems appropriate. This model divides role acquisition into four stages. The first stage is the anticipatory stage. This stage preceeds the actual performing of the role. Generalized sources (i.e., radio, TV, movies, and ideals) identify appropriate role behaviors which lead to the development of unrealistic and ambiguous role expectations.

The anticipatory stage begins in early childhood with doll play, modeling behavior and other role gender specific activities. During pregnancy, all of the cultural norms, values, and expectations of what motherhood entails are intensified for the pregnant woman in preparation for taking on the role. In Thornton and Nardi's (1975) terms, the match between what she has learned to anticipate and what she subsequently expresses will likely determine the speed and ease of role adaptation. The discrepancies between anticipation and realization will vary from mother to mother.

The second stage of role acquisition is the formal stage. Here the correct behaviors are derived mainly from significant others (i.e., her own and other mothers, the father of the baby, and the baby itself) and from within herself. Delivery of the baby marks the passage from the

anticipatory to the formal stage of role acquisition for the new mother. She spends the early part of the postpartum in the hospital where the new family-centered approach to maternity care provides the new mother an opportunity to practice the behaviors now expected of her (i.e., infant care, positive mothering). The mother identifies a new reciprocal role set--that of her infant, the one that truly makes her a mother. She is playing at the role, acting out the formal behavior which is expected of her. During this time the new mother has the support of health care providers to teach her skills, answer her questions and encourage her attempts as she cares for her baby. The new mother is free from the stress that other roles might place on her (i.e., those of wife and homemaker); free to act her part. When she is discharged and she returns to the community to make her debut as a mother, she will still attempt the formal behaviors. Shortly, however, the new mother faces the strain of the real against the ideal, and she begins stage three, the informal stage of role acquisition.

The informal stage of role acquisition is a time for confusion and disillusionment (Thornton and Nardi 1975); the time when the musts of the formal role are questioned. The individual attempts to find her way, bending the fixed and rigid rules of the formal role to allow the new mother the freedom of self-expression within the role, modifying

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behaviors and techniques to fit her ability, personality, and environment. It is during the six weeks postpartum that such modification takes place. Physically the new mother lacks strength because of the insult of labor and delivery, and the new responsibility of infant care leads to disturbance in sleep patterns and fatigue. Psychologically, the new mother may be feeling the loss of a self-identity, one separate from the baby. She may fear the role of mother will consume her in total. The psychological struggle may produce guilt feelings which make adapting the formal behaviors even more difficult because the new mother cannot live up to her own standard. The availability of role models, support, and guidance at this time appears critical to ease these physical and psychological elements of role strain.

The final stage of role acquisition in Thornton and Nardi's model is the personal stage; the individual has worked out the discrepancies between anticipated and actual behaviors and is comfortable in the role. The new mother has imposed her own expectations and conceptions on the role, modifying role expectations according to her own unique personality (Thornton and Nardi 1975).

The inability to work through the incongruence between formal and informal role behaviors of a new role with a personalized role set can lead to role strain. The

family assumes a key position in situations of role strain (Goode 1960) by providing role models, counsel, and support. Historically, families were extended to include several generations; however, the contemporary nuclear family tends to be isolated from these generations. Thus, role models, counsel, and support may be absent (Parsons 1965). Clearly, the health care system can provide these missing elements. Within the health care system, nursing seems most able to assist in minimizing role strain.

Nursing theory interfaces role acquisition theory at all four stages. In the anticipatory stage, nursing is part of the generalized other, helping shape the accepted behaviors surrounding the role of mother by virtue of the nurses' contributions to establishing cultural norms. In the formal stage, nursing can affect role development by using the hospital confinement period to teach role behaviors such as how to diaper, bathe, and feed the new baby. Often the nurse is seen by the new mother as "the baby care expert." However, when the new mother began the informal stage (the most difficult of the developmental processes), the nurse does not normally provide any assistance because the new mother exits the health care system at this time, entering again only briefly, six weeks postpartum, for the "routine" check-up with the doctor.

It is apparent that maternal role acquisition may require nursing intervention at the informal stage because nuclear families of today are independent of kin, and the presence of role strain may interrupt the mother's state of health and inability to pursue her own self-care. The anticipated outcome of this process is acceptance of self in the role and comfort with the obligations the role entails. If she has help, then role strain will be eased.

The focus of Dorothea Orem's nursing theory of self-care is "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and well-being" (Orem 1971, p. 913). Self-care is learned behavior and is the product of the cultural norms of a given social group.

A self-care practice is therapeutic "to the degree that it actually contributes to the maintenance of normal growth, development, and maturation" (Orem 1971, p. 20). There are two kinds of self-care: (1) universal human needs, and (2) health deviation (illness focused). Orem further subdivides universal self-care into six categories: (1) air, water, food; (2) excrements; (3) solitude and social interaction; (4) activity and rest; (5) hazards to life; and (6) being normal. The category of solitude and social interaction proposes that social contacts provide conditions essential for socialization, and to be therapeutic

self-care must "(1) provide social warmth and closeness essential for development as well as conditions which permit development and use of individual talents; (2) stimulate the continuing development and adjustment by the person of a realistic concept of himself which will be expressed in what he strives for, what he expects, and what he values; (3) promote both individual autonomy and group membership; and (4) prevent personality impairments" (Orem 1971, pp. 25-26).

When the mother is unable to provide her own self-care, nursing, a health service designed to assist a person to achieve a level of self-care, should intervene (Orem 1971). Orem defines nursing intervention within three systems, each of which represents a variation in the role of the nurse and patient in the performance of health care activities by the patient. The nurse's method of assistance determines which system will be selected in any situation. The three intervention systems are:

- (1) Wholly Compensatory System: situations in which the patient has no active role;
- (2) Partly Compensatory System: both patient and nurse perform care measures;
- (3) Supportive-Educative System: the patient is able to perform or can learn to perform the therapeutic self-care (Orem 1971, p. 978).

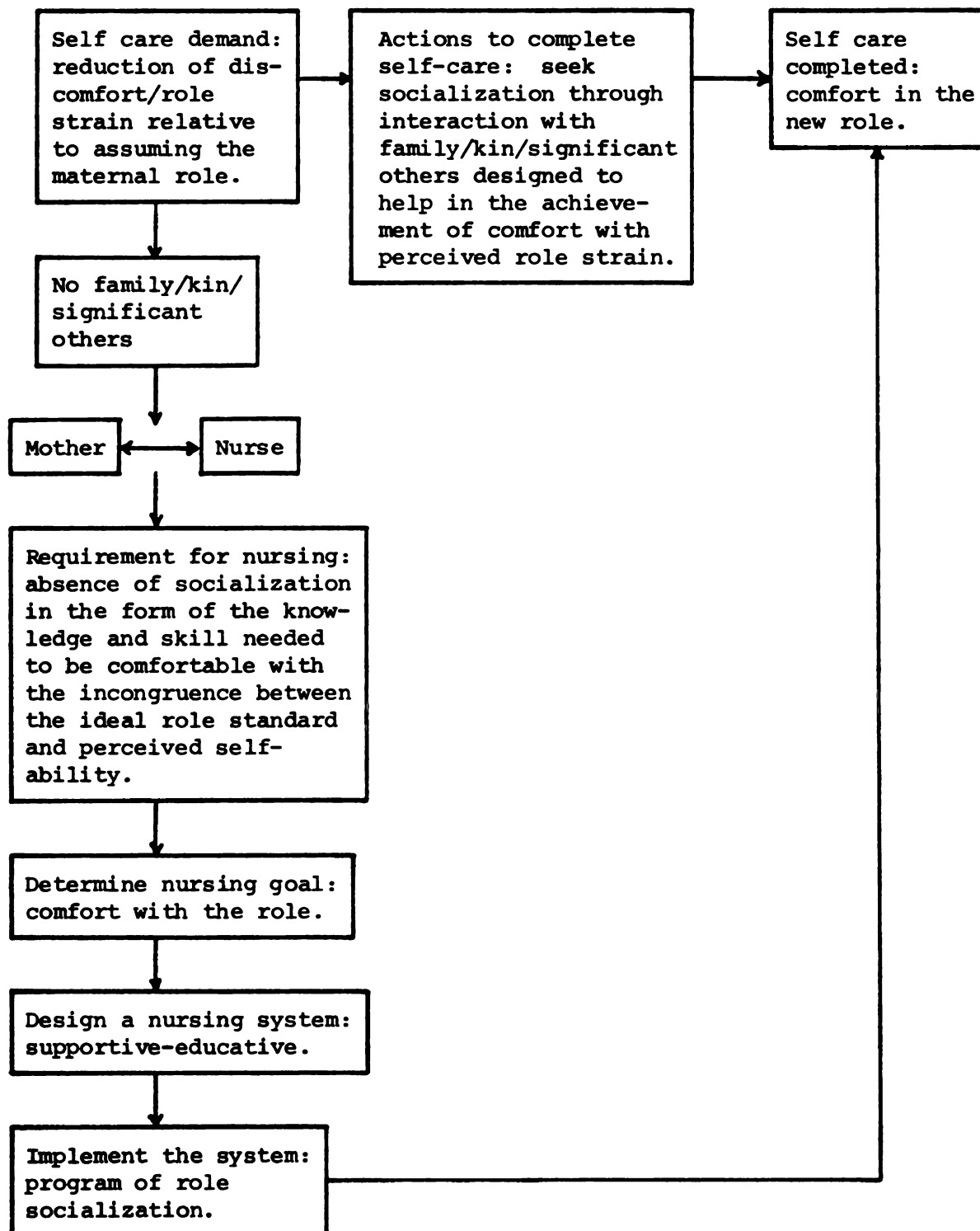
In the case of acquisition of the maternal role, a wholly-compensatory system does not exist except for the extreme

complication possible during the normal reproductive cycle. The partly compensatory system can be utilized well during the intrapartum where the mother is a very active participant within the limits of her ability. The postpartum period most frequently requires the use of the supportive-educative system with the mother playing a vital role in its planning and execution. Orem has identified two parts of this system, support and teaching, which can be used to assist the mother in learning to perform the therapeutic self-care measures she needs to be comfortable in her new role. Incorporating role theory and using the techniques of nursing assistance in the supportive-educative nursing system as proposed by Orem, a program can be designed to provide realistic role socialization at the point where the formal and the informal stages of maternal role acquisition meet. The anticipated outcome of such a program is the reduction of role strain through the use of education and support (see Figure 1).

Three basic role concepts, the social self, role language, and role behavior, are central to maternal role acquisition. Knowledge of the social self as manifested in the maternal role enables the nurse to devise appropriate interventions for assisting the mother in acquiring the new role. The social self is defined by Meade (1934) as a person's view of himself, "a reflection of the attitudes

Figure 1

OPERATIONAL MODEL OF OREM'S THEORY APPLIED
TO THE CLINICAL SITUATION: ACQUISITION OF
THE MATERNAL ROLE



that others hold toward him," and by Thomas and Biddle (1966, p. 10) as "a sense of personal identity, the set of all standards, descriptions, and concepts held by an individual for himself." The social self is included in this study because of the high level of interrelatedness between role and self, and because if inconsistency between role expectations and self-appearance and performance exists, role strain develops (Sarbin 1954). The nursing function is to assist the mother to identify the range of acceptable performance with which she is comfortable. The concept of social self also includes body image, how she "appears" in the role, e.g., Does she look like a mother should look? Rubin (1967, p. 240) incorporates body image within the concept of social self, believing "Status role achievement is contingent upon body image. Therefore, a new mother needs to feel she has some control over her body and needs to relate satisfaction with how she looks."

Role interactions are circular in that each encounter provides information to the social self regarding performance, information that can be either positive or negative (Heiss 1976). Nursing intervention during the transition between the formal and the informal stages of the mother's role dealing with dimension of the social self development can help to provide the information necessary to establish a positive role base.

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Along with knowledge of the social self, the nurse needs to understand role language as manifested during the maternal-infant interaction, so important to role acquisition. Role languages are defined as: symbols, verbal and non-verbal, that have social referents and are "aids in the perceiving, identifying and conceptualizing of roles and role expectations" (Sarbin 1954, pp. 242-243). The verbal and non-verbal communication of the infant is a language the mother is unfamiliar with and one which has a great impact on the development of the mother/infant relationship. Because the infant has not learned the expected social behavior (i.e., speech, smile), he lacks a means of reinforcing those maternal behaviors which best attend to his needs.

The nurse can assist the mother to develop an awareness of how the infant gives and takes within the relationship and the importance of their interaction. This awareness forms the basis for developing some feedback mechanisms until the infant is capable of employing the appropriate response to the provided maternal stimuli. A better understanding of infant language will be useful in role performance behavior since the mother will continue to evaluate her role performance in relation to how the infant responds to her. If the mother can understand and interpret the infant's behavior and see positive reinforcement for

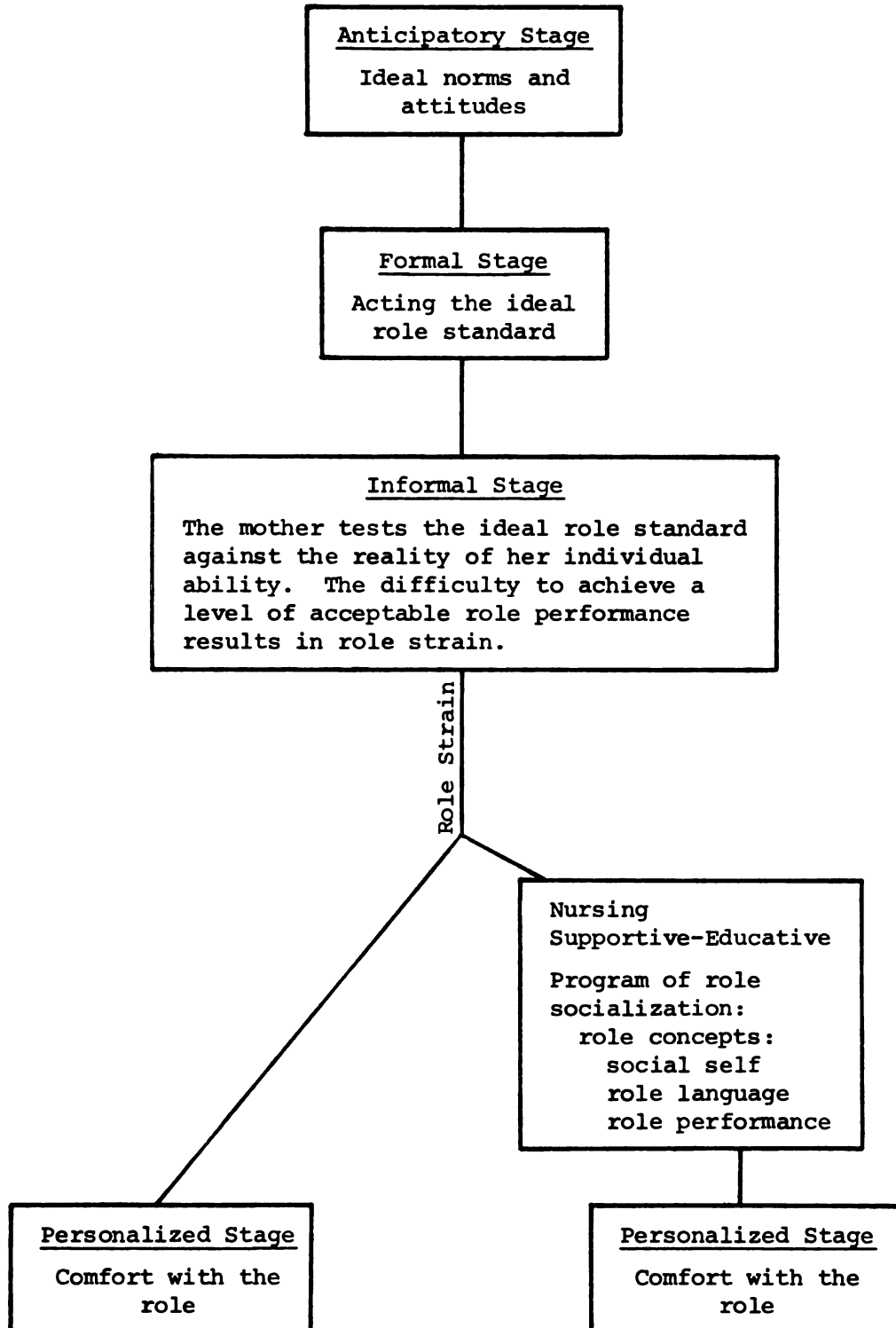
her own, she should become more confident in performing, or taking on the role of mother. However, if she does not understand the cues of the infant, or if she is confused regarding appropriate action, incongruence will occur between the ideal role of mother and the mother's actual performance. She will likely view this incongruence as lack of success, and role strain will result.

Finally, along with knowledge of social self and role languages, the nurse must understand the dynamics of the actual role performance. Role performance is defined as overt activity including gross skeletal movements, verbal and motoric gestures, posture, styles of speech and accent, and wearing of certain forms of dress and the use of material objects (Sarbin 1954, p. 232), "action behavior" (Thomas and Biddle 1966, p. 26), and "role enactment" (Sarbin 1954, p. 232), or role behavior related to infant care, (i.e., diapering, bathing, and feeding). The new mother, having discovered the actions involved in role performance during the anticipatory and formal stages of maternal role acquisition, must now perform. Any incongruence between the obligations and expectations of her role and her performance will cause role strain (i.e., lack of confidence, anxiety over her clumsiness or incompetent actions).

The need to assist the new mother to learn the manual skills necessary in infant care has been addressed by providing postpartum classes during the hospital stay. However, demonstration of skills is not enough. Role strain develops when the new mother does not feel comfortable modifying formal (ideal) role behaviors. The nurse must also, according to role theory, help the mother to understand that modifications of the formal role behaviors can be, and rightfully will be, incorporated into her interpretation and personalization of the role of mother. An understanding of the three concepts of role theory discussed here, social self, role language, and role performance, provide nursing with the tools necessary to support and teach new mothers therapeutic self-care practices designed to ease the normal role strain involved in maternal role acquisition (see Figure 2).

Figure 2

MOTHER ROLE ACQUISITION



CHAPTER III

REVIEW OF THE LITERATURE

The review of the literature will focus on role theory, family structure, and nursing intervention in role development. The objective of the review of the literature is to isolate the complimentary aspects of these areas as they describe the acquisition of the maternal role in the postpartum period and as they direct the formulation of a nursing intervention program.

The postpartum period is an important time in maternal role acquisition. The changing shape of the American family increases the role strain normally associated with initial development of the mother-child relationship. It is appropriate to begin with a discussion of roles, role acquisition, and role strain.

Role Theory

The discussion of role theory provides a perspective of how individuals function and affect each other within a social context. Contemporary role theory regards human conduct as the product of the interaction of self and role. Sarbin (1954) described culture as "an organization of learned behaviors and the products of behavior which are

shared and transmitted" (p. 224). A social position involves sets of learned behaviors, called roles. Social positions are either achieved, based on what the person can do, or ascribed, based on what the person is in terms of sex, age, or family connections. Roles generally involve a complex combination of both achieved and ascribed behavior sets.

The concepts of self, role expectations, and role performance are central in role theory. The concept of self in role theory combines fairly constant cultural norms with the psychological variations of the individual personality. An organized system of role expectations is cognitive and serves as a significant guide and standard for appropriate conduct and behavior. Biddle and Thomas (1966) refer to the "shoulds" and "oughts" that are internalized as norms, while those that are overtly expressed are referred to as role demands.

Role performance refers to relevant role behaviors displayed by a person. The amount of discrepancy between role expectations and actual role performance is a source of conflict especially when the role expectations are unclear, when the individual has not had adequate experience and practice, or when the role is in the process of changing (Thornton and Nardi 1975).

When the individual mother attempts to fulfill the role expectations which surround a position and is unable to

perform the behaviors or exhibit the qualities needed to meet her expectations, she will experience role strain (Goode 1960). Goode posits that role strain is a normal outgrowth of any role acquisition.

The process of new role acquisition as described by Thornton and Nardi (1975) uses a developmental approach containing both social and psychological dimensions. The authors believe social adjustments, or the ability of the individual to perform the role within the level of society's expectations, and psychological adjustment, the "fit" between the individual's expectations of self in the role and the actual role performance, are necessary for comfortable role acquisition. Since there is a high degree of individuality in any role enactment, these adjustments include a certain amount of flexibility as the new role is taken on. Adaptation occurs when the role and the person become inseparable. Thornton and Nardi (1975) suggest that role acquisition involves four basic stages: (1) the anticipatory stage, (2) the formal stage, (3) the informal stage, and (4) the personal stage.

Individuals first develop preconceptions from observing others in the role or from the general socialization process of the culture. Anticipatory and Formal Stage--Once in the new role, formalized behaviors are enacted and tested in the "real" situation. Informal Stage--Social

roles do allow for latitude in performance; therefore, informal behavior with individual interpretation emerges to provide the balance between formal and informal. As the final process of adjustment, adaptation occurs (Personal Stage). Although Thornton and Nardi's model has not been directly investigated, this theoretical approach lends itself to use in this study.

As previously mentioned, role strain increases when individuals lack adequate experience and practice or when the role is being redefined. The changing shape of the family in America today places just such a burden on the new mother. Kennedy's research (1976) supports this. Kennedy studied 10 normal mother-infant couples during the first two weeks of the postpartum period. She found positive and negative responses to the acquaintance process. The mother embarks on this process to discover what her baby is actually like. Kennedy isolated 2 key factors involved in the acquaintance process: (1) the mother's past life experiences; (2) her capacity for human interaction. Kennedy found that the mother who perceives her baby's attitudes toward her as positive is inclined to feel positive in return, continuing the acquaintance process. Through observation and interaction she learns to enjoy her baby and is comfortable with herself in the role of mother. Negative

feelings emerged in part because of inadequate experience and role training. If Kennedy's findings are correct, the mother's past life experience with role models and her capability to communicate with others are important data to obtain when planning health care for new mothers.

In summary, role theory provides a developmental model for the maternal role acquisition process. Role theory also provides a framework to identify the factors involved in role strain. The next section of the literature review will focus on family support and kin structure, and their relationship to maternal role.

Family Support and Kin Structure

Because mother is such a central family role, becoming a mother for the first time clearly involves the family as individual members and as a group of role performers.

A century ago, the family unit was larger, often physically close and multigenerational; being born, working, playing, and dying together, drawing on each other's strengths, offering support during times of stress, and teaching the expected behaviors of the variety of roles within the social unit, including "mothering." Due to this structure, young girls had many opportunities to observe mothering behavior and be actively involved with child care activities with siblings. Assuming the mother role was a social expectation, and during the postpartum period,

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education, support, and guidance from the females within the family were available. If nursing was available, it was provided in the home and supplemented much of the actions already provided by close family members.

With the movement from an agrarian to an industrial society, large families began to disperse and nuclear families became "relatively isolated" (Parsons 1965). As early as 1943, Parsons emphasized this residential and economic isolation of the nuclear family. He believed it to be a result of the geographic mobility brought about by the demand of increased industrialization (Parsons 1943).

Sussman and Burchinal (1962) would argue that the kin network is still a very active part of family life, providing the exchange of services, gifts, advice, and financial assistance. The controversy seems to be one of narrowed vision. Parsons chose to contrast the contemporary with the American family of the past, focusing particular attention to how the nuclear unit has changed. However, Sussman et al. (1959) has evaluated the role kinship networks play in relation to the nuclear family and has chosen the term "modified extended family." But as Gibson (1972) points out, the criterion for the Sussman (1962) research is the quantity of interaction between nuclear and extended family members and not the quality of that interaction. Parsons does not argue that the modern nuclear family is

"totally" isolated, only relatively so. "Of course, with the independence, particularly the marriage of children, relations to the family of orientation are by no means broken. But separate residence, very often in a different geographical community, and separate economic support attenuate these relations" (Parsons and Bales 1955, p. 11). Goode (1960) indicates that family members support each other in the taking on of roles by providing "advice" and "concern." The geographic and economic isolation Parsons identifies clearly alters a family's ability to directly support role acquisition and reduce role strain. Sussman's "modified extended family" (1962) does not allow for such qualitative changes in role support. The problem of maternal role acquisition in Parsons' "isolated family" (1943) becomes one of providing new supports to replace the traditional support systems.

In summary, the acquisition of familial roles depends upon the support provided by the family structure. Traditional family units provided intimate multigenerational education and support. The contemporary American family is less extended and more isolated, creating gaps in the traditional structure, resulting in increased role strain for new mothers. In the next section the literature review will focus on nursing intervention in the maternal role acquisition process, specifically the postpartum period.

Nursing Intervention in Maternal Role Development

Child birthing practices have changed, with more and more deliveries taking place in sterile hospitals, separating the mother from a familiar and comfortable environment, separating the mother and her infant, and separating the mother from significant supporting family members (Newman 1976). Nurses in the 1940-1950's took on the appearance of baby care experts and often made the new mother feel she was inadequate when caring for her baby (Seiden 1976). Thus, the system sent her home from the hospital to take on her new role without sufficient practice or support. LeMasters (1957) reported, after conducting semi-structured interviews with 46 couples between the years 1953-1956, that 83% of the sample identified the adjustment to the parental role as an extensive or severe crisis. During the early adjustment period, LeMasters found the mothers in the study to be chronically tired, suffered feelings of social isolation, were concerned about their body image (added weight, muscle tone), and felt guilty because they were not better mothers. LeMasters' study gives some content targets for nursing intervention. Crisis, however, seems too narrow a term and denotes some type of pathology when in fact the role strain in the adjustment period is part of the normal transition in roles. Because LeMasters' research did not incorporate as tight a

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research design as those who followed, and because crisis is too limited in scope, this research design will not use crisis as a term for adjustment, but rather view taking on the new role as a developmental process (Hobbs 1965).

Hobbs (1965) concluded the beginning experience of parenthood was a period of transition. His sample of 53 couples was selected at random from the public birth records, and responded to an objectively scored check list of 23 items, using a five-point response scale: none, slight, moderate, extensive, severe. Of the sample, 86.8% described as a slight crisis the experience of becoming parents for the first time. Mothers reported significantly greater amounts of difficulty than did fathers. The check list contained several useful items, including: physical tiredness and fatigue, interruptions of routine habits of sleeping, going places, etc., worry about wife's personal appearance in general, worry about wife's "loss of figure," and doubting worth as a parent. When reviewing his results, Hobbs found that couples having difficulty adjusting did not agree upon the variables responsible. No one variable identified seemed related to difficulty in adjusting to the first child. Hobbs concluded that much remains to be done to identify predictor variables which might differentiate between persons with regard to the amount of difficulty they will experience in taking on paternal roles.

Hobbs and Cole (1976) repeated the original study, receiving 65 responses to his questionnaire from couples selected at random from county birth records. The findings confirmed the original research.

Rossi (1968) views becoming a new parent as a developmental phase in the life cycle; for American adults, one where there is little support. Rossi's description of the American family closely resembles Parsons' (1943). "Our family system of isolated households, increasingly distant from kinswomen to assist in mothering, requires that new mothers shoulder total responsibility for the infant precisely for that stage of the child's life when his need for mothering is far in excess of the mother's need for the child" (Rossi 1968, p. 27). Rossi theorized the phases of the role transition involved in becoming a parent to encompass the following: the anticipatory phase (the period of pregnancy), the honeymoon phase (post-delivery period of parent/child attachment), the plateau phase (the middle period of the role cycle when the role is "fully exercised"), and disengagement--termination phase--(the end of role responsibility often seen as the marriage of the child). Rossi's phases are global in scope; other role theorists propose more specific phases that parallel Rossi's. The anticipatory, honeymoon, and plateau phases closely follow the more indepth theory of role acquisition of Thornton and

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Nardi (1975), proposing that within each of Rossi's phases are repeated the four subphases, anticipatory, formal, informal, and personal. Providing role support for the "isolated new mother" will entail understanding these subphases in order to devise nursing intervention strategies appropriate to the particular moments or subphases the new mother undergoes.

The works of Rossi (1968) and Thornton and Nardi (1975) integrate nicely, providing a model for maternal role acquisition that nursing can use to devise effective support and education programs to fill the gap left by the changing family structure.

Within Rossi's (1968) honeymoon phase, Thornton and Nardi's (1975) subphases manifest themselves. Of interest to this study is the initial period of mother-child adjustment, Thornton and Nardi's transition between formal and personal subphases.

Rubin has long been recognized as a scholar and researcher in nursing who has acknowledged the importance of role theory in understanding the adjustments made in the family when a new member is added. Rubin's early work (1964, 1967) provides a background for the later identification of specific factors which assist the mother in the acquisition of the maternal role. Rubin (1964) defines a role as half a relationship. "For each role there is a complimentary reciprocal role" (p. 36), i.e., mother and child.

It is important that each member in the relationship identify the other. This process allows each member to "assess the personal implications of this new relationship in terms of the scope and limitations of one's role. The new mother who finds her baby so 'little and helpless' feels she should be big, protective, and a pillar of strength and wisdom" (Rubin 1964, p. 37). New mothers then need to understand the "nature of infant communication" (Rubin 1964, p. 38).

Rubin's statement is supported by the findings of Robson and Moss (1970) who studied 54 primiparous mothers in relation to their feelings of infant attachment. The study included pre and postpartum interviews, tape recorded 1½ hours long, and home observation from birth to 3 months of life. They concluded that patterns of attachment are determined by the interplay of maternal attitudes and specific infant behaviors.

During the first 3 to 4 weeks at home, mothers were: tired and insecure, focused energies on mastering the tasks of infant care, fearful of injuring the babies by handling them ineptly, and concerned with their inability to control their infants' crying, food intake, and sleeping patterns. The mothers were uneasy because they felt they could not communicate with their babies.

Communication with the partner in the relationship is essential. Because the infant often does not contribute

to the interaction in a way that the new mother understands or expects, the relationship may be strained. "A one-way relationship is difficult to bear" (Robson and Moss 1970).

Continuing to use role theory as a base, Rubin (1967) conducted a research study to determine how the maternal role was acquired. Five long term tracer subjects, primiparas, were interviewed in an unstructured style an average of 23 times, while four long term tracer subjects, multiparas, were interviewed in an unstructured style an average of 11 times, during their pregnancies and up to four weeks postpartum. At the same time, 70 control subjects were interviewed to provide cross-sections in time situations. The sample came from 2 hospitals, drawing from both private and university maternity services. The interviews were conducted during the antepartum, either with office visits or in the home, and in the hospital daily during the postpartum stay. By not directing or structuring these interviews Rubin gathered spontaneous responses to parental adjustment inquiries. The data collected was classified in three dimensions: (1) the self system, including the ideal image, the self-image, and the body image; (2) the taking-in process; and (3) role models. The results demonstrated a higher frequency of role-taking statements by multigravidas than primiparas.

The greatest number of statements made regarding the self system by primiparas during the antepartum were those related to the ideal image defined as "those qualities, traits, attitudes, and achievements that each subject found desirable for maternal behavior" (Rubin 1964, p. 240).

During the postpartum period the self-image, or the self in the here and now, was of greatest concern. The taking-in process encompassed five distinct operations: (1) mimicry, (2) role playing, (3) fantasy, (4) introjection-projection-rejection, and (5) griefwork. The end goal of the process Rubin identified as identity or "I am the role." Selection of role models tended to be gender and situation specific, beginning with the subject's own mother and progressing to peers. Primiparas tended to select peer models outside the family. This research allows Rubin to further expand on her theory regarding the need to identify the partner with whom the anticipated role is to be enacted. She established that the identification of the partner followed the same five operations of role taking, and the extent of role achievement was largely dependent on the extent of partner (infant) identification.

Rubin's research identifies the individual process of role taking. The focus is on the antepartum and only briefly on the postpartum period (her contact with postpartum subjects was limited to the time of hospital confinement).

In a paper dealing specifically with the postpartum period, Rubin (1977) introduces "binding-in" as a term describing the initial role development between mother and child. Binding-in as a process "is active, intermittent and accumulative, and occurs in progressive stages over a period of 12-15 months" (p. 67). This process begins during the pregnancy itself with the perception of fetal movement. After delivery the process accelerates, moving from a symbiotic relationship to one of separate reciprocal roles, mother and child.

Maternal "binding-in" during the postpartum period has three mutually dependent aspects: (1) polarization, the psychological loosening of the infant from herself to accepting the infant as an independent human being; (2) identification of the infant in reality instead of fantasy; (3) claiming of the infant by association with significant others (i.e., the baby looks like Aunt Sue). Factors that determine the length of time required to bind-in to the role relationship are: (1) the mother's own recovery and state of well-being; (2) the amount and kind of socially significant support available; and (3) the endearing inputs of the baby itself. Rubin (1964) believes nurses are viewed by family members as knowledgeable resource people when the family is trying on new role relationships, and therefore is in an opportune position to influence the outcome of the changing roles and family relationships.

Recognizing the transitional nature of role acquisition and the "binding-in" process in maternal role acquisition, this study will develop a complete intervention program, implemented by nursing in the postpartum adjustment period and designed to reduce role strain and ease the postpartum adjustment necessary for new mothers.

To support nursing's role in this process, Brazelton, drawing on his experience with infant and maternal attachment, believes professionals can provide supports. "If we can support parents to feel secure, and if we can then support them in developing awareness of their baby's assets as well as deficits, we should be able to play an important role in starting them on the road to parenthood" (Brazelton 1976, p. 379). The postpartum period is a time when support and concern are greatly needed. Benedek (1949) stated, "The postpartum mother, for many reasons, has a regressive tendency, and therefore has a great desire to be mothered" (p. 644). It is through receiving love from others that she is able to give to her child. Therefore, a key function for nursing is to provide the support, concern, and guidance needed either directly or through the identification of support structures in the environment which could meet the new mother's needs.

Researchers have recognized the importance of the postpartum period, but have not tested intervention programs for this period. Gordon and Gordon (1960) were able to

reduce the incidence of postpartum "emotional upsets" by including two antepartum classes focusing on the psychological adaptation to motherhood. Control and experimental groups of prenatal couples attended identical antepartum classes conducted by the Public Health Service of the community hospital. The experimental group participated in an additional two 40-minute instruction periods on the psychological and social adjustment of the postpartum period. Some important points covered included: (1) The responsibilities of being a mother are learned; therefore, ask for help and advice; (2) get plenty of rest and sleep; (3) don't give up outside interests. The experimental group did significantly better than controls when their adjustment was judged at six weeks and six months by the attending obstetricians. This demonstrated that using anticipatory guidance to facilitate role acquisition is a technique which can be used to reduce role strain. However, this approach is not the total answer. Gruis (1977) found, when questioning a total of 40 mothers one month after delivery, that providing anticipatory guidance for the puerperium during the prenatal care may be convenient for health care. It should not be viewed as a "catch all" for areas of need. The new mother needs to be provided some link with the support structure of the health care system. Gruis suggested (1) 2-week rather than 6-week checkup,

(2) 24-hour hotline linked to the hospital maternity unit, (3) home visits by public health nurses.

In this study, Gruis identified the foremost concerns of primiparas as: (1) return of figure to normal, which Gruis sees as part of the accomplishment of the task of physical restoration; (2) regulating family demands or incorporation of the new member into the family system and adjusting to the changes in life style that this requires; (3) understanding infant behavior, encompassing the development of a satisfying relationship between mother and infant. Concern for physical care of the infant seemed minimal, and the author reasoned this was due to the prenatal emphasis given this area and postnatal classes in the hospital.

Cronenwett (1976), first looking at the effectiveness of group support for childbearing families and ways of coping with the experience, established a group designed to help new parents during the postpartum adjustment period. These support groups give information and advice, and provide reassurance and support. While the Cronenwett experience is limited, the results of the group are positive. The group did indeed fill the need for support and education felt by new parents. However, as Cronenwett (1976) points out, several questions are still to be answered, "(1) For what segments of society are lay support groups effective? (2) What factors contribute to the success or failure of

the groups? (3) Should groups be formulated on the basis of a particular focus (e.g., cesarean section mothers)? (4) When is the best time for initial formulation of the group--during the antepartum period" (p. 187)? This approach may be one way of dealing with the anxiety and stress of new parents.

Various methods of nursing intervention to assist in the alleviation of these role adjustment problems have been proposed: the specific inclusion of postpartal concerns into expectant parent curricula (Gordon and Gordon 1960); nursing's continued involvement in teaching infant care tasks; actively including exercise and diet regimens in postpartum classes (Gruis 1977); establishing community support groups (peer and professional) for encouragement and assistance (Summer 1977).

For this study, a program to meet the new mother's need for support and education included the following concepts: the social self, infant communication, and role performance, and was supported by the following research studies.

Perdue et al. (1977) stresses the importance of maternal self-development. She points out that to focus exclusively on the infant's growth and development does not take into consideration the mother's progress as a person.

The task for the nurse, then, is one of anticipatory guidance to help mothers identify areas where infant and mother's needs may clash, and assist the mother to identify strategies designed to reduce role strain. This can be done by educating and supporting her as she assumes the new role, providing her with a realistic picture of the infant's needs, and her abilities and resources; helping her to see that she need not lose her self-identity in the mother role.

Brown and Hurlock (1977), while conducting a study on the effectiveness of accepted methods on preparing the breasts for breastfeeding in a sample of 60 mothers, with contact every day in the hospital and every other day after discharge for a total of 2 weeks from the day of delivery, determined that new mothers need to be mothered themselves. The researchers (all nurses or student nurses) felt comfortable providing the support and knowledge requested by the sample. One recurrent question had to do with diet and weight loss, demonstrating interest in body image. Corbeil (1971) points out that the quality of the disturbance in a changed body image is much more related to the individual's perception of it than to the actual fact. This closely parallels Rubin's (1967) thinking that a positive body image is necessary; without it the mother risks role failure and low self-esteem. The mothers in Brown's study expressed

concerns about the baby centering around the following areas: crying, feeding, sleeping, stooling, and weight gain. The need to provide a gender specific teacher to instruct new mothers regarding mothering skills and to provide her with emotional support was verified by the mothers in the study, who almost always expressed gratitude for the nursing service.

Kennedy (1973) stresses the need to teach new mothers about infant communication and individualize to assist the mother-infant identity process in a positive manner. The importance of the infant's behavior in eliciting positive or negative interpretations from the mother is now being recognized. Kennedy found that mothers thought their infants liked them if their babies nursed eagerly, cuddled, smiled after feeding, listened to voices, quieted when touched, and slept for long periods. Mothers felt their babies did not like them if the infant refused to suck, vomited, cried during or after feedings, turned away from touch, resisted being held closely, or closed their mouths firmly.

The findings of Adams (1963) conclude that a large population of new mothers experience relatively inadequate role behavior education. Adams studied the concerns of 40 primigravida mothers regarding their ability to provide the care-taking needs of the infant. It was found that the areas of concern ranked in the following order: feeding,

bathing, crying, care of the navel and/or circumcision.

One general finding of interest is that of her total sample, only 25% had prior experience caring for a newborn.

Summer (1977) identified the need for support.

When conducting a study of phone call concerns of new patients to health care facilities, found that while many new mothers phoned to ask questions related to infant care instruction, the real reason for the call seemed to be validation of their ability to handle the problem.

Summary

Acquiring a new role inevitably involves some role strain, especially during the transition periods between anticipatory, formal, informal, and personal stages of role development. Role studies indicate the value of intimate role models and supports in the easing of role strain. The maternal role is typical in this respect. The woman undergoes anticipatory and formal socialization throughout her childhood and up through delivery. Birth clearly divides these formal stages of role development from the informal and personal stages. Traditionally, family structures have provided the educational and psychological supports new mothers needed to move comfortably into their new roles.

The increased isolation of the nuclear family has necessarily weakened or even removed these traditional supports. Given the importance of the mother-child

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relationship to the overall health of the family, the health care system can logically intervene and assist new mothers to adapt and adjust to motherhood.

Currently, the health care system treats mothers extensively during the antepartum and intrapartum periods. If role and family theorists are correct, and role adjustment involves informal and personal stages where support and education ease adjustment, then the health care system should continue intervention into the postpartum period.

Some programs now in existence identify considerations and concerns valuable to new mothers. But these programs tend to be selective and limited, focusing primarily on teaching mothering skills. Only rarely do they deal with helping the mother to feel positive about herself or teach the mother infant communication skills necessary for effective mother-child "binding-in."

This study proposes integrating these separate concerns; the mother's social self, knowledge of infant communication, and mothering skills into a nursing program of education and support designed to supplement traditional family role support.

CHAPTER IV

METHODOLOGY AND PROCEDURE

Overview

This research was designed to implement and test the effect of a program of role socialization on new mothers in the immediate postpartum period.

The program applied a nursing intervention in the form of role socialization designed to facilitate acquisition of the maternal role. The program involved the following role concepts: social self, role language, and role performance as they applied to acquisition of the maternal role.

Using a two-stage screening process, a subject group of pregnant women was selected from several large group obstetric and gynecology practices located in an urban community with a population of approximately 200,000. The majority of the client population for this study was white and paid privately for their care.

The primary data collection instruments for this study were the Basic Data Profile, the Ideal Mother Index, and the Self Mother Index. The research questions were formulated based on a review of the literature and personal experience as a practitioner. Data were collected from subjects prior

to labor and delivery, from the medical record, and three weeks postpartum. The results were analyzed to determine if a program of role socialization provided to new mothers early in the postpartum could reduce the strain felt while adapting to the maternal role.

A pilot study using eight patients was conducted to test the procedure and the instruments. Revisions that resulted from the pilot test included rewording several items on the indices and refining program content to limit interaction time and to standardize the program content. After revisions were made, the study was conducted.

The purpose of this chapter is to present the methodology and procedure used to provide an experimental program of role socialization to new mothers. Included is an outline of procedures and an explanation of how the testing instruments were developed (for complete program content and a copy of the instruments used, see Appendices).

Population

The initial step in selecting the subjects was to develop the following criteria for identifying subjects to be included in the study.

- (1) 38-42 weeks pregnant
- (2) low-risk pregnancy identified by an absence of the following:

- (a) chronic kidney disease
 - (b) cancer of the cervix or uterus
 - (c) diabetes
 - (d) history of rheumatic fever
 - (e) toxemia: 3+ proteinuria, edema of the face and hands, diastolic blood pressure above 90
 - (f) viral infections during the first 12 weeks of pregnancy
 - (g) heart disease
 - (h) chronic hypertension
 - (i) chronic respiratory disease
 - (j) major endocrine disorder
 - (k) psychiatric disorders
- (3) married at least one year before this pregnancy
 - (4) This pregnancy is the first carried to term.
 - (5) literate with the English language
 - (6) verbalize a willingness to participate
 - (7) unable to identify a sustained support individual to assist her with assumption of the maternal role

The researcher reviewed office records to identify possible study participants who met the Stage I criteria.

This stage in the screening process included approximately twice as many subjects as the design of the proposed study required, to allow for attrition due to an inability to meet the criteria for continued participation.

Forty-two subjects were identified from the total possible population of three private group office practices of obstetricians. This group was obtained by review of each office record of primiparas clients due to deliver their first babies between February 20, 1978, and April 3, 1978. The office practices were large, each seeing a volume of between 40-60 new obstetric clients each month. The three were in different geographical locations of the community, providing access to a cross-section of clients from the outlying areas to the inner city. The community had a large number of childbearing-age women who are re-located here to use the educational setting of the state college. Perhaps this added to the number of clients found in this population who were separate from a sustained support individual.

Data Collection Procedure

After 42 pregnant women were identified from the records, the office nurse contacted each by phone, generally introducing the study, requesting participation of the subject, and asking questions to determine if she would or would not have a sustained support individual¹ to

¹Sustained support individual defined as: a female who is trusted and depended on for support and information regarding infant care, and who will live in with the new family for more than ten consecutive days, starting at the time of hospital discharge (or within the first week) and extending through the first six weeks postpartum.

assist her with assumption of the maternal role. Any woman with access to such a support person was not included in the research sample. The office nurse made the initial contact for two reasons. First, it was believed that if the office supported the study, the client would be more apt to become involved and perceive the interaction as positive. Secondly, providing a neutral party to obtain consent, the client would feel free to refuse without threat or pressure. The nurse allowed questions and assured the individual she did not have to agree to be part of the research group. All 42 identified subjects were asked to participate in the study. Twenty-seven agreed. Upon consent, the name of each client, having met Stage I criteria, was given to the researcher and the criteria form (see Appendix F) was begun for each study subject. This information (consent form, Basic Data Profile, and Ideal Mother Index) was filed by the researcher until the subject delivered. Because the program was designed to be implemented in the postpartum, no further contact with any of the subjects was made until after delivery.

The researcher checked the delivery records of the local hospital daily to ascertain when each subject delivered. Continued participation in the study was dependent on meeting the Stage II criteria:

- (1) Completes an uncomplicated labor and delivery course.

Uncomplicated defined as:

- (a) labor not to exceed 24 hours (Pritchard and Hellman 1971, p. 396)
- (b) a vaginal delivery which may be assisted by low forceps, episiotomy, analgesia, and anesthesia

- (2) Infant Apgar scores of 6 or above at birth, 1 and 5 minutes

- (3) Physical exam findings on the infant are normal.

- (4) Physician's statement of mother's health is satisfactory.

Satisfactory defined as: hemoglobin level greater than 10 gm. Delivery blood loss of less than 500 cc.

- (5) Infant admitted to term nursery.

- (6) Infant discharged with mother.

- (7) Expresses a willingness to continue in the study.

These criteria were selected based on the literature as being within normal limits of pregnancy outcome for mothers and indicative of a normal adaptation pattern for the newborn.

Group assignment (socialization program and non-socialization program) was alternated depending on the order of delivery. The first subject to meet the criteria for continued participation was assigned to the program group,

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the second such subject was assigned to the non-program group, until there were 10 in the program group and 10 in the non-program group and all of the original sample had delivered.

Both groups were exposed to the same in-hospital postpartum course. They had the opportunity to attend classes taught by a registered nurse covering the following topics: "Infant Care"--how to bathe and diaper; "Infant Feeding"--including both breast and bottle feedings; "Parenting"--discussion and film centered around concerns parents have about being adequate; "Birth Control"--methods and reliability. Each had an equal opportunity to ask questions and practice infant care and feeding.

During the hospital stay, all subjects were contacted in person by the researcher. This face-to-face interaction on the maternity unit occurred during the first or second day postpartum. After a brief statement to the subject regarding her group assignment, for the non-program group contact would be made at the three-week follow-up, and for the program group contact would be made on the day of discharge.

For each subject in the program group an appointment was made by the researcher, at the subject's convenience, for a meeting in her home during the afternoon or evening of the day of hospital discharge. The purpose of this appointment

was to provide a program of role socialization to the new mother. This could be done with or without family or friends present. This contact required no less than 60 minutes or more than 90 minutes.

The day of discharge was selected for program intervention because the researcher felt that it was at this critical point when the formal role behaviors would clash with the informal. A pilot test of the program indicated that 90 minutes was sufficient to present the program and still provide the new mother the opportunity to ask particular questions or address concerns not included in the program.

The program of role socialization began with an overview. This nursing intervention was designed to help new mothers become comfortable with their role by providing information to help them understand themselves and their babies, develop confidence in their maternal role (i.e., diapering, bathing, understanding baby language), skills, and satisfaction with their abilities as mothers. Next, the researcher proceeded with a discussion designed to foster a positive social self and body image. It was necessary to discuss social self and body image because ego strength is weak during the early postpartum period (Benedek 1949), and mothers traditionally are dismayed over the changes their bodies have undergone. Rubin (1967) found every change in body image to be significant. "Loss of

functional control lowers self-esteem and raises the risk of role failure. When the pregnancy is terminated, all vestigial traces in body and clothing must be abandoned quickly" (p. 240). Open-ended questions which were exploratory, clarifying statements, and active listening were employed by the researcher to gain an understanding of the mother's view of self in the new role. The researcher then selected the appropriate anticipatory guidance and support information necessary to improve the subject's social self-image.

Following social self concept, the researcher introduced the concept of mother/infant role language. This allowed the new mother the opportunity to become aware of how her infant communicates with his environment and how her care can enhance emotional and physical development. Since the baby and mother are active participants, the emphasis here was on the reciprocal nature of the social interaction. This understanding allowed the opportunity for positive feedback during the early weeks of their relationship before the infant responds with the expected social language.

Discussion of comfort with role performance and learning role behaviors, or the skills necessary to care for baby, were individualized, allowing time for demonstration, practice, and further clarification of mothering skills.

These skills included diapering, bathing, formula preparation, breast care, circumcision care, and various caring and holding techniques which provide support and stimulation, i.e., football, sling, papoose, infant seat, dressing skills, and comforting measures. Emphasis was placed on the fact that mothering is a learned skill, one that takes time and practice to acquire. Finally, this stage included some anticipatory guidance related to the changes the new baby will bring to the mother's life style such as altered family pattern, changes in the husband and wife relationship, and ways she might adapt to lessen the stress and more comfortably assume the new role. The freedom to change and modify the role to "fit" the individual was discussed as formal behaviors contrasted with the informal. Each subject in the program group was given a packet of material that was developed to reinforce these concepts and to be used as reference. At this time, appointments for three-week follow-up visits for the program subjects were made.

Evaluation of the impact of this program consisted of all subjects repeating the Ideal Mother Index and completing the Self Mother Index questionnaire 3 weeks postpartum. This time window was selected because it was believed that role strain would be at its peak at this point; any later and some adjustment occurs (Caplan 1959; Aquilera and Messick 1974).

Methodology of the Study

The experimental design of this study used a small sample t test to identify differences between the program and non-program groups, because the total sample did not exceed thirty.

The t test is based on the following assumptions: (1) random assignments of the sample, (2) normal distribution of the characteristics in the population, (3) equality of population variance with an equal μ in each group. Assignment of the sample to the program or non-program group does not conform to the strict definition of the random assignment of the first assumption. However, because the procedure can be defined to be a series of random samples of one, because of the measurement scale used, and because of the robustness of the technique with respect to the other two assumptions, the t test is the most appropriate measure of statistical analysis.

Hypotheses were developed to address questions about the differences in role strain between the program and non-program group, in addition to questions about the components of role strain that were measured by particular items on the Self Mother Index.

The alpha level for the t test was set at .10 because of the nature of the study (testing a program) and because the chance of a type one error (rejecting a true null) is not potentially harmful to the research subject.

In addition, a second part of the study was to address the question of the difference between pre-Ideal Mother Index scores and post-Ideal Mother Index scores in the program group. In this hypothesis using a difference score, two assumptions were made: (1) random selection of paired observations (scores), and (2) normality of differences in the sample. The t test was again selected as the appropriate measure of statistical analysis.

Instruments

The following section will deal with the development of data collection instruments, instrument pre-testing and scoring procedures (see Appendix E).

The initial content for the ideal self index was suggested to this researcher by Deborah Tanzer (1967), while the scales, administration, and scores were developed from the techniques of Elsie Broussard (1971).

The instrument was developed by the researcher after it was determined that none existed. One study that used the self/ideal difference as a measure of self-image administered one month after delivery was conducted by Tanzer in a study regarding natural childbirth. The instrument itself was not available for this researcher to peruse; however, a phone conversation with Tanzer (Summer 1978) was helpful in providing understanding regarding procedures for developing such an instrument.

Broussard (1971), investigating maternal perception of the first born, used a neonatal perception inventory which asked the mother (on the first or second day postpartum) to describe the average baby and then to describe her own baby on a six-item inventory scored on a five-point scale. The mothers repeated the two inventories when the infant was four weeks of age. The scoring was of particular interest to this researcher. Each item added to total an "average baby score" and "your baby score"; the two were then subtracted to determine the discrepancy score.

In preparing the research instrument, a list of 25 ideal qualities and actions was generated from the literature; pregnant and newly delivered women were asked to rank the qualities and actions in order of importance. In addition to these rankings, the women were asked to generate response to the following open-ended statements:

"A mother is _____."

"A mother does _____."

No limit was placed on the number of responses a woman could list. Seven individuals completed the task, 4 who had yet to deliver and 3 second day postpartum mothers. Using the responses of these subjects, a new list was developed using the top ten ranked statements plus ten suggestions offered by the subjects. The new instrument had only 20 items, asking the subject to rank the statement, connect with lines those they saw as the same, and fill in the blanks.

"A mother is _____."

"A mother does _____."

These suggestions were pooled to avoid duplicates and added to the list of 20, while the statements which were consistently unranked were deleted from the total. This new instrument was submitted to 12 additional subjects who identified no new qualities or actions.

To pre-test the refined instrument, it was given to eight subjects who met the proposed research criteria on their second day postpartum. The Ideal Mother Index was completed first, taken from the subject, and then the Self Mother Index was completed. A period of 8-22 hours elapsed before each subject again responded to the questionnaire. The test re-test correlations for the Ideal Mother Index and the Self Mother Index were $r = .858$ and $r = .823$, respectively. These correlations are sensitive to sizes of the sample, but were acceptable for this study. Each of the eight subjects, after completing the questionnaires, were asked if there were any statements which were unclear, and if the directions were understandable.

A few editorial changes were made to take the suggestions into account. One new statement was added to even the number of statements for each variable, and the Self Mother Index was rephrased to refer directly to the subject as "I."

The scoring procedure was as follows: Role strain, the dependent variable, was the difference between the post-ideal mother score and the self mother score at the three-week follow-up. The Self Mother Index was designed to allow the researcher to score each of the three sub-concepts, i.e., social self, role language, and role performance (see Appendix I for complete scoring instructions).

The pre and post-ideal scores of the program group were evaluated for differences to determine if the ideal model was changed 3 weeks after assuming the role. By subtracting the pre-ideal from the post-ideal score of each individual a mean and variance of the difference scores was then calculated and a t score computed.

Socialization Program

The program consisted of the content found in Appendix G. The concepts presented were the social self, role language, and role behavior. After a brief introduction, the order of the presentation was determined by the subject. The discussion of social self dealt with body image, feelings about role changes, with anticipatory guidance and nursing intervention designed to foster positive feelings about self. The program provided information regarding infant communication which could help the new mother understand more fully infant behavior. The "hows" of caretaking skills or role performances were reviewed and

each mother was given an opportunity to ask questions, have techniques demonstrated, or practice a particular skill with which she felt uncomfortable. Briefly, the main areas of caretaking skills identified in the literature were reviewed for each mother. To ensure all areas were covered, an instruction sheet (see Appendix H) was completed by the researcher on each program subject.

To ensure human subject protection (see Appendix A), careful consideration was given to the selection of subjects, the design of the study, and the manner in which the data was displayed. Written permission was obtained from each subject.

CHAPTER V

DATA PRESENTATION AND ANALYSIS

Overview

In this chapter, findings based on the interaction with the new mothers and data collected from the 20 subjects included in the study will be presented. The presentation of the findings will be divided into: (1) descriptive information of the study population, (2) descriptive information relative to the program and non-program groups, and (3) data presentation for each of the hypotheses.

Descriptive Information of the Study Population

A total of 42 subjects who met Stage I criteria was identified. Fifteen of that number, when contacted by the office staff, preferred not to participate in the study. Nine of the fifteen were already involved in another study, and six had other reasons for opting not to become research subjects. The remaining 27 comprised the original study group. One subject was lost to the study because she delivered before the pre-delivery Basic Data Profile and pre-Ideal Mother Index could be administered. Another subject was lost because she developed toxemia prior to delivery. Four subjects were omitted because they were delivered by

cesarean section. One subject was deleted from the study because her infant was born with multiple anomalies. The final sample consisted of 20 subjects, 10 in the program group and 10 in the non-program group.

Non-Program Group Description

The Basic Data Profile revealed the following descriptive information about the non-program group. The mean age was 25.9 years, with ranges from 22-34 years. The average number of years married for this group was 2.6, with a range of 1-4.5. The mean for the item related to adequacy of experience caring for infants was 2.7 (on a 4-point scale). The mean for the item related to feelings of adequacy in observing care of infants was 2.9 (on a 4-point scale). The group rated their mothers' performance as a role model more satisfactory than unsatisfactory, with a mean of 3.6. Subjects in the non-program group had an average length of labor of 13.1 hours, with a range of 8-20 hours. The second day postpartum hemoglobin values averaged 12.1 and ranged from 10.6-13.4. Eight of the ten pregnancies in this group were planned by the couple. Nine of the ten subjects attended prenatal education classes in the area. A summary of the descriptive data for the non-program group appears in Table 1.

TABLE 1
DESCRIPTIVE DATA FOR PROGRAM AND
NON-PROGRAM GROUPS

Descriptive Item	N = 10 Program Group		N = 10 Non-Program Group	
	Range	$\bar{X}$	Range	$\bar{X}$
Age	22-29	25.1	22-34	25.9
Years married	1.5-5.5	3.2	1-4.5	2.6
Length of labor	6.5-23	13.9	8-20	13.1
Hemoglobin 2nd day postpartum	10.8-13.4	12.3	10.6-13.4	12.1
Experience caring for infants (scale: inadequate 1 - adequate 4)	1-4	2.2	1-4	2.7
Experience observ- ing care of infants (scale: inadequate 1 - adequate 4)	1-4	2.6	2-4	2.9
Mother's perform- ance as a role model (scale: satisfactory 1- unsatisfactory 4)	3-4	3.8	2-4	3.6
Prenatal classes	10		9	
Separation from infant	9		3	
Planned preg- nancy	9		8	

Program Group Description

The Basic Data Profile provides the following information for the program group. The mean age was 25.1 years with ranges from 22-29. The subjects had been married an average of 3.2 years with a range of 1.5-5.5. In addition, the data profile provided information dealing with adequacy of past experience caring for and observing care of infants. The means of these measures were 2.2 and 2.6, respectively. On the item designed to evaluate the subjects' satisfaction with their mother's performance as a role model, the mean was 3.8. Data obtained from the hospital record during the intrapartum identified the average length of labor for the program group to be 13.9 hours with a range of 6.5-23 hours. On the second day postpartum the hemoglobin level for program mothers was 12.3 with a range within the group of 10.8-13.4. Nine of the ten pregnancies for this group were planned by the couple. All subjects in this group attended prenatal education classes. A summary of the descriptive data for the program group appears in Table 1.

Descriptive Information Relative to the Program and Non-program Groups

The program was provided in the subject's home on the day of discharge from the hospital at a time convenient for the new mother. Only two of the subjects were alone

with their babies during the program presentation. Five of the sample had their husbands present and they were included in the discussion of program content. One subject had her mother with her and another had her mother-in-law present. The last subject was at home with her baby and her father-in-law who played with the baby during the program and did not enter into the discussion. The program length ranged from 60-90 minutes with an average of 81.5 minutes. After an introduction, an overview of the program was provided by the researcher, and the mother then directed the program. Six subjects selected the content related to the social self to be first. Four subjects selected role language and the areas related to infant communication first. Role performance or skills was not addressed by any subject first. The program subjects were instructed not to contact the researcher during the three-week interval before the second set of criteria was collected.

When the program group was asked the open-ended question at the three-week follow-up visit, "What about the program was most helpful?" one respondent identified the information concerning mothering skills, four identified the added information about infant communication, and five identified the material related to social self.

Both groups were asked the question "What questions have you had since you came home from the hospital related

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to yourself or your baby?" In the program group, six mothers identified infant care concerns (i.e., bathing, how to know when baby is sick, feeding, normals for infant weight gain, understanding crying) as areas for questions. Four mothers had concerns dealing with their own health and body functions (i.e., lochia, chronic fatigue, minimal weight loss, breast care). The sources of help identified by these mothers to answer questions and provide information for their concerns were: four of the ten asked professionals (doctors and nurses), three asked family members, and the remaining three turned to friends.

The non-program group had questions dealing with the same concerns. Four mothers raised questions related to caretaking skills (i.e., infant sleep patterns, feeding schedules, and infant skin care). Three mothers expressed concerns about their own bodily functions and unhappiness related to their view of themselves in other roles (i.e., wife, job, friend). The remaining three had questions regarding the infant's crying, behavior, and infant personality factors. The non-program group also asked help of family, friends, and professionals. However, two subjects in the non-program group were unable to identify a source of help. Consequently, their questions had remained unanswered.

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At the three-week follow-up visit when the mothers were asked if they had left their babies with others for at least 1 hour, nine of the ten subjects in the program group had separated, while only three of the non-program group had.

Data Presentation for Each of the Hypotheses

As indicated in Chapter IV, hypotheses were developed to compare scores of the program and non-program groups (see Appendix J for the null and alternative hypotheses for statistical analysis) of the study. The results of this analysis demonstrate impact of the program of role socialization on role strain and its component parts social self, role language, and role performance. The formulas for this analysis (see Appendix J) computed means and variances, becoming the information that was used to calculate (1) a pooled variance, and (2) a t score. The remainder of this section will address each hypothesis, present the research findings, and state an acceptance or rejection of the null hypothesis based on the statistical evidence.

Presentation of Hypotheses

Hypothesis 1: New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly lower scores on a measure of role strain than those mothers who did not receive the

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program. The role strain raw score was the difference between the self and the ideal index at the three-week follow-up visit. The range for the program group was 0-13 with a mean of 5.3. The non-program group range was 0-37 with a mean of 10.8. This hypothesis is rejected because there is statistical significance with a critical $t = -1.59$ (see Tables 2 and 3).

Hypothesis 1A: New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of social self than those mothers who did not receive the program. The social self score was obtained by scoring the seven items which define social self on the Self Mother Index which was administered at the three-week follow-up visit. Seven items covered this concept and a scoring total of 42 points was possible. The range for the program group was 34-42 with a mean of 38.2. The non-program group had a range of 32-41 with a mean of 37.6. This hypothesis is accepted since the calculated t , .467, demonstrated no statistical significance at a .1 alpha level (see Tables 2 and 3).

Hypothesis 1B: New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of role language than those mothers who did not receive the

TABLE 2
SUMMARY

Variable	Program Group	Non-Program Group
<u>Hypothesis 1: role strain</u> $\bar{X}$ S^2 $S_p^2 = 60.21$ $t = -1.59$	 5.3 22.9	 10.8 97.51
<u>Hypothesis 1A: social self</u> $\bar{X}$ S^2 $S_p^2 = 8.23$ $t = .467$	 38.2 9.29	 37.6 7.16
<u>Hypothesis 1B: role language</u> $\bar{X}$ S^2 $S_p^2 = 10.52$ $t = -.276$	 37.5 4.5	 37.9 16.54
<u>Hypothesis 1C: role performance</u> $\bar{X}$ S^2 $S_p^2 = 9.58$ $t = 1.23$	 38.9 6.32	 37.2 12.84
<u>Hypothesis 2: ideal score</u> $\bar{d} = .3$ $S_d^2 = 3.9$	 $t = .482$	

TABLE 3
SUMMARY OF STATISTICAL TESTS

Hypotheses	Calculated t	Decision Regarding the Null Hypotheses
1 : Role strain	-1.59	reject
1A: Social self	.467	accept
1B: Role language	-.276	accept
1C: Role performance	1.23	accept
2 : Difference pre and post-ideal scores	.482	accept

program. The role language score was obtained in the same manner as the social self. The range for the program group was 35-40 with a mean of 37.5. The non-program group had a range of 27-40 with a mean of 37.9. This hypothesis is accepted. The calculated t score = $-.276$, showing no statistical significance at a .1 alpha level (see Tables 2 and 3).

Hypothesis 1C: New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of role performance than those mothers who did not receive the program. The role performance score was calculated in the same manner as social self and role language. The program group scores range was 34-41 with a mean of 38.9. The non-program group range was 28-41 with a mean of 37.2. This hypothesis was accepted with the $t = 1.23$ below the point of significance with a .1 alpha level (see Tables 2 and 3).

Hypothesis 2: There is no significant difference between the pre and post-test scores of the Ideal Mother Index for new mothers who received a program of role socialization during the informal stage of role acquisition.

The raw data showed a range of difference scores from 0-4 points. Four of the ten subjects received identical

scores on both the pre and post-test. The value of the t test of difference scores was .482. Therefore, the hypothesis was accepted (see Tables 2 and 3).

In this chapter, data was presented relative to each research hypothesis. The general characteristics of the study groups were presented. Discussion of the findings, conclusions, and recommendations for future study will be presented in Chapter VI.

CHAPTER VI

SUMMARY OF FINDINGS

The purpose of this study was to design and implement a role socialization program for new mothers during the informal stage of maternal role acquisition in an attempt to determine if the program would reduce role strain. The model and design used are displayed in Figure 2 (p. 23) and in Appendix C. Specifically, the hypotheses were:

Hypothesis 1: New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly lower scores on a measure of role strain than those mothers who did not receive the program.

A. New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of social self than those mothers who did not receive the program.

B. New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of role language than those mothers who did not receive the program.

C. New mothers who receive a program of role socialization during the informal stage of role acquisition will not have significantly different scores on a measure of role performance than those mothers who did not receive the program.

Hypothesis 2: There is no significant difference between pre and post-test scores of the Ideal Mother Index for new mothers who received a program of role socialization during the informal stage of role acquisition.

Summary of Inferential Findings

Hypothesis 1: The evidence supports the hypothesis that role strain exists for new mothers and that a program of role socialization can be one way of reducing that strain. New mothers who received a program of role socialization did have lower scores on role strain measure; the data identified a significance at the .1 alpha level. These findings suggest the impact of the program was consistent with the theoretical base of the study.

Hypothesis 1A: New mothers who received the program of role socialization did not have a significantly different score on the component of social self.

Hypothesis 1B: New mothers who received the program of role socialization did not respond significantly different on role language items.

Hypothesis 1C: New mothers who received the program of role socialization did not demonstrate statistical significance on items related to the concept of role performance.

However, it was the closest of the program components to reach a statistically critical level.

Hypothesis 2: There was no significant difference on different scores on pre and post-Ideal Mother Index for the program group, indicating a relatively stable ideal mother image.

In summary, role strain exists for new mothers, and a program of role socialization focusing on social self, role language, and role performance, and administered by nurses, reduces that strain. Means were very close. Of the three program components, role performance seemed most important to the subjects in the sample, indicating that traditional emphasis in this area is valuable and effective. The ideal mother image appears relatively stable, supporting theoretical discussions.

Other Findings

Comparison of the two groups revealed that the program group had a lower mean on both items dealing with past experience with infants than did the non-program group (see Table 1). Despite this practice and exposure disadvantage, the program group rated their mother's role model

performances slightly more satisfactory (see Table 1). This may have contributed to their decreased role strain. The program group was slightly younger and had been married longer than the non-program group. Having been married longer, the mothers of the program group may have moved into the new role more comfortably due to the fact that they had already had time to adjust to the role of wife. Nine of the ten pregnancies in the program group were planned by the couples, while eight of the ten pregnancies in the non-program group were planned. This information suggests that if role strain is identified in a group where the pregnancies were planned, how "strained" are pregnancies which are not planned? The sample of three was too small to draw any conclusions.

The average lengths of labor for both groups were similar, as were hemoglobin levels. Only one of the couples of the entire sample of 20 had not attended prenatal classes.

The evidence of reduced role strain in the program group is significant, and lends support to further research on the effect of a nursing intervention program to facilitate role acquisition and reduce role strain. A discussion of some additional information regarding program components is needed.

Social self means were very close, but the items designed to test for this may not have been sensitive enough to reveal the wide variation in group behavior. For example, the item designed to test physical separation from the baby: "A mother is also a woman separate from her baby," did not discriminate well if means are evaluated. The non-program group mean was 5.2, or slightly past moderately comfortable, while the program group mean was 5.9, or just below very comfortable. But the individual groups demonstrated a much greater difference, with 9 subjects of the program group leaving their babies with others for fairly long periods (one hour or more), and only 3 of the non-program group completing this task. These findings suggest that social self, especially the distinction between the roles of mother and woman, is an important program component, but the instruments must be refined or further tested.

The role language component of the role socialization program produced conflicting results: mothers agreed it was a helpful component; but mothers exhibited increased discomfort over communication performance. Were mothers in the program overloaded with new information? Did they become so aware of how the baby interacted in the role set that their level of frustration and discomfort, related to meeting demands placed on them by the new baby, only increased as they strived harder to provide positive communication?

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The hypothesis for role performance approached the critical level. The concerns the program mothers identified closely paralleled Robson and Moss's findings (1970). Careful evaluation of this result suggests that actual caretaking skills are necessary to fill role requirements immediately. Role performances can be seen and evaluated by significant others whose feelings the mother respects in judging herself. Perhaps the need to be successful at these skills is so primary that this is what the new mother heard and remembered during the program, even though the content was not covered first. Since this is the area for the hospital postpartum classes, mothers might be more sensitized to role performance.

The findings relative to Hypothesis 2 support theoretical discussions of ideal roles; they appear before pregnancy, and, as ideals, undergo little change themselves, instead forming a standard against which the new mother measures her performance.

Recommendations

To further clarify and validate the findings of this study, questions will need re-investigation using a much larger sample population. Testing the hypotheses using a sample of all cesarean section clients, or multigravids might further define the questions and help to plan changed curricula for the program. Additional testing of large

samples not confined to narrow geographic, national, or socioeconomic groups or obstetricians should provide data from which generalizations might be drawn. Certainly it is evident that one encounter for implementation of the program is not adequate to meet the needs of new mothers. Some of the content could be incorporated into antepartum classes. More than one encounter should be planned for the postpartum period. Only further research can indicate how many contacts will be needed, and whether contacts need to be face to face, phone, group, or one to one.

One point was made very evident while conducting this study: fathers need help also. The volume of literature deals only with the mother-child relationship. Clearly motherhood and fatherhood are complimentary roles (hence the growing interest in parenting research and education). Paternal role acquisition involves role strain and obviously affects maternal role acquisition. Only further research can pinpoint effective components of a role socialization program for fathers. How much do couples support each other? Does the father need a role model? What information and support can nursing provide new fathers? Husbands whose wives were involved in this study's program group indicated interest in information about infant communication. They also remained during discussions of social self and role performance, suggesting their interest in these components.

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Given the complimentary nature of parental roles, it is likely that fathers would benefit from much of the same material that new mothers need, and new mothers need some anticipatory guidance about the role strain new fathers may experience.

Since the program group requested information related to social self, support is provided for this content area to remain in the program. Incorporating the role language concept much earlier in the role acquisition process seems appropriate with only review and demonstration necessary during the postpartum period. Comfort with role language is important, however; new mothers did identify it (regardless of increased discomfort) as the second most helpful component of the role socialization program. It appears that a mother needs an opportunity to learn about role language before actually assuming the role.

If repeated, this study needs to be carried further than 3 weeks into the postpartum period. Role performance is an important issue at 3 weeks postpartum. This study supports its inclusion in any postpartum intervention program. The possibility exists that social self or communication with the role partner would assume greater importance at six or nine weeks as comfort is achieved with the technical skills (role performance) necessary to meet the infant care needs.

Other uses for the instruments by nursing need to be explored. Perhaps using the Ideal Mother Index as an assessment tool during the antepartum would provide information to direct the focus of teaching and individual anticipatory guidance.

It is recommended by this researcher to better control and/or monitor the assistance or help provided new mothers by others during the time covered in the study. Further research should collect additional information about specific support when it was obtained, what it was about, and how it was obtained. Researchers could gather this information by phone, during home or office visits, or by asking participants to keep a diary of questions asked of other people. Evaluating both quantitative and qualitative assistance may also provide further insight into the questions, problems, and intervention necessary to reduce role strain.

This program could be incorporated into the present system with little expense, except the initial outlay for teaching nursing staff the content. This could be done by several staff continuing education units. By using this existing health care structure and staff, cost is not increased. The existing support systems such as prenatal education could also be used for sections of the program. Nursing staff is available 24 hours a day at local hospitals.

A worried or anxious mother would be greatly relieved at 2 a.m. if she could address her questions to a knowledgeable support individual. Providing additional information on areas included in this program at postpartum visits to physicians' offices might also support new mothers and facilitate maternal role acquisition.

Conclusions

1. Primiparas post normal vaginal deliveries experienced less role strain during the early postpartum period after receiving a program of role socialization. This finding is compatible with theories on role strain and is enough evidence to support the need for further exploration and research into the use of the proposed role socialization program.
2. The findings related to the ideal self evaluation provided additional research support, and are compatible with role theories which address the stability of the ideal self.
3. Following the lead of nursing theorists such as Orem, nurses in their capacity as client educators and counselors occupy an ideal position to present programs to facilitate self care. The hypotheses related to the three concepts: social self, role language, and role performance, though accepted, require closer examination to better understand the impact of each on adaptation of the maternal role.

APPENDICES

APPENDIX A

**PROCEDURES TO BE USED IN THE PROJECT TO OBTAIN
CONSENT AND TO SAFEGUARD THE RIGHTS AND
WELFARE OF RESPONDENTS**

Procedures to be Used in the Project to Obtain Consent and to Safeguard the Rights and Welfare of Respondents

Potential Risks to Sample: There are no physical risks involved in the study, and at any point the subjects are free to withdraw from the study.

Consent Procedures: (copy enclosed) Participation in the study is voluntary. Verbal consent is obtained by the office staff rather than the researcher to allow more freedom for the subject to ask questions and refuse if so desired.

Protecting Respondents: The identity and responses of all subjects will remain confidential. Never will the subject's name be associated in discussion or displayed with data. The subjects will be assigned a letter (i.e., "A" in the non-program group, or "AA" in the program group).

Potential Benefits of the Study: The information will provide nursing with better understanding of how to help mothers with their adjustment to the new role.

Study Instruments: (copy enclosed) Each have been carefully prepared using both literature and client input. Several members of the review committee have had active input in instrument development and have critiqued each periodically.

APPENDIX B

**INVESTIGATOR'S STATEMENT
AND SUBJECT'S STATEMENT**

Michigan State University

School of Nursing

For: Master's Thesis

Investigator's Statement:

This research study involves completing a questionnaire now (time involved: 10 minutes) and if you are randomly selected as one of the experimental group, you will be asked to participate in a scheduled 1-1½ hour interaction with me on the day you and your baby are discharged from the hospital. This interaction will be a teaching program designed to facilitate your adaptation to the maternal role. All participants will be contacted three weeks after the baby is born and, at your convenience, you will be asked to complete two more questionnaires similar to the one completed today (time involved: 15 minutes).

This study is being conducted with new mothers who anticipate and subsequently experience a normal labor, delivery, and postpartum course. Therefore, if any problems are encountered during the 6-8 week contact time, you would not continue as a study subject.

The information obtained from this study will provide me with a better understanding of how nurses can assist new mothers with the adjustment each woman makes to her role as mother. Your name will never be associated with the data and your identity and all responses will remain confidential.

Thank you for your time and cooperation.

Elizabeth Price, R.N.
Graduate Student
Family Nurse Clinician, MSU
Home phone 627-7527

Subject's Statement

I voluntarily consent to participate in this activity. I have had an opportunity to ask questions, and I understand that I can change my mind before the study is completed if I choose to.

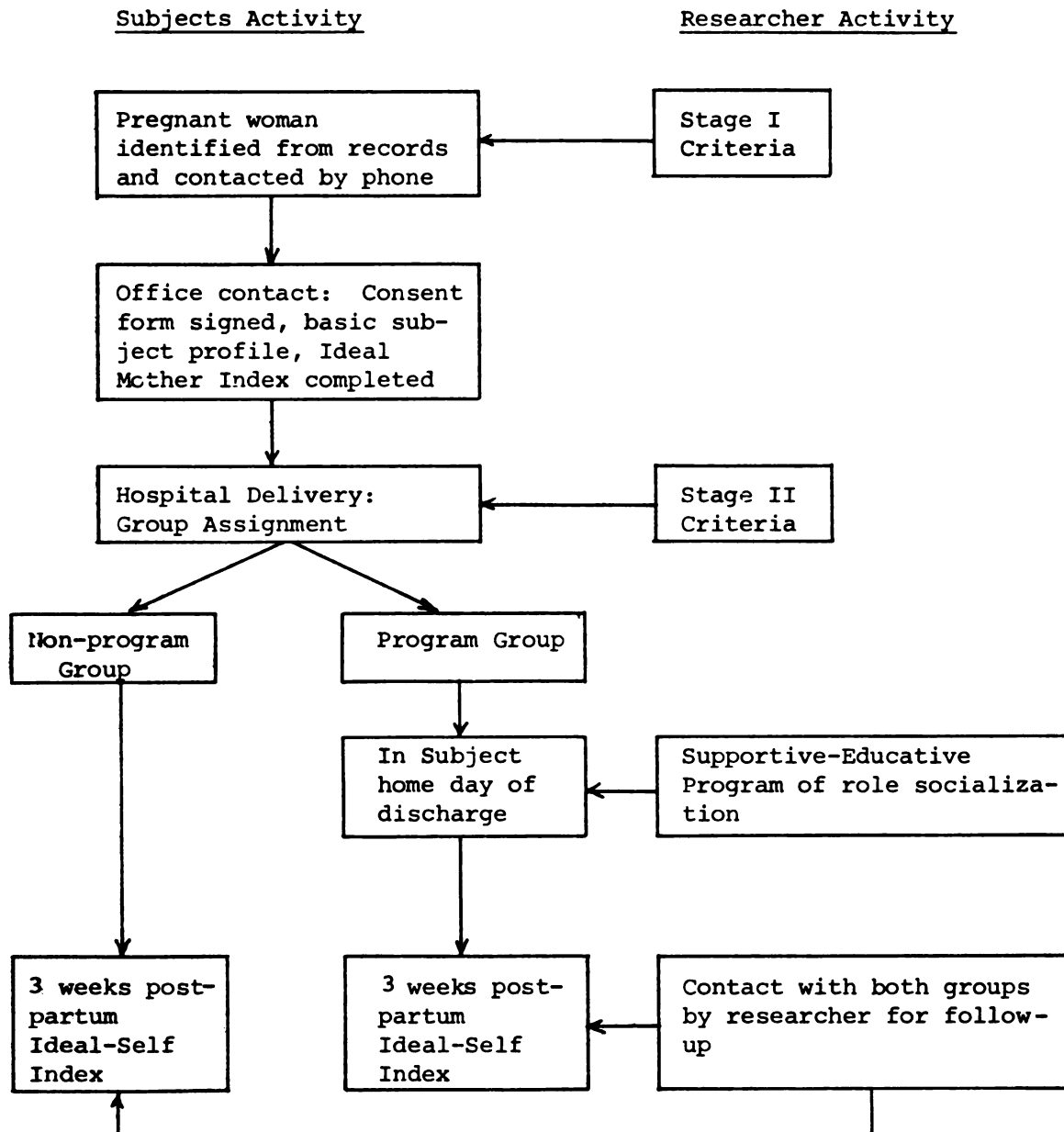
Signature of Subject

Date

APPENDIX C

RESEARCH DESIGN

Research Design



APPENDIX D

BASIC DATA PROFILE

Basic Data Profile

Name: _____

Age: _____

Number of years married prior to birth of this child: _____

Years of school completed (circle): grade school

high school

college

Did you attend childbirth preparation classes? ☐yes ☐no

Number of children in the family in which you were reared: _____

Your position in the family (circle; 1 indicates the oldest):

1 2 3 4 5 6 other _____

With discharge from the hospital, will you have a woman (friend or family member) stay with you for at least 1 week, but not more than 10 days, who will help you care for the baby? ☐yes ☐no

Is this a pregnancy which was planned? ☐yes ☐no

The amount of experience a young woman has caring for infants prior to assuming the role of mother is said to assist in becoming a mother. Circle the number of the response on the right which best describes how adequate you believe your premotherhood experience has been as preparation for your own role as mother.

	<u>Inadequate</u>		<u>Adequate</u>	
. . . experience you had caring for infants (birth-3 mos. of age)	1	2	3	4
. . . experience you had <u>observing</u> others caring for infants (birth-3 mos. of age)	1	2	3	4

Much of what we learn about being mothers has to do with what we learned from our basic role models. How would you describe your own mother's performance as a role model? (check one)

_____ unsatisfactory

_____ mostly satisfactory

_____ slightly satisfactory

_____ satisfactory

APPENDIX E

**IDEAL MOTHER INDEX AND
SELF MOTHER INDEX**

IDEAL MOTHER INDEX

The statements below list qualities and actions identified with the mother role as she interacts with her baby. Using the six numbered responses listed below, circle the number on the right which best describes your idea of how important the attitude or skill in each statement is to being an IDEAL mother.

	1	2	3	4	5	6			
	very unimportant	moderately unimportant	slightly unimportant	slightly important	moderately important	very important			
A mother:									
. . . is happy				1	2	3	4	5	6
. . . talks to her baby				1	2	3	4	5	6
. . . is skillful feeding and burping her baby				1	2	3	4	5	6
. . . is concerned about her family				1	2	3	4	5	6
. . . understands her baby's different cries				1	2	3	4	5	6
. . . is competent with the tasks of bathing and dressing her baby				1	2	3	4	5	6
. . . is consistent and dependable				1	2	3	4	5	6
. . . touches her baby gently				1	2	3	4	5	6
. . . protects her baby				1	2	3	4	5	6
. . . is also a woman separate from her baby				1	2	3	4	5	6
. . . communicates with her baby through looks and gestures				1	2	3	4	5	6
. . . holds and rocks her baby				1	2	3	4	5	6
. . . is strong				1	2	3	4	5	6
. . . cuddles her baby tenderly				1	2	3	4	5	6
. . . changes her baby's diaper with ease				1	2	3	4	5	6
. . . feels good about herself				1	2	3	4	5	6

IDEAL MOTHER INDEX (Cont.)

. . . is able to interpret what her baby wants and needs	1	2	3	4	5	6
. . . provides physical care for her baby	1	2	3	4	5	6
. . . is important	1	2	3	4	5	6
. . . listens to her baby when baby talks to her	1	2	3	4	5	6
. . . adapts to change	1	2	3	4	5	6

SELF MOTHER INDEX

The statements below list qualities and actions identified with the mother role as she interacts with her baby. Using the six numbered responses listed below, circle the number on the right which best describes how comfortable you now feel with the attitude or skill in each statement.

1 very uncomfort- able	2 moderately uncomfort- able	3 slightly uncomfort- able	4 slightly comfort- able	5 moderately comfort- able	6 very comfort- able			
I:								
. . . am happy			1	2	3	4	5	6
. . . talk to my baby			1	2	3	4	5	6
. . . am skillful feeding and burping my baby			1	2	3	4	5	6
. . . am concerned about my family			1	2	3	4	5	6
. . . understand my baby's different cries			1	2	3	4	5	6
. . . am competent with the tasks of bathing and dressing my baby			1	2	3	4	5	6
. . . am consistent and dependable			1	2	3	4	5	6
. . . touch my baby gently			1	2	3	4	5	6
. . . protect my baby			1	2	3	4	5	6
. . . am also a woman separate from my baby			1	2	3	4	5	6
. . . communicate with my baby through looks and gestures			1	2	3	4	5	6
. . . hold and rock my baby			1	2	3	4	5	6
. . . am strong			1	2	3	4	5	6
. . . cuddle my baby tenderly			1	2	3	4	5	6
. . . change my baby's diaper with ease			1	2	3	4	5	6
. . . feel good about myself			1	2	3	4	5	6

SELF MOTHER INDEX (Cont.)

. . . am able to interpret what my baby wants and needs	1	2	3	4	5	6
. . . provide physical care for my baby	1	2	3	4	5	6
. . . am important	1	2	3	4	5	6
. . . listen when my baby talks to me	1	2	3	4	5	6
. . . adapt to change	1	2	3	4	5	6

APPENDIX F

CRITERIA FORM

Criteria Form

Program

Non-program

STAGE I

Name _____

Address _____ Phone _____

Age _____ Years married _____

Number of pregnancies _____

EDC

Low risk pregnancy according to established criteria: ____ yes ____ no

Sustained support individual identified: ____yes ____ no

STAGE II

Labor length _____ Delivery (type) _____

Episiotomy: ____yes ____no

Anesthesia/analgesia _____

Infant Apgar score: ____ 1 minute ____ 5 minutes

Infant physical exam findings: ____ normal ____ abnormal

variations from normal: (1) _____

(2) _____

Nursery assignment _____

Mother's health: Hgb _____ 2nd P.P. day

Blood loss post-delivery _____

Temp. range during the postpartum period _____

Elevation above 100⁴: ____ yes ____ no

Episiotomy intact with discharge: ____yes ____no

Infant and mother discharged together: ____yes ____no

Date _____

Time _____

Program group appointment time _____

3-week follow-up: Time _____ Date _____

Non-program group 3-week follow-up: Time _____

Date _____

•

APPENDIX G

PROGRAM OF POSTPARTUM ROLE SOCIALIZATION

Program of Postpartum Role
Socialization

Environment: Subject's home the afternoon or evening of the day of discharge from the hospital.

Individuals present: Mother, infant, researcher, and perhaps significant others.

The researcher will be dressed in street clothes and will be known to the subject because of the earlier hospital contacts.

Content of experimental program:

1. Introduction regarding the general nature and purpose of the study.
2. Information related to the normal anatomy and physiology of involution:
 - (a) What physical changes occur during involution?
What she can expect (i.e., afterpains, lochia, the return of menstruation).
 - (b) When she will regain control over body functions.
 - (c) Female hormones (i.e., estrogen, progesterone, Pitocin, and prolactin) and their influence over the mother's physical and psychological self.
3. Questions concerning role expectations. Example:
"Share with me some of your ideas about what being a mother will be like." "What are some of your expectations of the next six weeks?" Depending upon the answers to the questions: anticipatory guidance.

4. Questions regarding the mother's sense of her new role.

Example: "What is it like for you to be a mother?"

"Tell me how it feels for you to be in this new role."

"How do you feel when you have the baby with you?"

Depending upon the answers of the questions: statements of support and encouragement. Examples: "The baby may look different than you imagined. You expected a boy, you had a girl. It is normal for you to feel some disappointment." "You may not feel the instant unqualified love for your baby you might have expected. This doesn't mean you are not a 'good' mother. You just need time to get to know each other." "Being awkward in no way means you are inadequate. It may simply mean you haven't been a mother long enough to feel comfortable 100% of the time."

5. Questions concerning body image and its relation to role.

Examples: "What is it like not to be pregnant any longer?" "How do you feel about yourself, your body shape?"

6. Information related to weight loss and body shape.

- (a) normal expected weight loss in six weeks.
- (b) diet and exercise programs.
- (c) suggestions designed to promote positive feelings about appearance.

7. Demonstration and/or discussion of the infant's communication patterns.
 - (a) perceptual abilities, visual, auditory, response to touch.
 - (b) basic reflexes (i.e., rooting, sucking, swallowing, grasp, mono, and dancing).
 - (c) reasons for crying (i.e., overstimulation, loneliness, tension and tiredness, comfort).
 - (d) behavior modes for quieting fussy baby (i.e., touching, holding, rocking, cuddling).
8. Questions concerning mother's caretaking skills.

Examples: "How do you feel about caring for the baby?"

"New mothers often have concerns regarding infant care. How do you feel about your skills in taking care of the baby?" "Mothers often are uncomfortable holding a brand new baby for fear he will break. How do you feel?"

Given negative response, the researcher will provide strategies to improve role performance.

 - (a) encourage positive reinforcement and support her performance.
 - (b) relating past positive accomplishments to transfer positive feeling related to learning a new skill.
9. Identification of a possible peer gender specific support person in the environment.

10. Coping strategies to deal with the anticipated changes in family life style. Example:
 - (a) limit visitors
 - (b) modify housekeeping tasks
 - (c) get plenty of rest
 - (d) open communication with significant others in the environment to share feelings of joy, anxiety, and frustration surrounding the new role (i.e., husband, mother, close friend)
 - (e) plan time just for herself
11. Two booklets, Caring for Yourself After the Baby is Born, Ross Laboratories, Columbus, Ohio, 1975; and Becoming a Parent, Ross Laboratories, Columbus, Ohio, 1973, designed to provide reinforcing information for home reference. The following topics were included:
 - (a) content related to normal anatomy and physiology
 - (b) high protein, modified calorie diet
 - (c) postpartum exercise program
 - (d) list of behaviors designed to reduce stress during the early postpartum period

APPENDIX H

**POSTPARTUM ROLE SOCIALIZATION:
INSTRUCTION SHEET**

Postpartum Role Socialization: Instruction Sheet

Subject _____

Date _____

Time _____

	<u>Accomplished</u>
1. Introduction of study	
(a) nature	_____
(b) purpose	_____
2. Information	
(a) physical changes and hormones	_____
(b) control of body functions	_____
3. Discussed role expectations	
(a) for herself now	_____
(b) for the next six weeks	_____
4. Discussed feelings about the new role	
(a) for mother	_____
(b) about baby	_____
5. Discussed how mother views body image	_____
6. Information about weight loss	
(a) normal expectations	_____
(b) diet and exercise program	_____
7. Demonstration and/or discussion of infant communication	
(a) perceptual abilities	
(1) visual	_____
(2) auditory	_____
(3) response to touch	_____

	<u>Accomplished</u>
(b) reflexes	
(1) rooting	_____
(2) sucking/swallowing	_____
(3) grasp	_____
(4) mono	_____
(5) dancing	_____
(c) discussed reasons for crying	
(1) overstimulation	_____
(2) loneliness	_____
(3) tension and tiredness	_____
(4) discomfort (hunger, wet, etc.)	_____
(d) discussed ways to quiet fussy baby	
(1) touching	_____
(2) holding	_____
(3) rocking	_____
(4) cuddling	_____
8. Asked questions related to caretaking skills.	_____
9. Identified a woman to be used as a support.	_____
10. Discussed coping strategies.	
(a) limit visitors	_____
(b) modify housekeeping tasks	_____
(c) increase rest	_____
(d) open communication	_____
(e) time for self	_____
11. Information packet given.	_____

APPENDIX I

EXAMPLE SCORING PROCEDURE

Example Scoring Procedure

Ideal Mother Score

Each subject in the study was asked to complete the Ideal Mother Index some time between the 38-42 week of gestation. A raw pre-ideal score was obtained by adding the response numbers 1-6 together to equal a total. Three weeks postpartum each mother was again given the Ideal Mother Index; the post-ideal scoring was identical to the pre-ideal. To obtain a difference score for the testing of Hypothesis 2, the pre-ideal score was subtracted from the post-ideal score. Then the statistical technique was applied to these scores.

Self Mother Score

The scoring of the Self Mother Index was divided into two parts. Part 1 was the self mother score. This score was obtained by adding the number for each response (a possible choice of 1-6) for all 21 items to obtain a raw score for each individual subject in the study. The second part of the scoring procedure consisted of arriving at a score for each of the three subcomponents of the instrument: social self, role language, and role performance. The following illustration will demonstrate how these two steps were accomplished.

Given the following responses to each item:

<u>Item #</u>	<u>Response</u>	<u>Item #</u>	<u>Response</u>	<u>Item #</u>	<u>Response</u>
1	= 6	8	= 5	15	= 6
2	= 4	9	= 6	16	= 6
3	= 5	10	= 4	17	= 5
4	= 6	11	= 5	18	= 4
5	= 3	12	= 5	19	= 5
6	= 5	13	= 4	20	= 3
7	= 6	14	= 5	21	= 4

Social Self is measured by the sum of items: 1, 4, 7, 10, 13, 16, 19. In the example, Social Self = 37.

Role Language is measured by the sum of items: 2, 5, 8, 11, 14, 17, 20. In the example, Role Language = 30.

Role Performance is measured by the sum of items: 3, 6, 9, 12, 15, 18, 21. In the example, Role Language = 35.

The subscores were then added:

$$37 + 30 + 35 = 102 \quad \text{Total Self Mother Score}$$

Role Strain: The role strain score was obtained by subtracting each subject's self mother score from her post-ideal mother score. After tallying scores for each subject in each group, scores of the program and non-program group were analyzed by the statistical technique selected.

APPENDIX J

HYPOTHESES IN STATISTICAL NOTATION/FORMULAS

Hypotheses in Statistical
Notation/Formulas

HYPOTHESIS 1: (difference of means) t scores small sample theory because: $N_1 + N_2 < 30$

or

$$t = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{S_p^2 \left(\frac{1}{N_1} + \frac{1}{N_2} \right)}}$$
$$S_p^2 = \frac{(N_1 - 1)S_1^2 + (N_2 - 1)S_2^2}{N_1 + N_2 - 2}$$

$$H^0 \mu_p \geq \mu_{np}$$

$$H^1 \mu_p < \mu_{np}$$

$$\alpha = .1$$

$$t \text{ critical} = -1.33$$

HYPOTHESES 1A, 1B, 1C:

$$H^0 \mu_p = \mu_{np}$$

$$\mu_p \neq \mu_{np}$$

$$\alpha = .1$$

$$t \text{ critical} = \pm 1.729$$

HYPOTHESIS 2: will be tested by using different scores on repeated measures.

$$t = \frac{\bar{d} - \mu_d}{\frac{s_d}{\sqrt{N}}}$$

$$d = x_{\text{post}} - x_{\text{pre}}$$

$$\bar{d} = \frac{\sum d}{n}$$

$$s_d^2 = \frac{N\sum d^2 - (\sum d)^2}{N(N-1)}$$

$$\mu_d = \mu_{X_2} - \mu_{X_1} = 0$$

$$H^0 \mu_d = 0$$

$$H^1 \mu_d \neq 0$$

$$\alpha = .1$$

$$t \text{ critical} = \pm 1.833$$

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