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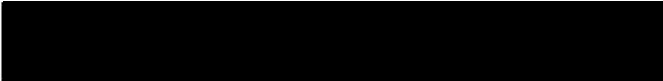
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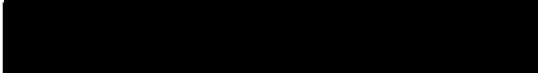
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School of Nursing
Virginia Commonwealth University


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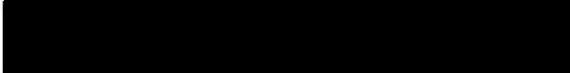

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The Relationship Between Maternal
Self-Concept and Demonstration
of Adaptive Behavior

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science
at Virginia Commonwealth University

By

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B.S.N., Virginia Commonwealth University, 1969

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Richmond, Virginia
August, 1980

Dedicated To

My Mother and My Daughter

Together they have taught me
more about motherhood than
books or research ever could.

ACKNOWLEDGEMENTS

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Chapter 1

THE PROBLEM

Introduction

A primary responsibility of the maternal child health nurse is the assessment of the new mother's potential for effective parenting. One part of this assessment occurs in the post-partum setting where the nurse can observe the mother's ability to adapt to the demands of the puerperium. Increasingly, maternity nurses, through the use of assessment tools and observational skill, are differentiating between those mothers who are adapting to the many changes they are experiencing from those mothers unable to adapt without assistance. Erickson and Hurd have written of the importance of assessment at this time to help detect potential mother-child interaction problems.^{1,2}

Roy defined documentation of the client's adaptation state as the first step of the Adaptation Nursing

¹M. L. Erickson, Assessment and Management of Developmental Changes in Children (St. Louis: C. V. Mosby, 1976), p. 2.

²J. M. L. Hurd, "Assessing Maternal-Attachment - First Step Toward the Prevention of Child Abuse," JOGN Nursing, 4:26, 1975.

system.³ Following this documentation, the nurse must identify factors that are either promoting or inhibiting the adaptive process. In the post-partum setting, this step can be difficult as there are many stimuli or variables which can influence the new mother's ability to adapt. The nurse must know how to assess the influence of each stimulus on individual mothers. This study sought to provide information that would help the nurse make an accurate assessment by identifying behaviors that correlated with one variable - the mother's self-concept.

Shereshefsky and Yarrow reported "findings that view the woman's personality characteristics . . . as basically determinative of her capacities as a mother."⁴ Ballou saw pregnancy as a time to develop a sense of a new person (the baby) and used object-relations theory to study adaptation to pregnancy and the puerperium. She proposed that a woman's sense of herself and her sense of relationships with her own mother were pivotal factors in determining adjustment during this time.⁵ Ballou and Benedek spoke of the importance of the woman's relationship with her own

³Sr. C. Roy, Introduction to Nursing: An Adaptation Model (Englewood Cliffs, N.J.: Prentice-Hall, 1976), p. 26.

⁴P. Shereshefsky and L. Yarrow, ed., Psychological Aspects of a First Pregnancy and Early Postnatal Adaptation. New York: Raven Press, 1973.

⁵J. W. Ballou, The Psychology of Pregnancy: Reconciliation and Restitution, (Lexington, Mass.: D. C. Heath, 1978), pp. 10-11.

mother as the first object relationship which influence both her sense of her child and her sense of herself.^{6,7} Kennedy proposed that since a "negative experience [during pregnancy or the puerperium]⁷ can wear down emotional reserves and self-image,"⁸ strength in these areas can assist in adapting to negative situations.

These authors saw a relationship between adjustment to pregnancy and parenting and the individual's psychosocial makeup, including the mother's image or sense of herself. Their positions supported those of self-concept theorists who proposed viewing self-perception or concept of the self as both an independent and dependent variable. In other words, just as events and others' perceptions influence the development of self-concept,⁹ the self-concept influences the perception of the situation and the indivi-

⁶T. Benedek, "Motherhood and Nurturing," Parent-hood, Its Psychology and Psychopathology, eds. E. J. Anthony and T. Benedek (Boston: Little, Brown and Company, 1970), p. 158.

⁷Ballou, p. 11.

⁸J. D. Kennedy, "The High-Risk Maternal-Infant Acquaintance Process," Nursing Clinics of North America, 8:3,350, 1973.

⁹Roy, p. 172.

dual's behavior.^{10,11} Roy proposed that the self-concept is one of four methods (modes) of adaptation (with physiological needs, role function, and interdependence) allowing the individual to use his own perception of himself to adapt to new roles or crisis situations.¹²

Purpose of the Study

The study examined whether adaptive maternal behaviors correlated with a positive self-concept measurement. The adaptive behaviors observed were those which the literature suggested indicate a positive response to the changes of the puerperium. The study aimed at assisting the nurse in assessing the self-concept level of clients. The researcher also hoped to contribute to the continued development of nursing theories and the application of the theories to the arena of clinical practice.

Statement of the Problem

The question posed by this study was "What is the relationship between a mother's self-concept and the fre-

¹⁰A. W. Combs and D. Snygg, Individual Behavior: A Perceptual Approach to Behavior (New York: Harper and Bros., 1959), p. 122.

¹¹W. H. Fitts, The Self-Concept and Self-Actualization (Nashville: Dede Wallace Center, 1971), p. 6.

¹²Roy, p. 12.

quency of adaptive behaviors she exhibits?" The study assessed maternal adaptive behaviors during the first three days post-partum and correlated these behaviors with a self-concept measurement. The study used a standardized, self-administered, self-concept scale (Tennessee Self-Concept Scale) and a researcher designed observation guide (Maternal Adaptive Behaviors Checklist) to obtain quantitative data. The researcher was a non-participant observer.

Definition of Terms

Self Concept: The central and critical variable in human behavior, "the self as seen, perceived, and experienced by the individual,"¹³ the individual's self-perception. For the purpose of this study, self-concept was operationalized as the scores achieved on the Tennessee Self-Concept Scale (TSCS).

Maternal Adaptive Behavior: Actions and reactions of the mother¹⁴ which indicate a positive response to the demands of the puerperium, including interaction behaviors with her infant, interaction with others, and response to her own needs. For the purpose of this study, maternal adaptive behavior was operationalized as the score achieved on the Maternal Adaptive Behavior Checklist (MABC).

Positive Self-Concept: A perception of the self as a worthwhile, adequate individual. For the purpose of this study, a positive self-concept was operationalized as a score on the Tennessee Self-Concept Scale above the sample mean.

¹³Fitts, 1971, p. 3.

¹⁴Roy, p. 25.

Negative Self-Concept:

A perception of the self as less than adequate, worthless individual. For the purpose of this study, a negative self-concept was operationalized as a score on the Tennessee Self-Concept Scale below the sample mean.

Limitations

The limitations of this study were:

1. Acknowledged observation of subjects could have influenced their behavior and the study results.
2. The Maternal Adaptive Behavior Checklist was an instrument designed by the researcher and was not shown to have statistical reliability and construct validity.
3. The Tennessee Self-Concept Scale has not been used in the post-partum setting.
4. The researcher was unable to control for external events which may have influenced the results.
5. The researcher depended on subjects to respond to the Tennessee Self-Concept Scale honestly.

Assumptions

This study depended on the following assumptions:

1. Self-concept can be measured.
2. Self-concept is stable and not quickly changed by the events surrounding childbirth.

Theoretical Rationale

The theoretical framework for this study was Roy's theory of adaptation nursing. The researcher specifically drew from Roy's descriptions of the nursing process and the self-concept mode of adaptation to develop the basis of the study. The researcher accepted Roy's premise that an individual's self-concept can be assessed by observing his behavior and tested her premise that self-concept influences behavior.

In seeking to identify behaviors correlated with a positive self-concept, the researcher hoped to contribute to the development of Roy's model and provide nursing practitioners with information they could apply in the clinical setting.

This presentation describes Roy's model in terms of:

A. Adaptation Nursing

1. the nature of man and his relationship with his world;
2. man's response to changes in his world (adaptation/maladaptation);
3. factors influencing his response;
4. nursing role in promoting a positive response.

B. Self-Concept Mode of Adaptation

1. self-concept development;
2. self-concept as an adaptation mode;
3. nursing assessment of self-concept.

Because the study applied Roy's theory to the post-partum setting, examples typical of post-partum situations are included in this discussion.

Adaptation Nursing

Roy proposed an organization of ideas about the nature of man and the nature of man's interaction with his surroundings (environment) to provide a framework for nursing which will support man's nature and strengthen his interaction with the environment. The Adaptation Model "views man as a biopsychosocial being with modes of adapting to a changing environment, and which acts through a nursing process to promote man's adaptation in each of these modes in situations of health and illness."¹⁵

Roy described man's nature as having three levels: biological, psychological, and social. Each level has unique needs. Biological needs are those of the body's physical systems that enable the body to maintain physiological balance and integrity, e.g., the need to regain non-pregnant hormonal and fluid balance after delivery. The psychological needs relate to man's attempts to perceive himself as an integrated whole; e.g., the need to see consistency between his image of himself and his behavior. Social needs are those pertaining to man's relationships with others; e.g., the mother's need to perform the infant care tasks expected by those around her.¹⁶

Roy separated these three levels for discussion purposes but believed they were actually interrelated

¹⁵Roy, p. 3.

¹⁶Roy, p. 11.

views of the same person. The three levels interrelate with each other and together they interact with the environment external to the person. Both the person and the external environment influence and are influenced by each other.¹⁷

Adaptation is man's positive response to this changing external environment, a response that maintains the person's integrity by resisting negative stimuli or incorporating positive ones. Roy identified several factors, or 'stimuli', that she believed determined man's ability to adapt, his 'adaptation level'. Roy used the term 'focal stimulus' to identify the nature of the change required in a given situation. In other words, a situation has a weak 'focal stimulus' if the individual needed to make only a small adjustment to adapt to the situation such as raising an umbrella in the rain. Childbirth is a situation of strong 'focal stimuli' since it requires the woman to make major changes within her physical, psychological, and social levels.^{18, 19, 20}

¹⁷Roy, p. 11

¹⁸E. E. LeMasters, "Parenthood as a Crisis," Crisis Intervention: Selected Readings, ed. H. J. Parad (New York: Family Service Association of America, 1965).

¹⁹G. Bibring, et al., "A Study of the Psychological Processes in Pregnancy and of the Earliest Mother-Child Relationship," Psycho-Analytic Study of the Child, 16:9-25, 1961.

²⁰Ballou, 1978.

The adaptation level is also determined by 'residual' and 'contextual' stimuli. Residual stimuli are values, memories, and experiences from the past which the individual brings to a present situation and influence his ability to adapt. Benedek spoke of the memory traces of one's own mothering influencing one's ability to be a mother.²¹ Contextual stimuli are integral factors of a situation, including the person as she is then, which influences the ability to adapt.²² Dunbar thought the restrictive hospital routines could inhibit the normal maternal-infant acquaintance process.²³ Rubin identified the mother's self-concept as one dimension that influences her ability to change during pregnancy and the puerperium.²⁴

"The adaptation level sets up a zone within which stimulation will lead to a positive or adaptive response while stimuli outside of the zone lead to a negative or maladaptive response."²⁵ Because the external environment is always changing, man must continuously adapt to changes.

²¹Benedek, p. 155.

²²Roy, p. 13.

²³J. Dunbar, "First Encounters of Mothers With Their Infants," Maternal-Child Nursing Journal, 5:1, 1976.

²⁴R. Rubin, "Attainment of the Maternal Role, Part 1," Nursing Research, 16:3:240, 1967.

²⁵Roy, p. 13.

If the stimulus is outside his normal adaptation level, he can continue in a state of maladaptation or adjust his adaptation level by implementing one of the four methods, or 'modes', of adaptation. By acting through one of these 'modes', man is able to change something in the external environment or change something within himself that allows him to handle the stimulus creating the maladaptation state.

Roy identified four 'Adaptation Modes' that enable him to make this adjustment: physiological needs, self-concept, interdependence, and role function.²⁶ Each is a way of using his physiological, psychological or social level to react constructively to the situation. The adaptation modes are ways of automatically or consciously choosing a coping mechanism or behavior which will make a positive change in the environment and positively effect the adaptation level.

Thus, the mother of triplets may find the situation outside her normal adaptation ability and be in a state of maladaptation. She finds herself unable to cope with the situation because residual stimuli (past experiences with infants, memory trace) are not able to tell her how to handle the demands of three infants. Contextual stimuli increase the pressure: the family finances are limited and she does not know how they can afford three babies;

²⁶Roy, p. 14.

there is a nursing shortage on the unit that week and the staff finds it difficult to give her enough time and attention. This mother might remain in maladaptation or instead mobilize one or more of the four modes to help her deal with the situation. She may use her concept of herself (self-concept mode) as a competent, organized, resourceful person who has been able to handle problems well in the past. With this self-confidence, she will feel able to search the environment for assistance, find ways to organize her time and the supplies needed for the babies, etc.

By doing these things, she is able to change the environment enough so that her adaptation level encompasses the stimuli and she is able to adapt. However, if she is unable to use any of the Adaptation Modes, she will be unable to adapt to the situation on her own. If her self-concept is very low, she may not have the confidence to reach out for help. If she remembers past failures and sees herself as generally incompetent, she will have less emotional energy to tackle the organization tasks. Her integrity as a person is threatened: she is faced with the fact of being a mother to triplets, but feels incapable of acting like one.

Roy sees the nurse as having a definite role in both maladaptive and adaptive situations. The role includes:

1. assessment of the client's adaptation state;
2. assessment of the client's ability to use

- the adaptation modes to strengthen adaptation or move away from maladaptation;
3. determination of the stimuli affecting the client's adaptation level;
 4. planning nursing actions that reinforce the client's adaptation or help her move toward adaptation by removing or changing the strength of influencing stimuli.²⁷

Self-Concept Mode

"Self-concept is defined as the composite of beliefs and feelings that one holds about oneself at a given time, formed from perceptions particularly of other's reactions, and directing one's behavior."²⁸ Self-concept is the individual's perception of the self, the inner picture he holds of his being. Roy saw the self-concept in both active and passive roles: Self-concept is affected in its development by the stimuli around the individual; and it acts as a stimulus in directing that individual's behavior.²⁹

The development of self-concept is a life-long process. Roy held that one of the primary influences in its development is the person's success or failure in the

²⁷Roy, p. 18.

²⁸Roy, p. 169.

²⁹Roy, p. 174.

major tasks associated with developmental stages.³⁰ Past success in achieving trust, autonomy, and identity, influences how a person feels about himself. These feelings about his ability to master the primary tasks of living help form the core of his self-concept. The core also includes perceptions of himself that are basic to his identity, e.g., male, and perceptions that have received more reinforcement from the environment (success in many areas, at many times, leads to a perception of competence).³¹

This core, usually established by maturity, becomes quite stable and resistant to change. New stimuli may influence its future development; new roles, physical changes, perceived evaluation of others. Generally, these stimuli bring about adjustments to the mature self-perception, not major changes. However, if the stimuli continue over time, receive reinforcement from other stimuli, and involve a major part of the individual's life, they could effect a dramatic change in the self-concept. Thus, Roy saw the self-concept as generally resisting change once developed, but nevertheless capable of minor or major adjustments, depending upon the strength and consistency of the stimuli demanding change.

Roy also saw the self-concept as a factor in an individual's life which influenced his behavior. Roy defined

³⁰Roy, p. 183.

³¹Roy, p. 172.

the influence of the self-concept as the self-concept mode of adaptation, the ability of man to use his own image to direct his behavior.³²

"The self-concept is a basic variable affecting and controlling perceptions, which eventually affects the behavior of man."³³ Man's interpretation of the world around him depends on the nature of his self-concept. A positive self-perception allows him to see changes as positive or, at least, manageable because he sees himself as capable of dealing with the change. This positive view of the environment enables him to actively seek and deal with changes rather than withdraw from them.³⁴ On the other hand, the man with a negative self-concept sees the environment as negative and threatening, and responds to stimuli in defensive ways.

In the post-partum situation, the woman who has a concept of herself as a worthwhile person and receives feedback from others to reinforce that concept, will experience a strengthening of her core perception. As she experiences success as a mother, she can incorporate the mother image into her self-concept. If she experiences consistent difficulty with the baby and others show their

³²Roy, p. 16.

³³Roy, p. 171.

³⁴Roy, p. 233.

displeasure with her futile attempts, the positive core will resist any change initially but eventually weaken if the negative stimuli continue. She will see herself failing in her new role and failing to handle the developmental tasks of generativity. Eventually, this perception of incompetence will become incorporated into the very core of her self-concept.

Roy proposed that the nurse must assess the self-concept mode before planning intervention. Self-concept, like the other adaptation modes, is assessed by observing client behavior. Roy defined human behavior as "actions or reactions under specified circumstances."³⁵ These reactions may be internal or external and will require different assessment techniques, but all are signals of how the individual is responding to stimuli.

Because of the internal nature of the self-concept, the individual's responses in this mode can be difficult to assess accurately. Roy suggested two methods. Interviewing techniques and active listening provide the client's description of himself in his own words.³⁶ The nurse can also assess visible actions that indirectly reflect the self-concept to obtain initial assessment data and/or confirmation of the client's verbal self-assessment.³⁷ Roy

³⁵Roy, p. 25.

³⁶Roy, p. 177.

³⁷Roy, p. 236.

suggested many behaviors, e.g., body posture, eye contact, appetite and sleep patterns, that can reflect the response of the self-concept to a situation and can be observed rather easily.³⁸

The nurse who assesses the woman's self-concept will have an understanding of the woman's view of the world, positive or negative. If the nurse assesses a negative self-concept, the nursing plan will need to include strategies for dealing with client defensiveness, avoidance, or withdrawal by helping the client to examine her responses, ensuring positive feedback, and minimizing challenging stimuli until the self-concept is healthier. The nurse will be better aware of the need for referral for counseling or therapy if the client's self-concept continues to inhibit adaptation.

In summary, Roy's theory of Adaptation Nursing provided the basis for this study. The researcher accepted Roy's premises that:

1. Adaptation is man's positive response to a change in his external environment.
2. The nurse can assess man's ability to adapt by observing his behavior.

This study tested Roy's premise that self-concept influences man's ability to adapt.

³⁸Roy, p. 382.

Hypothesis

Based on the review of the literature and the theoretical framework of this study, the researcher tested whether:

Mothers with a positive self-concept will exhibit a greater frequency of adaptive behaviors than mothers with a negative self-concept.

Significance to Nursing

Since the self-concept is an important stimulus in determining behavior and is believed to influence a woman's reactions during the puerperium, it is essential that the nurse accurately assess the health of a mother's self-concept. Roy proposed that assessment be based on a client's behavior, but behaviors that reflect self-concept levels of mothers are not specifically discussed in the maternal-child nursing literature. The focus of assessment is usually on the nature of the maternal-child interaction. For example, Johnson proposed several post-partum assessment guides.³⁹ While these guides listed very specific behaviors for determining how the mother related to her newborn, they contained only vague references to behaviors indicative of the mother's perception of herself. These guides would help the nurse begin to document the adapta-

³⁹S. H. Johnson, ed., High-Risk Parenting: Nursing Assessment and Strategies for the Family at Risk (Philadelphia: Lippincott, 1979), pp. 28-35.

tion state but would not provide much assistance in identifying behaviors which signify a positive or negative self-concept. Yet, this information is needed before intervention can be planned.

For instance, Dunn recommended sharing information about infant temperament differences to minimize mother-child interaction problems.⁴⁰ But "it should be obvious that education cannot remove unconscious conflict in a mother nor make a tender and loving mother out of an anxious and defensive one."⁴¹ Before educating the mother about infant temperament, the nurse would need to know how the mother saw the situation, saw the infant, and saw herself. This study attempted to identify behaviors the nurse could look for in assessing a mother's self-concept level and to explore the relationship between self-concept and maternal adaptation.

⁴⁰B. H. Dunn, "Interactional Effects in the Mother-Infant Dyad: A Study of Maternal Attitude and Behavior and Infant Social Responsiveness (M.S. thesis, University of Virginia, 1974), p. 98.

⁴¹S. Brody, Patterns of Mothering: Maternal Influence During Infancy (New York: International Universities Press, 1956), p. 329.

Chapter 2

REVIEW OF THE LITERATURE

In preparation for this study, the researcher reviewed research and theory proposals regarding the nature of self-concept and its influence on behavior. Literature concerned with adaptation during the puerperium was reviewed, with emphasis on index behaviors and factors that influence adaptation.

Self-Concept

William H. Fitts proposed that the self-concept is the "central and critical variable in human behavior,"⁴² more predictive than demographic variables. Fitts believed that unless professionals seek to understand the client's person, rather than facts about him, "all attempts to do something to him or for him or with him may be in vain."⁴³ A knowledge of the client's self-concept provides "vital and relevant data about a person that supercedes other things in importance to the individual."⁴⁴

⁴²Fitts, 1971, p. 1.

⁴³Fitts, 1971, p. 2.

⁴⁴Fitts, 1971, p. 2.

Fitts defined self-concept as "the self as seen, perceived, and experienced by him."⁴⁵ It is developed by combining "each person's unique experiences, both internal and external . . . a lifetime of experiences with himself, with other people, and with the realities of the external world."⁴⁶ It is the key to understanding an individual's behavior because it is the most prominent and most stable factor of the 'phenomenal' or perceived world. Because of its stability and prominence, it provides one with a 'frame of reference' from which to view the world.⁴⁷

Fitts used his theory to develop an instrument to measure an individual's level of self-concept, the Tennessee Self-Concept Scale (TSCS). The TSCS has been used in numerous studies to develop and to test Fitts' premises. Thompson summarized research done with the TSCS to determine behavioral correlates.⁴⁸ Conclusions relevant to this study were that a healthy or 'high' self-concept level was correlated with:⁴⁹

⁴⁵Fitts, 1971, p. 3.

⁴⁶Fitts, 1971, p. 3.

⁴⁷Fitts, 1971, p. 3.

⁴⁸W. Thompson, Correlates of the Self-Concept, Research Monograph, No. 6 (Nashville, Dede Wallace Center, 1972), pp. 18-80.

⁴⁹Thompson, p. 80.

1. A greater frequency in behaviors which express affection, inclusion, and control than behaviors which seek those from others.

2. A greater frequency of behaviors seeking affection and inclusion than with low self-concept.

3. Good interpersonal communication.

4. Less anxiety in stressful situations.

While Thompson reported that scores were consistent within age groups, teens and adults over 60 showed unique patterns and, therefore, they would need to be considered separately from adults between 18 and 60 years of age.⁵⁰

Early studies found blacks with characteristically different profiles than whites. Thompson observed, however, that the scores of younger blacks (18-30 years) were similar to those of whites their age. He speculated that the similarity was due to the improved educational and job opportunities, fewer concrete racial barriers, and positive role models younger blacks experienced.⁵¹

Thompson reported the correlation between socioeconomic level and self-concept increased with age. "The self-concept scores of an adult are likelier to be an index of the effectiveness with which he has dealt with his disadvantages than the actual degree of the disadvantage

⁵⁰Thompson, pp. 18-23.

⁵¹Thompson, pp. 38-40.

itself."⁵²

Combs and Snygg's theoretical discussion of the self was similar to that of Fitts. They proposed that "all behavior is a function of the individual's perceptions,"⁵³ and that the perception of the self, the 'phenomenal self', was the most important factor in determining the nature of all other perceptions.⁵⁴ Man's self-perception judges his adequacy in a given situation and chooses the action that he perceives he can do well or that will improve his adequacy. Thus, the man with a positive self-perception sees few situations as threatening because he believes himself to be quite adequate or at least capable of becoming more adequate.

Combs and Snygg believed that this view of the self becomes clearer and more stable with maturity.⁵⁵ They proposed that self-concept develops during youth as a result of self-exploration and social interaction,⁵⁶ years of testing behavior to determine what seems appropriate to himself and to others. Once developed, self-concept seeks to maintain a stable, consistent organization of the self-

⁵³Combs and Snygg, p. 18.

⁵⁴Combs and Snygg, p. 122.

⁵⁵Combs and Snygg, p. 125.

⁵⁶Combs and Snygg, p. 134.

images,⁵⁷ a perception of adequacy in a variety of situations.

These authors differentiated between stability and rigidity in the self-concept. They proposed that the self-perception can remain basically stable while making minor adjustments to meet the demands of a changing world.⁵⁸ This would be similar to water's ability to retain its chemical ingredients but react differently to heat and cold. Minor adjustments in one's self-concept are needed if the individual's experiences do not provide him with a proven way of handling the situation or if the self he perceives is different from the self he perceives is needed.⁵⁹

Turner's thoughts on self-concept theory complemented those of Fitts and Combs and Snygg. In his discussion, he differentiated between "passing images of the self (self-image) and the vague but much more vital sense of self as the real and lasting 'I myself' (self-conception).⁶⁰ The 'self-image' can change momentarily; in fact, it can be several images at once. Self-conception changes slowly and gradually. It maintains its integrity by avoiding and/or changing stimuli that contradict it.

⁵⁷Combs and Snygg, p. 125.

⁵⁸Combs and Snygg, p. 157.

⁵⁹Combs and Snygg, p. 157.

⁶⁰R. H. Turner, "The Self-Conception in Social Interaction," The Self in Social Interaction, eds. C. Gordon and K. J. Gergen (New York: John Wiley and Sons, 1968), p. 94.

Turner described the self-concept as a "vague but vitally felt idea of what I am like,"⁶¹ that can be edited by momentary self-images but not quickly changed by them. The self-concept, then, can "not be undermined by a small difference from the conception held by others."⁶² Turner felt that the self-concept can even withstand behavioral discrepancies, e.g., occasional successes at sports, except when the behavior:

1. is extreme (murder);
2. contradicts a major cultural standard (bigamy);
3. shows a discrepancy between behavior and feelings (anger toward a loved one).⁶³

In summary, the self-concept literature contributed these ideas to this study's development:

1. The self-concept has a core which is stable and resistant to change and contains the most vital and basic perceptions of the self.
2. Positive self-concept is associated with more adaptive responses than negative self-concept.

⁶¹Turner, p. 98.

⁶²Turner, p. 98.

⁶³Turner, p. 98.

Factors Influencing Puerperal Adaptation

Shereshefsky and Yarrow reported "findings which view the woman's personality characteristics . . . as basically determinative of her capabilities as a mother."⁶⁴ Their longitudinal survey examined 57 middle-class, urban families' reactions to pregnancy and parenthood through interview, psychological testing, and observer rating techniques. All independent variables, grouped under life history, current personality, current life situations, and pregnancy experience categories, were positively correlated with adjustment to pregnancy and maternal adaptation. The strongest correlations were between the factors of ego strength and nurturance with acceptance of the infant and the maternal role ($r=0.56, 0.55$ respectively, $p < 0.05$). Correlations of the other current personality factors were all significant at the $p 0.05$ level, with correlations between $r=0.26$ and 0.49 .⁶⁵ These authors also reported a majority of women "tended to remain at the same level of personality development"⁶⁶ throughout pregnancy and six months post-partum.

Brody studied maternal adjustment during the post-partum period by observing mother-infant interaction during

⁶⁴Shereshefsky and Yarrow, p. 179.

⁶⁵Shereshefsky and Yarrow, p. 49.

⁶⁶Shereshefsky and Yarrow, p. 173.

infant care activities. This study was part of a larger observational study of variations in normal infant behavior. Brody selected 32 mothers from the larger sample of 128 who volunteered for participation. Data consisted of a content analysis of four hour observation periods monthly by three observers from four to thirty-two weeks post-partum. Observations were made both at the mother's home and the research office.

Brody did not report statistical analyses. However, based on her observations, she stated that "the form and intensity of the mother's reaction [to the infant] are determined by her own history of biological and psychological needs and by her knowledge of infant care."⁶⁷ When influences on feeding techniques were examined specifically, Brody reported "the mother's personality, experience and attitudes [were more significant] than their infant's age or activity level."⁶⁸ She proposed that while education in proper feeding techniques seemed to guarantee a mother could exhibit adequate feeding behavior, only mothers who felt positive about themselves as mothers moved their children with adequate support, emotional warmth, and physical closeness.⁶⁹ She found no relationship between the infant's

⁶⁷Brody, p. 347.

⁶⁸Brody, p. 349.

⁶⁹Brody, pp. 331-332.

age, sex, or activity level and the mother's behavior.⁷⁰

Ballou reviewed research on variables correlated with maternal adaptation and found that the "concepts which have guided the most productive research have been concepts of an object-relations sort such as the woman's sense of herself, her mother and her child."⁷¹ She proposed that how a woman sees herself and sees others in the world determines how she will react to new situations and new relationships.

Ballou explored this proposal in a descriptive study of twelve women as they experienced pregnancy and the first few months post-partum. She used interview and psychological testing techniques. Although her results are descriptive only due to her small sample, she found the pivotal factor in adapting seemed to be the woman's sense of her own mother as this directly influenced both her sense of herself and later her sense of her infant.⁷² Therefore, Ballou advised further assessment of object relations variables (sense of self, sense of mother) to predict maternal adaptation.

Benedek's use of psychoanalytic theory as the basis for her study created a classic work on the process of

⁷⁰Brody, pp. 343-346.

⁷¹Ballou, pp. 10-11.

⁷²Ballou, pp. 9-10.

maternal adjustment to pregnancy and motherhood. She proposed that pregnancy "requires physiologic adjustments and psychological adaptation [that] lead to a new level of integration."⁷³ Benedek believed that the woman's perception of her relationship with her mother was the most important influence on her ability to adjust to becoming a parent. Women who have a positive impression of their relationship with their mother, i.e., felt they had received adequate support and care as children, can incorporate a positive mother image, or 'memory tracing', into their own self-perception.⁷⁴ Women with a negative impression of their relationship with their mother would have more difficulty adjusting to motherhood. Because they perceive their primary feminine role model as a negative one, they would have difficulty with the feminine role and, especially, the most uniquely feminine function of childbirth.⁷⁵

Bibring described pregnancy as a normal developmental crisis as the mother experiences a great deal of psychological upheaval during pregnancy to enable her to reorganize her psyche to a new level of maturation. Pregnancy is a turning point for women - after childbirth the mother is unable to return totally to her former self.

⁷³Benedek, p. 137.

⁷⁴Benedek, pp. 153-156.

⁷⁵Benedek, p. 154.

Bibring identified what she considered the three primary tasks for the mother:

1. acceptance and incorporation of the knowledge of intrusion of another into oneself;

2. adjustment to the reality of another and realization of its separateness;

3. readiness to see the baby after birth as separate but also part of the self forever.⁷⁶

Bibring's research was a longitudinal, descriptive study of fifteen married primipara. Data included results of standard psychological tests, psychological pregnancy evaluation tests designed for the study, interviews and guided observations. The researchers formulated a complex, detailed outline of variables felt to be possible influences on the woman's reactions to pregnancy and the puerperium. The research focused on differentiating healthy from neurotic reactions in order to determine the comprehensive care needs of mothers.⁷⁷

Although Bibring does not report statistical data due to the small sample size and nature of her study, she found evidence to support many of her initial assumptions, including some relative to this study.⁷⁸

⁷⁶Bibring, p. 15.

⁷⁷Bibring, pp. 14, 30-36.

⁷⁸Bibring, pp. 26-27.

1. Incomplete psychological reorganization of the mother can prolong the crisis state and lead to mother-child interaction problems.

2. Psychological support and management by the obstetrical team can decrease the mother's tension and help her resolve the psychological disorganization.

Bibring identified several factors which seemed to affect the mother's stress level: the mother's perception of herself, of her relationship with her mother and of her relationship with the baby's father.⁷⁹ A high degree of stress appeared to limit the amount of psychological and emotional energy the mother had available to achieve the needed reorganization of her psychic equilibrium.

Gordon, et al., studied 435 primiparas and multiparas to determine the effects of prenatal classes on a mother's post-partum adjustment. Using a variety of statistical measurements, the researchers established a positive correlation between post-partum adjustment, personal background, social history, and class participation.

The most significant correlation (Wherry-Doolittle multiple correlation coefficient = 0.51, significant at $p < 0.05$) was between post-partum adjustment and a personal history of failure, fear, loss.⁸⁰ Gordon termed this

⁷⁹Bibring, pp. 19-26.

⁸⁰R. E. Gordon, et al., "Factors in Postpartum Emotional Adjustment," Obstetrics and Gynecology, 25:2:162, 1965.

Factor 2 - Personal Insecurity Factor. Mothers with a high degree of this factor experienced more difficulty in the post-partum period.

Another factor which negatively affected post-partum adaptation consisted of personality items that indicated a desire to achieve outside of the home. A third factor consisting of items indicating the mother's willingness to relate to other mothers and to replace former priority activities with activities related to baby and husband, was positively correlated with adaptation.⁸¹

Klaus and Kennell's studies on the effects of separation on maternal adjustment and maternal-child interaction provided a great deal of data on the factors influencing adaptation to motherhood. They defined maternal behaviors as those "that serve both to maintain contact and to exhibit affection toward a particular individual."⁸² The initiation and continuation of these behaviors was seen as a primary indicator of a positive response to motherhood. Klaus and Kennell identified an early sensitive period, immediately after birth, when both mother and baby were more likely to begin the acquaintance process. One study assigned matched samples of fourteen mothers to routine contact or extended early contact groups. Significant

⁸¹Gordon, et al., pp. 163-164.

⁸²M. H. Klaus and J. H. Kennell, Maternal-Infant Bonding: The Impact of Early Separation or Loss on Family Development (St. Louis: C. V. Mosby, 1976), p. 2.

differences ($p < 0.05$) in the quality of mother-infant contact were reported at one month, one year, and two years.⁸³ Other studies essentially confirmed these initial findings.⁸⁴

Based on these findings, Klaus and Kennell recommended all mothers have an opportunity for close, intimate contact with their infants during the first hour postpartum and extended contact (rooming-in) during the post-partum hospital stay. These measures would promote the mother's adaptation by providing an opportunity for her to become acquainted with her baby.⁸⁵

Robson and Moss studied maternal adjustment from a maternal-infant attachment perspective. They defined maternal attachment as the "extent to which a mother feels that her infant occupies an essential position in her life."⁸⁶ They described attachment behaviors of 54 primiparas at one week and three, seven, and nine months post-partum.

Robson and Moss differentiated three categories of attachment progression: typical, early, and late. All mothers initially demonstrated passive behavior toward their babies. They were assigned to an attachment category based

⁸³Klaus and Kennell, pp. 55-59.

⁸⁴Klaus and Kennell, pp. 59-66.

⁸⁵Klaus and Kennell, p. 85.

⁸⁶K. S. Robson and H. A. Moss, "Patterns and Determinants of Maternal Attachment," Journal of Pediatrics, 77:6, 977, 1970.

on the change in the quantity, quality, and timing of their attachment behaviors over the study period.⁸⁷ Thirty-eight mothers were identified as progressing in a 'typical' manner because the changes in their attachment behaviors were so similar. Seven mothers were classified as 'early attachers' because they completed the process much faster than the 'typical' group. Background data on the early attachers revealed a very high investment in having a child. Six 'late attachers' took much longer to complete the attachment process and three never completed it.⁸⁸

Observers for this study also reported that early and late attachers differed in how the infant's responses to them influenced their own behavior. Late attachers were more negatively influenced than early attachers who appeared only mildly affected and sometimes not affected at all. Only if there was a long period of consistent, negative reaction from the baby did the early attachers become strongly affected by it.⁸⁹

Kennedy observed the interaction between ten mothers and their infants. Although she did not report any statistical data because of the small sample size, Kennedy wrote that mothers differed in their perceptions of their infants' reactions to them. Mothers who felt their babies

⁸⁷Robson and Moss, pp. 978-980.

⁸⁸Robson and Moss, p. 980.

⁸⁹Robson and Moss. pp. 982-985.

reacted positively exhibited more attachment behaviors than mothers who perceived negative reactions from their infants.⁹⁰ Her observations appear to support those of Robson and Moss.

Kennedy proposed several maternal characteristics, based on this study, her experience, and other observations, which she believed influenced the mother's perception of her baby's behavior and her ability to attach: emotional maturity and reserves; skill and style with interpersonal relationships in general; and experience with infants. Further, Kennedy believed that a negative experience (e.g., difficult labor, premature birth) can decrease the mother's emotional reserves and lower her self-image. The woman whose self-image is already low or whose reserves are minimal will be more affected by a negative experience, including negative feedback from her infant, than other mothers.⁹¹

Mercer believed that illness of the mother during the puerperium inhibited her ability to adapt and initiate the attachment process. Based on a limited, observational study (no statistical data reported), she identified that illness of the mother inhibited positive adaptation to the new child by prolonging the 'taking-in' phase as the mother remained oriented to herself and her own physical

⁹⁰Kennedy, pp. 552-553.

⁹¹Kennedy, p. 550.

needs rather than reaching out to become acquainted with the baby.⁹²

Behaviors Indicative of Maternal Adaptation

In addition to knowing what factors influence the adaptation of mothers, maternal-child nurses must be aware of which behaviors indicate adaptation. In 1961, Reva Rubin began to describe maternal behaviors associated with adjustment to the maternal role. The behaviors were categorized as those involved with either identification of the child or the "mother's own concern for her ability to function in a mothering capacity."⁹³ Within the first category, Rubin described maternal behaviors (quiet concentration, approval-seeking questions) and physical sensations (flushing, perspiration, exhaustion) that reflected the mother's apprehension about this initial contact. Once the mother felt relaxed handling the child, she proceeded to identify the baby. The identification of the child began by first associating him with other family members and then determining what differentiated him from these same family members. The identification process also included beha-

⁹²R. T. Mercer, "Postpartum: Illness and Acquaintance Process," Nursing Clinics of North America, 8:3: 1175-1177, 1977.

⁹³R. Rubin, "Basic Maternal Behavior," Nursing Outlook, 9:11:684, 1961.

viors to ascertain his wholeness and normal body function.⁹⁴

Rubin developed a conceptual framework which described maternal adaptation from identified maternal behavior throughout the pregnancy and post-partum period. The research was a longitudinal, descriptive study and "the frequency of relevant items were a measure of commitment to the role."⁹⁵ Each item reflected three dimensions: self-concept, operations, and model. The self-concept dimension of a behavior identified whether it reflected the mother's ideal image of herself in the role, her present self-image in the role, or her body image.⁹⁶

The model dimension referred to the significant person whose behavior or reaction to the mother's behavior influenced how the mother continued her behavior. Initially, models were other women, other parents, especially her own mother, who acted as a role model. Later, the baby became the model as his reactions indicated her success or failure in the role.⁹⁷

The operations dimension reflected the motivation for the particular behavior. The operations were viewed as a quiet but active process. "Each part of the process may become the motivation or rationale for behavior but the

⁹⁴Rubin, 1961, pp. 684-686.

⁹⁵Rubin, 1967, p. 239.

⁹⁶Rubin, 1967, p. 240.

⁹⁷Rubin, 1967, p. 240.

underlying motivation is the wish or intent to become."⁹⁸
Rubin identified the steps of this process as,⁹⁹

1. Taking-On
 - a. Mimicry
 - b. Role Play
2. Taking-In
 - a. Fantasy
 - b. Introjection-Projection-Rejection
3. Letting-Go (Grief Work)
4. Identity

During 'taking-on', the pregnant woman's behaviors were closely related to behaviors of significant others. Externally, she tried first simple and then more complex behaviors of other mothers. Progressing to 'taking-in', the woman began to internalize these behaviors, to adapt them to her own self-concept, and to imagine herself doing exactly as others do with her own baby. She moved from imagining herself as doing like others to individualizing the actions to suit herself (and in the puerperium, suiting the real baby) and rejecting behaviors which did not fit.¹⁰⁰

During the puerperium, reality eventually replaced fantasy for the mothers in Rubin's study. Although mimicry

⁹⁸Rubin, 1967, p. 240.

⁹⁹Rubin, 1967, p. 240.

¹⁰⁰Rubin, 1967, pp. 240-243.

and role play were observed in the puerperium, there were fewer of these behaviors than there were prenatally and more introjection-projection-rejection. The mother learned to see the baby as separate from herself and separate from her fantasies. Identity behaviors reflected the strong sense of 'I' taking charge: I know he prefers this, I will feed him. Still, the woman worked at grieving for the lost fantasies of the ideal child, her image of herself as the ideal mother, and the loss of roles she had to relinquish to assume the mother role.¹⁰¹

Rubin later expanded her framework to include the concept of 'binding-in', the distinctive process of interweaving the real child with the real mother. The process was compared to the making of a tapestry, with the weaving beginning with the mother's sensation of intra-uterine movement and ending with the realization of the infant as a separate but always related being.¹⁰²

Rubin identified the mother's ego as one of the primary threads of this tapestry. Ego strength enabled the relationship to develop with strength by providing a strong sense of the real mother. This strength positively influenced the mother's adjustment during the difficult post-

¹⁰¹Rubin, 1967, pp. 244-245.

¹⁰²R. Rubin, "Binding-In in the Postpartum Period," Maternal-Child Nursing Journal, 6:2:69, 1977.

partum period when she had to relate to the real child.¹⁰³ Other factors which influenced the establishment of the relationship during the puerperium were the child itself and the society - did they inhibit or ease the mother's work?¹⁰⁴

Rubin's work formed a basis for other studies in nursing literature on the process of maternal adjustment and nursing assessment of the process. Although the work of these authors followed Rubin's extensive research logically, their own studies involved much smaller samples and were primarily descriptive rather than experimental studies.

Cannon compared Rubin's description of maternal touch behavior with Klaus' work. She found that most mothers followed Rubin's description but did so at a much faster rate than Rubin had described.¹⁰⁵ She explained this difference as occasioned by the opportunity of her subjects to hold their infants more after delivery, while Rubin's subjects generally saw their infants first not until 12 hours after delivery.

Funke and Irby categorized maternal adjustment behaviors as either adaptive or maladaptive. They designed

¹⁰³Rubin, 1977, p. 70.

¹⁰⁴Rubin, 1977, p. 67.

¹⁰⁵R. B. Cannon, "The Development of Maternal Touch During Early Mother-Infant Interaction," JOGN Nursing, 6:28-35, 1977.

a coded observation list, based on the descriptive research of other authors, with progressive, adaptive behaviors to be used to diagnose the quality of maternal behavior.¹⁰⁶

Ludington-Hoe differentiated between mothering (physical care) and maternicity (emotional component of the maternal role). The adjustment process identified by this author contained steps similar to Rubin, but added information about the mother's ability to recognize and respond to the baby's own rhythm of interaction.¹⁰⁷

Clark proposed during Rubin's description of the process of maternal touch to assess the developing quality of maternal adaptation to the infant, and thereby begin the identification of potential mother-child interaction difficulties. "The rate of progression from one predominating form of touch or contact to another is dependent on how she feels herself in this particular function of her role, on how she perceives her partner's (the infant's) reciprocal response to her, and on the character of the relationship at any given time."¹⁰⁸ Clark explained a

¹⁰⁶J. Funke and M. I. Irby, "An Instrument to Assess the Quality of Maternal Behavior," JCGN Nursing, 7:5:21, 1978.

¹⁰⁷S. M. Ludington-Hoe, "Postpartum: Development of Maternicity," American Journal of Nursing, 77:7:1171, 1977.

¹⁰⁸R. Rubin, "Maternal Touch," Nursing Outlook, 11:829-830, 1963.

mother's initial hesitancy and passivity were to be expected, since the baby is really a stranger and most people wait for some response from a stranger before they become more familiar. Adaptation is evident when the mother moves from this hesitant stage to reach out to become acquainted with the baby.¹⁰⁹ Hurd also believed that careful assessment of the mother's behaviors based on Rubin's work could identify those mothers who had difficulty attaching to their infants and who were high risk for abuse or neglect.¹¹⁰

Dunbar believed that maternal touch behavior is a reflection of the work being done to accomplish the tasks of early mothering: establish an identity of the self as mother, establish identity of the infant as a separate reality, and reestablish a sense of unity with the infant. Thus, close observation of the frequency and manner of a mother's touch of her infant can yield important data regarding the mother's progress toward adaptation. Dunbar also suggested that hospital routines which inhibited the mother's opportunity to touch and explore her baby could delay the accomplishment of these tasks and make it difficult for the mother to adapt during the puerperium.¹¹¹

¹⁰⁹A. L. Clark, "Application of Psychosocial Concepts - Postpartum," Childbearing: A Nursing Perspective, eds. A. L. Clark and D. D. Affonson (Philadelphia: L. A. Davis, 1976), p. 462.

¹¹⁰Hurd, p. 71.

¹¹¹Dunbar, pp. 1-4.

The literature on maternal adaptation during the puerperium contributed these concepts to the development of this study:

1. While a variety of factors have been identified as influencing a mother's ability to adapt, psychological factors (including a mother's self-concept) play a pivotal role equal to or greater than the role of external factors.

2. Mothers responding to the demands of the puerperium exhibit characteristic behaviors which reflect their level of adaptation.

3. Assessment of these characteristic behaviors is a nursing activity that permits the nurse to individualize intervention strategies to each mother's needs.

Chapter 3

METHODOLOGY

Introduction

This study was an explanatory, ex post facto, correlational study. Subjects completed a self-test measurement instrument, Tennessee Self-Concept Scale (TSCS), to determine the self-concept level. A non-participant observer recorded the frequency of behaviors listed on the Maternal Adaptive Behaviors Checklist (MABC). The data from the TSCS and MABC were examined using an inferential statistic to determine correlation and test the hypothesis.

Setting

The setting was the post-partum unit of a southeastern medical center hospital. The unit has a combination of private, semi-private, and four-bed rooms. Both 'private' and 'staff' patients are admitted to the unit and may elect the rooming option if their own and their baby's conditions permit.

Population

The hospital serves an area population of approximately 162,100, residents of a small urban, university

community and seven rural counties.¹¹² Forty percent of the area's residents are between 18 and 44 years; seventy-five percent are white, twenty-five percent are non-white.¹¹³

The post-partum population from which the researcher obtained the study sample consisted of 141 post-partum patients admitted during the month of June, 1980.

Sample Selection

The researcher chose to study 30 subjects, or 1/5 of the sampling frame. Subjects were chosen using a sequential probability technique: All post-partum patients meeting the criteria and admitted during the study period were invited to participate until data were complete for 30 subjects.

Subjects met the criteria of being at least 18 years old and able to have their newborns with them in their rooms. These criteria were established because the TSCS norms applied to those over 18 years, and the MABC required recording mother-child interaction.

Initially, the researcher planned to exclude patients in private rooms, expecting too few opportunities to observe

¹¹²J. H. Martin and M. A. Spar, Estimates of the Population of Virginia Counties and Cities: July 1, 1971 to July 1, 1978. (Charlottesville, Virginia: Tayloe Murphy Institute, May, 1979), pp. 2-6.

¹¹³J. H. Martin, et al., Estimates of Demographic Characteristics of Virginia's Cities and Counties, 1976. (Charlottesville, Virginia: Tayloe Murphy Institute, 1979), pp. 1-3.

the mother's interaction with others required by the MABC. During pretesting, however, the researcher observed that these patients tended to have more visitors and as much staff interaction as patients in multiple bed rooms. Therefore, patients in private rooms were included in the study.

Initially, thirty-five patients meeting the criteria were invited to participate. Subjects who had vaginal deliveries were invited on the second day post-partum; subjects who had cesarean deliveries were invited on the third post-partum day to allow for the more extensive recovery of an operative delivery.

The researcher assured all patients approached that participation was voluntary and would not affect the quality of the care they received. Three patients (two cesarean deliveries) declined to participate; two patients (both cesarean) withdrew prior to data collection completion because they did not feel well enough to continue.

The most frequent factor ($n=14$) preventing inclusion in the study was age under 18 years. Six mothers were excluded because their newborns were confined to the special care nursery. Two mothers were of foreign nationality and had difficulty reading English. One mother had experienced the death of her husband one week prior to delivery and was excluded at the request of the unit staff.

Subject confidentiality was protected by using numbers to identify test answers and observed behaviors.

Results of the TSCS were not shared with the staff. A few observations (e.g., questions, anxiety about treatment procedures) were reported to the charge nurse for follow-up.

Sample

The study sample consisted of thirty (n=30) post-partum women. The mean was 23.8 years, with a range of 19-36 years. Table 1 shows that the sample was heterogeneous in terms of marital status, race, and parity. The most common delivery method was vaginal.

Table 1

Distribution of Subjects by Marital Status,
Race, Parity and Method of Delivery

	Number	Percent
Marital Status		
Married	19	63.3%
Single	10	33.3%
Divorced	1	3.3%
Race		
White	17	56.6%
Black	13	43.3%
Parity		
Multipara	16	53.3%
Primipara	14	46.6%
Method of Delivery		
Vaginal	29	96.6%
Cesarean	1	3.3%

The subjects' obstetrical histories were varied. Sixteen mothers delivered females while fourteen mothers had boys. One mother had twin boys. There were fourteen primiparas and sixteen multiparas. Two of the primiparas were multigravidas. The mean parity was 2.3 with a range of one to six. All but one of the subjects delivered vaginally.

Four subjects received no medication during labor and delivery. Others received one or more medications, including local anesthetics (n=10), epidural anesthesia (n=5), pudendal anesthesia (n=5), analgesics (n=5), and pitocin (n=2). Twelve subjects had a non-complicated pregnancy course. Eleven subjects experienced prenatal complications; three of these women required prenatal hospitalization. Six subjects experienced a complicated delivery (e.g., breech, shoulder dystocia). Five women had perineal tears or hematomas.

The sample contained a few subjects with unusual child-bearing histories. One delivered identical twins, while another had been told she would never conceive. One multipara had a severely retarded three year old child who had appeared to be normal until age two months. Another subject delivered her fourth child twelve years after her previous pregnancy.

Instruments

Tennessee Self-Concept Scale (TSCS)

The TSCS (Appendix B) is a self-administered scale designed by Fitts as a quantitative measure of an individual's self-concept.¹¹⁴ It consists of 100 self-descriptive statements with five possible responses, ranging from 'completely true' to 'completely false.' The TSCS was originally designed for subjects age 12 and over with a sixth grade reading level. However, studies have shown the need to use different score standards for subjects 12 - 18 and those over 55.¹¹⁵ The scale takes 10 - 20 minutes to complete.

The statement pool was derived from literature and client reports. Final statements were chosen by a panel of clinical psychologists. Ten items were designed to indicate subject defensiveness in completing the scale.¹¹⁶ Ninety statements were chosen to identify various aspects of the subject's internal and external frames of reference. Statements relating to five aspects of the external frame of reference (physical self, moral-ethical self, personal satisfaction, and social self) interrelate with those re-

¹¹⁴W. H. Fitts, Manual, Tennessee Self Concept Scale (Nashville: Counselor Recordings and Tests, 1965), p. 1.

¹¹⁵Thompson, pp. 18-20.

¹¹⁶Fitts, 1965, p. 2.

ferring to the internal frame of reference (identity, self-satisfaction, and behavior).¹¹⁷

The TSCS provides many scores, all based on the subject's responses to the statements as being positive or negative in relation to self-regard.¹¹⁸ The Total P or Positive score indicates the general level of self-esteem. Another 28 scores can be obtained by considering the eight frames of reference aspects individually or in combination with one another. The subject's self-concept profile is obtained by charting the scores on a graph, profile sheet and comparing subject scores with the mean scores.¹¹⁹

Bentler and others reported a high correlation with other personality measures.¹²⁰ Test-retest reliability on the P score, after two weeks, equalled 0.92, $p > 0.05$. Fitts also reported a "remarkable similarity of profile patterns found through repeated measures of the same individuals over long periods of time."¹²¹ Reported test-

¹¹⁷Fitts, 1965, pp. 2-3.

¹¹⁸O. K. Buros, ed., The Seventh Mental Measurements Yearbook, Volume 1 (Highland Park, N.J.: The Gryphon Press, 1972), #151.

¹¹⁹Fitts, 1965, pp. 5-6.

¹²⁰J. P. Robinson and P. R. Shaver, eds., Measures of Social Psychological Attitudes (Ann Arbor: Institute for Social Research, 1973), p. 68.

¹²¹Fitts, 1965, p. 15.

retest reliability of subscores ($p < 0.05$) used in this study were,¹²²

<u>Score</u>	<u>Reliability</u>
Physical Self	0.87
Personal Self	0.85
Family Self	0.89
Social Self	0.90

Robinson states that weaknesses of the TSCS include the possibility of the client's responses geared to what he saw as socially desirable and an over-interpretation of the many subscores.¹²³ Crites criticized self-concept instruments in general for not allowing the subject to choose his own words.¹²⁴ However, Wylie stated it was the best of its kind at this time and Bentler commended it for the vast amount of information it could provide.¹²⁵

Maternal Adaptive Behavior Checklist (MABC)

The MABC (Appendix F) was designed by the researcher for use in this study. It is a sign system of listing behaviors believed to occur in the study setting.¹²⁶ A

¹²²Fitts, 1965, p. 14.

¹²³Robinson and Shaver, pp. 68-70.

¹²⁴Robinson and Shaver, p. 70.

¹²⁵Buros, 1972, #151.

¹²⁶D. Polit and B. P. Hungler, Nursing Research (Philadelphia: Lippincott, 1978), pp. 311-312.

check was placed beside an item if it was observed. Completion of the MABC provided behavior frequency data.

The listed behaviors were derived from the literature as those indicating adaptation in the post-partum setting. Items 7 - 9 and 12 - 24 were drawn from nursing assessment tools Johnson recommended.¹²⁷ Items 1 - 6, 10, 11, and 25 - 30 were adapted from behaviors Roy identified as indicative of low self-esteem.¹²⁸ The researcher reversed the Roy behaviors to relate them to positive self-esteem and applied them to the post-partum setting.

The items were organized by inspection to correspond with four of the TSCS categories to facilitate correlation:

A. Physical Self: This category included items which indicated an "individual's view of her body, state of health, physical appearance, skills and sexuality."¹²⁹

C. Personal Self: This category included items which indicated "one's feelings of adequacy, personal worth as a person."¹³⁰ The items were chosen to reflect a feeling that the subject's thoughts, feelings, and abilities, were worthwhile and her shortcomings acceptable.

D. Family Self: This category included items

¹²⁷Johnson, pp. 21-30.

¹²⁸Roy, pp. 390-391.

¹²⁹Fitts, 1965, p. 3.

¹³⁰Fitts, 1965, p. 3.

which indicated "one's feelings of adequacy, worth, and value as a family member."¹³¹ The items were chosen to reflect that the subject felt an important part of her family; her family needed her and wanted her to relate with them; and her baby needed and wanted to get to know her.

E. Social Self: This category included items which indicated a "person's sense of adequacy and worth in her social interaction with other people in general."¹³² These items reflected the subject perceived other people liking her and saw her as adequate. Perceiving this, she was able to reveal parts of her inner self to others.

Prior to collecting data for the study, the researcher conducted preliminary testing of the MABC. There were three stages to this pretest period:

1. Review of the MABC for appropriateness of content;
2. Pilot study to test the MABC for clarity and content appropriateness in the study setting; and,
3. Pilot study to determine investigator reliability.

Three maternal-child nursing faculty members, each with at least five years experience, reviewed the behaviors list of the MABC to determine the appropriateness of observing these behaviors to assess maternal adaptation. The

¹³¹Fitts, 1965, p. 3.

¹³²Fitts, 1965, p. 3.

faculty members agreed that the content was appropriate.

The researcher conducted a small pilot study with seven post-partum patients. This study clarified scoring directions and content appropriateness in the study setting.

A second pilot study was done with four patients to determine investigator reliability in the use of the MABC. A maternal-child nursing faculty member observed and recorded patient behaviors on the MABC simultaneously with and independently of the researcher. Observation was done for ten minutes.

Table 2 details the results of this pretest. The faculty member (Observer A) and the researcher (Observer B) recorded similar ratings for all pretest subjects.

Table 2
Pretest Ratings

Subject	Ratings	
	Obs. A.	Obs. B
1	18	19
2	20	20
3	14	16
4	33	32

Correlation between the observers' ratings was $r = 0.99$, $p < 0.01$. Because of the high correlation, no further pretest was done.

Data Collection

Data collection had two phases: administration of the TSCS and non-participant observation of maternal behavior and recording on MABC.

Each eligible patient, selected by the sampling procedure described earlier, was approached by the researcher and invited to participate in the study. The researcher explained the purpose of the study as "to find out more about how women feel about themselves soon after they've had a baby and also to see what women feel like doing soon after childbirth." Initially, the researcher planned on obtaining consent and administering the TSCS 30 - 60 minutes prior to the observation period. However, the subjects completed the consent and TSCS the evening before observation because the researcher felt the subject would be self-conscious soon after completing the self-descriptive TSCS.

If the subject agreed to participate, the researcher obtained her signature on the consent form. The researcher then provided instructions for completing the TSCS. The researcher explained that each item was a statement that people might use to describe themselves. The subject was to read each statement and decide how well it described her. She would then choose one of the five choices at the bottom of each page (completely false - completely true) to indicate how well the statement described her. Subjects were instructed to put their answers directly on the test booklet.

The researcher emphasized the anonymity of the subject's responses, explaining that her answer sheet would be kept in a folder with other answer sheets after she had completed it, and that not even the researcher would be able to identify which answers were hers. The researcher answered any questions about how to complete the scale, and stated she would return the next day to collect the booklet and conduct the observation.

On returning to the subject, the researcher checked that the TSCS had been completed and placed the test booklet in the folder. The researcher determined an observation period convenient to the subject. When the observation was ready to begin, the researcher reinforced the subject's freedom to act as she wished. The researcher also repeated that she would be unable to talk with the subject during the observation. The researcher sat at least three feet away from the subject to minimize the effects of her presence on the subject's behavior.

During the pre-test period, the researcher observed that infant feeding restricted the mothers' choice of other behaviors, and that interaction between staff, visitors, and other patients was very limited during feeding. Therefore, no observations were made during scheduled feeding times. A few mothers attempted an additional feeding after the observation had started. The researcher chose to continue since these feedings were not activities scheduled by the unit staff but chosen by the mothers.

The researcher used the time-sampling method of observation. Each minute, the researcher observed for 30 seconds and recorded for 30 seconds. This method was chosen to ensure observations were not forgotten before they could be recorded accurately. A check was placed in the appropriate time interval column if the behavior was observed during that time interval. The observer also recorded the baby's sleep/awake status and visitor/staff interruption for each time interval.

Following the observation period, the researcher thanked the subject and answered questions from the subject about the study. If the subject had questions about herself or her baby that required extensive explanations or familiarity with the subject's medical record, she was referred to the unit staff.

Chapter 4

DATA ANALYSIS

Indices of Central Tendency

Figure A (p. 59) illustrates the distribution of the TSCS Total P score with a score interval of ten. The distribution was non-symmetrical and multi-modal. Subjects scores ranged from 262 to 406.

Table 3 shows the mean, median, and standard deviation values for TSCS total and four subscores. The mean P score was 348.8 with a standard deviation of 33.8.

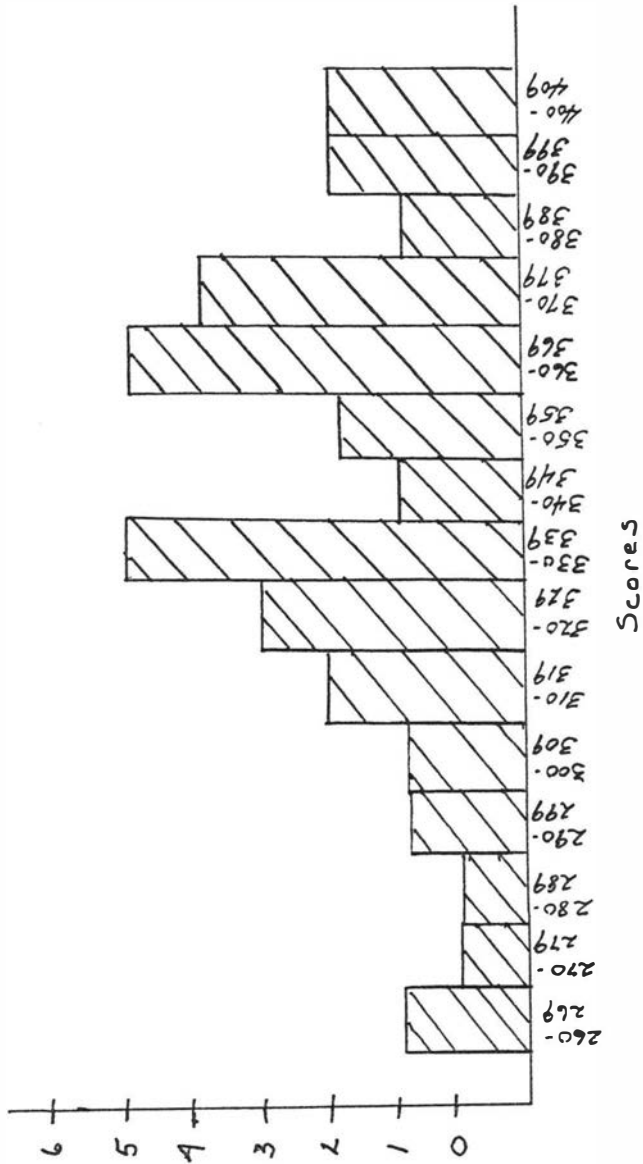
Table 3

Mean, Median, and Standard Deviation
TSCS Total P and Subscores

Score	Mean	Median	Standard Deviation
Total P	348.8	353.5	33.8
Physical Self	68.4	70.0	8.4
Personal Self	69.0	70.5	6.8
Family Self	71.0	72.0	9.2
Social Self	68.9	70.5	6.9

Figure A

Distribution of TSCS Total Scores



Sixteen subjects scored above and fourteen subjects scored below the Total P mean. The Total P scores of four subjects were below one standard deviation, while another four were above one standard deviation.

Figure B (p. 61) illustrates the distribution of subjects' Total MABC scores with a score interval of ten. The distribution was non-symmetrical and multi-modal. The scores ranged from 72 to 224.

Table 4 shows the mean, median, and standard deviation of MABC total and four subscores. The total MABC mean was 148.4.

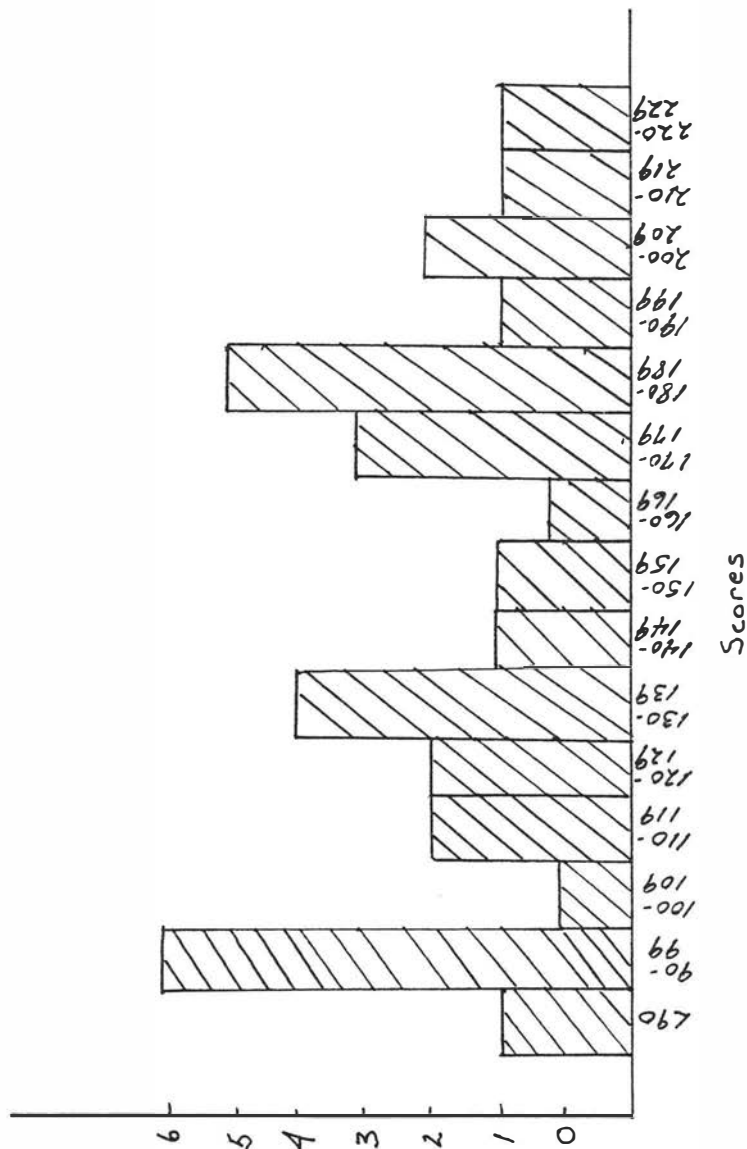
Table 4
Mean, Median, and Standard Deviation
MABC Total and Subscores

Score	Mean	Median	Standard Deviation
Total	148.4	142.5	43.2
Physical Self	14.2	12.8	9.0
Personal Self	14.4	14.0	7.1
Family Self	108.1	94.0	49.4
Social Self	27.6	25.5	15.7

Fourteen subjects scored above the MABC total mean while sixteen scored below. Seven subjects scored below and five subjects above one standard deviation of the MABC total mean.

Figure B

Distribution of Total MABC Scores



Correlation Coefficients

Hypothesis: Mothers with a positive self-concept will exhibit a greater frequency of adaptive behaviors than mothers with a negative self-concept.

Subject scores from the Tennessee Self-Concept Scale (TSCS) and the Maternal Adaptive Behavior Checklist (MABC) were examined for correlation using the Pearson product moment correlation coefficient ('r' statistic). This statistic provides a correlation index for interval data to determine the degree and direction of the linear relationship between the independent and dependent variables.¹³³ Table 5 contains 'r' values for total scores and subscores.

Table 5

Total and Subscore TSCS and MABC
Correlation Values
($r = 0.36$, $p < 0.05$, d.f. = 28)

Score	Pearson 'r' Value
Total Scores	-0.01
Physical Self	0.04
Personal Self	0.11
Family Self	-0.13
Social Self	0.00

¹³³Polit and Hungler, pp. 531-533, 561.

There was a non-significant correlation ($p < 0.05$) between total self-concept and adaptive behavior scores. Correlation between TSCS and MAEC subscores also were non-significant. The data did not support the hypothesis.

Additional Findings

Although the data did not support the hypothesis, it did provide some interesting findings.

This was the author's first experience with broad provision of a partial rooming-in experience. Post-partum patients, except those whose babies required special care, were allowed the opportunity to keep their babies at the bedside from 9:00 a.m. to 10:00 p.m. It was apparent, from the data and informal observation, that most of the mothers used the non-feeding time to initiate and maintain contact with their infants. Eighty-seven percent of the subjects ($n=26$) recorded the greatest frequency of behaviors in the Family Self category, consisting entirely of infant-related activities. Seventy-three percent of the subjects ($n=22$) maintained physical closeness to their infants more than half of the observation period. When this group was combined with those maintaining visual contact for at least half the observation, eighty percent ($n=24$) of the mothers were involved with some kind of mother-infant contact for at least fifteen minutes.

Although not formally analyzed, these data were consistent with Klaus and Kennell's observations of mothers

who had extended contact with their infants.¹³⁴ Although no formal evaluation was done, the researcher felt that an atmosphere of intimate involvement and fascination with the infant surrounded these mother-infant couples. Mothers did not seem to need a 'task' to perform in order to initiate contact with their babies.

The extensive contact also appeared to support Rubin's description of the identification process.¹³⁵ The most frequently observed behaviors (mean > 10) were: baby in bed/chair with mother (17); gazes at baby (21); converses with others (26); kisses, etc. baby (18); cradles baby against own body (16); smiles/vocalizes to baby (13); activity with baby (22). Items 21 and 26 were observed at least once with all subjects. Table 6 contains mean and frequency data for these behaviors.

Table 6

Sample Frequency and Mean of Selected Adaptive Behaviors in Order of Frequency

Behavior #	17	21	26	18	16	13	22
Mean	19.1	17.7	15.3	12.3	11.6	11.4	10
Sample Frequency	574	531	460	370	349	341	300

¹³⁴Klaus and Kennell, pp. 68-80, 90-93.

¹³⁵Rubin, 1972, pp. 109-110.

On inspection, there was no relationship between TSCS 'P' score and frequency of these three behaviors. Subjects with TSCS 'P' scores below the mean had a higher frequency of two behaviors than subjects with above the mean 'P' scores.

Six of the seven behaviors observed most often were involved with the infant and seemed to be motivated by the mother's need to become better acquainted with him. These mothers demonstrated a desire to touch, see, hear, and talk to their babies.

Observed fathers also seemed absorbed with learning about their infants. Three fathers compared this birth with another child's and said how much better it was for him to see and hold this baby so soon. Fathers asked questions about the babies' behavior and mothers seemed pleased to relate their own discoveries: 'She often hiccoughs'; 'He doesn't seem to jump when you move him like Tommy did.' Several mothers appeared to use the time to make very purposeful observations. For example, one mother held her sleeping baby next to her in bed while watching television. She later explained that she was testing his ability to tolerate noise while sleeping because he had teenage siblings.

It is possible that these behaviors were influenced by the observer's presence. However, the researcher often observed these close contact behaviors with other patients who were not in the study. Even when the babies were sleep-

ing, mothers changed the bassinet's position so that they could see the baby's face or reach over and adjust a blanket. Some mothers took naps with their sleeping infants in their arms.

Perhaps having the baby close met a mother's 'taking-in' needs as well. The majority of these babies did not seem very demanding at this stage. Except at feeding, the babies required very little care. Mothers, with their own post-partum needs of comfort and love, may have used the babies to experience the warmth, closeness, and pleasant physical sensations of another human, even a small one. Mothers isolated from familiar people and surroundings might have felt less lonely with their babies close by.

The third most frequent behavior (mean = 15.3) was conversing with others. This behavior was of varying quality, but the researcher was impressed with the striking difference between patient-staff communication and interaction between patient and visitors. It was remarkable to observe a woman, who had been quite quiet with her roommate and staff, become extremely talkative with those familiar to her. Perhaps assessment of patient-visitor interaction would be more informative of a mother's feelings and concerns than staff-patient interaction. This might be even more appropriate if the patient and staff members come from different backgrounds, since patient behavior might be more influenced by the hospital environment.

The researcher examined the frequency of three behaviors which appeared, on inspection, to have a high variability among the subjects. Mean and frequency data for these behaviors are listed in Table 7.

Table 7

Mean and Frequency Values of Selected Behaviors
for Subjects Scoring Above and Below TSCS Mean

Behavior	TSCS Mean		TSCS Mean	
	Frequency	Mean	Frequency	Mean
#11, Info re: self	35	2.2	46	3.3
#15, Pos. Observation of Infant	73	4.6	50	3.6
#22, Activity with Infant	114	7.1	186	13.3

On inspection, there was no consistent relationship between the frequency of these three behaviors and subjects' TSCS 'P' score. Subjects with TSCS 'P' scores below the mean had a higher frequency of two behaviors than subjects with above the mean 'P' scores, in contradiction of the hypothesis.

The researcher examined, by inspection, the difference between TSCS sample and standardized means. Table 8 lists the sample and standard means for Total P and sub-scores.

Table 8
Standard and Sample TSCS Means

Score	Standard	Sample
Total P	436	349
Physical Self	72	68
Personal Self	65	69
Family Self	71	71
Social Self	68	69

Sample means of all five scores were similar to the standard means. These data imply that post-partum women do not differ substantially from the general population in regard to self-concept levels.

Discussion

Data from this study did not demonstrate any relationship between a mother's self concept and her frequency of adaptive behaviors. As discussed in Chapter 2, other studies have found positive relationships between psychological characteristics of the mother, including her self-concept, and her ability to adapt during the puerperium.

The study's failure to support the hypothesis could be due to the limitations of the study design or a weakness in the theoretical base. Design limitations include sample deficiencies and instrumental weaknesses.

Sample Weaknesses

Although not statistically examined, the sample appeared to provide a representative sample of the hospital's post-partum population. It was heterogeneous in terms of age, race, parity, marital status, and sex of infant. It is doubtful, therefore, that the lack of correlation between the variables was due to homogeneity and/or bias of the sample.

Instrumental Weaknesses

The MABC was a researcher-designed instrument that was not tested statistically for reliability or validity and was used only in this study. Although the researcher conducted a limited pretest and consulted other maternal-child nurses about the instrument's content, these methods were not extensive and the usefulness of the tool in research can be questioned.

During data collection, the researcher especially observed the instrument's inability to measure the quality of behaviors. Some behaviors could have been more valuable than others in predicting adaptation, en face versus gazing activities, but the instrument weighed both equally. The instrument could not measure differences in how the mother approached a behavior, e.g., the difference between stroking the infant while smiling and talking to him versus stroking absentmindedly while watching television.

It also is possible that some of the MABC behaviors do not differentiate between mothers who are adapting from

those who are not. Perhaps almost all new mothers will keep their babies with them, given the opportunity to do so or feeling subtle pressure to do so. More extensive, systematic observations of post-partum patients prior to the study could have supplemented the literature and provided a better list of behaviors.

Some behaviors listed might have been elicited better in a structured situation. For example, few mothers were observed saying something positive about themselves unless directly asked by staff or visitors. Some mothers had this opportunity while others did not. This behavior might have been elicited more often in a structured interview.

Theoretical Framework

This study's major purpose was to test Roy's premise that self-concept influences adaptation.¹³⁶ Roy described the influence of self-concept on adaptation in general. Other authors found relationships between maternal adaptation and 'psychological variables,' not necessarily self-concept. This researcher could have erred in applying these generalities to the specifics of self-concept

¹³⁶Roy, p. 16.

and maternal adaptation. However, others' reports^{137,138,139} specifying self-concept or sense of self as a major influencing factor, supported the researcher's reasoning.

It is likely, then, that adaptation is influenced by self-concept. The problem in testing this premise may be rooted in Roy's belief that adaptation and self-concept can be assessed by observing behavior. The concept of adaptive behaviors was a cornerstone in the development of this study. The MABC behaviors were drawn from literature resources which held that they were indices of adaptation to motherhood. Perhaps these behaviors represent a less complex process, such as a trial period with a new role. Adaptation to such a complex situation may be reflected by more complex behaviors, over a long period of time.

The study accepted Roy's premise that self-concept can be assessed by observing one's behavior.¹⁴⁰ Yet, because self-concept is an abstract entity, it is difficult to determine precisely those behaviors which would indicate self-concept. The premise depends on the evaluative implication in observation. It implies that a behavior itself is positive or negative. Yet the same behavior can

¹³⁷Ballou, pp. 10-11.

¹³⁸Bibring, pp. 19-26.

¹³⁹Brody, pp. 331-332.

¹⁴⁰Roy, p. 236.

indicate totally different even contradictory, feelings or motivations. It therefore, may not be possible to assess self-concept by observing behavior.

Chapter 5

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

Thirty post-partum patients were studied to determine whether there was a relationship between self-concept and adaptive behavior. The sample was selected using a sequential probability technique and was heterogeneous in regards to age, race, marital status, and parity.

The Tennessee Self-Concept Scale (TSCS) was administered to the subjects to measure self-concept. The researcher designed an observation checklist, the Maternal Adaptive Behavior Checklist (MABC). The researcher, a non-participant observer, recorded the frequency of adaptive behaviors on the MABC during a thirty minute observation period. Behaviors were categorized into Physical Self, Personal Self, Family Self, and Social Self Behaviors to facilitate correlation with TSCS subscores.

The researcher hypothesized that: Mothers with a positive self-concept will exhibit a greater frequency of adaptive behaviors than mothers with a negative self-concept.

The hypothesis was not supported by the data. There was no significant correlation between the variables self-concept and adaptive behavior, nor between any of the subscores. Pearson product moment correlation statistic was used to determine correlation. Frequency of infant-related behaviors supported the findings of other researchers.

Conclusions

The researcher was unable to make any conclusions from this study which could apply to the post-partum population due to the small sample size and the lack of reliability and validity of the observation instrument. Conclusions which applied specifically to this sample were;

1. There was no relationship between subjects' self-concept and their demonstration of adaptive behaviors.
2. Mean values for subjects' TSCS scores were similar to TSCS standardized means.
3. Subjects demonstrated infant-related behaviors more often than any other behaviors.

Implications

Several implications for nursing practice can be made from this study.

The researcher's observations reinforced others' findings that mothers make extensive use of extended contact time with their newborns. Many nurses seem hesitant

to encourage use of the rooming-in option, fearing that it will tire new mothers. Although no data were specifically collected concerning maternal fatigue and rooming-in, observation suggested that the infants were not very demanding generally, and mothers were able to choose between resting or interacting with their infants. This researcher believes nurses could be more assertive in encouraging the option by explaining the benefits as often quite enjoyable and assuring mothers of the staff's support and help if needed.

The rooming-in option offers a potential benefit to staff by providing an extensive opportunity for informal observation and nonstructured interaction. Each patient should have several meaningful contacts each hospitalized day with the professional nurses, focusing on assessment of the mother herself. More emphasis can be placed on gathering data about the mother's perception of herself and the post-partum situation. Although bonding behaviors are an essential part of post-partum assessment, the study data imply that these behaviors may be misleading or may not be sufficient to identify mothers who need additional intervention.

Although this study did not identify index behaviors of maternal self-concept, the literature emphasized the importance of the mother's view of herself in adjusting to motherhood. The nurse may need to combine behavior observation with relaxed, non-threatening interview tech-

niques to assess self-concept. Encouraging mothers to discuss their pregnancies, labor and deliveries, impressions of their infants, and expectations of the weeks to come can stimulate informative conversation. The nurses can also help the mother share her feelings by offering observations about concerns and feelings of mothers in general: e.g., most mothers feel a bit clumsy with their babies at first.

Teaching is an integral part of nursing care with new mothers. It is most effective when the nurse's approach considers the mother's personality, past experience, and present concerns. The nurse who takes time to get to know her patient will not waste time later teaching techniques the mother already knows. She will be able to emphasize information that most interests the mother and suits her home situation.

The nurse should also be more assertive in assessing the mother's interaction with her family and friends. Data from this study imply that these interactions may reveal helpful information about how the mother functions in her own setting.

Recommendations

The researcher recommends continued nursing research into the relationship between self-concept and maternal adaptation, and suggests nurses:

1. Replicate this study, observing mothers several times during their hospitalization.
2. Replicate this study, observing mothers in situations controlled for consistency in interaction opportunity.
3. Replicate this study, comparing the effectiveness of assessments based on controlled observations with structured interviews.
4. Redesign the observational tool by:
 - a. Rank ordering behaviors;
 - b. Eliminating mother-infant interaction behaviors;
 - c. Regroup behaviors according to Roy's expressive-instrumentive categories.
5. Design a prospective study to assess subjects prenatally for self-concept and adaptation behaviors and explore their predictive value in the post-partum period.
6. Design an experimental study to compare the effectiveness of different teaching approaches on mothers with contrasting self-concept levels.

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Appendices



VIRGINIA COMMONWEALTH UNIVERSITY

Inter-Office Correspondence

Date: July 10, 1980

To: Ms. B. W. Fleming ✓ (Dr. Ethelyn E. Exley, Advisor) [REDACTED]

From: Dr. Donald L. Brummer, Chairman
Committee on the Conduct of Human Research [REDACTED]

Subject: Protocol "Self-Concept Correlation with Maternal Adaptive Behaviors"

The above protocol was reviewed and approved by the Committee on the Conduct of Human Research on June 25, 1980, provided that you modify the accompanying consent form as follows:

- 1) In first paragraph - delete second sentence "I am conducting this study as part of the requirement for the Master's Degree in Nursing from Virginia Commonwealth University in Richmond.
- 2) Delete entire fourth paragraph about financial compensation.
- 3) In fourth and last paragraph delete word "now" from second sentence.

Kindly forward 2 copies of your revised consent form to Mrs. Alice Dwyer, 301 West Franklin Street, Holiday Inn Room 1620, upon receipt of which an approval notice will be sent to you.

DLB:dkr

UNIVERSITY OF VIRGINIA
SCHOOL OF MEDICINE
CHARLOTTESVILLE, VIRGINIA 22905

OFFICE OF THE DEAN

June 12, 1980

Ms. Barbara Fleming
1204 Welford Street
Charlottesville, Virginia

Dear Ms. Fleming:

MATERNAL ADAPTIVE BEHAVIORS CORRELATED WITH SELF-CONCEPT LEVELS
#1854

Thank you for attending the June 10th meeting of the Human Investigation Committee. I am pleased to report that your proposal was approved, 12-0.

The Committee requests that you obtain informal assent from the resident or attending physician prior to approaching any of the potential subjects of your study.

Also, the Committee recommends that you change the second sentence of the second paragraph of page 2 to read "If you or your child should suffer any physical injury directly resulting from your participation in this study, which is extremely unlikely, no financial...etc." (This was the final decision after some discussion after you had left the meeting).

When you return the revised consent form, we will return a signed HEW-596 form to you, which indicates that you may proceed with your research.


Since we have a responsibility for continued supervision of projects, we ask that you and Dr. Brodie sign both copies of this letter and return the original to Ethel Hastings, Secretary of the Committee, Box 483, for our files. The second copy is for your records. By so doing, you affirm your intention to adhere to the details of this protocol and to report to the Committee any unexpected developments arising during the course of the study. The Committee reserves the right to terminate this study at any time if, in its opinion, the risks of further experimentation are prohibitive.

When your project is finished, we would appreciate your

Ms. Barbara Fleming
June 12, 1980
Page Two

writing a letter to us, giving the date of completion.

Sincerely,



John A. Owen, Jr., M.D.
Chairman, Human Investigation Committee
JAO:eh

Barbara Fleming, R.N.
Investigator

Dr. Barbara Brodie
Department Chairman

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

 GRANT CONTRACT FELLOW OTHERPROTECTION OF HUMAN SUBJECTS
ASSURANCE/CERTIFICATION/DECLARATION NEW RENEWAL CONTINUATION
APPLICATION IDENTIFICATION NUMBER (If known) ORIGINAL FOLLOWUP REVISION

STATEMENT OF POLICY: Safeguarding the rights and welfare of subjects at risk in activities supported under grants and contracts from DHEW is primarily the responsibility of the institution which receives or is accountable to DHEW for the funds awarded for the support of the activity. In order to provide for the adequate discharge of this institutional responsibility, it is the policy of DHEW that no activity involving human subjects to be supported by DHEW grants or contracts shall be undertaken unless the Institutional Review Board has reviewed and approved such activity, and the institution has submitted to DHEW a certification of such review and approval, in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended, (45 CFR 46). Administration of the DHEW policy and regulation is the responsibility of the Office for Protection from Research Risks, National Institutes of Health, Bethesda, Md 20014.

1. TITLE OF PROPOSAL OR ACTIVITY

MATERNAL ADAPTIVE BEHAVIORS CORRELATED WITH SELF-CONCEPT LEVELS

2. PRINCIPAL INVESTIGATOR/ACTIVITY DIRECTOR/FELLOW

Barbara W. Fleming, R.N.

3. DECLARATION THAT HUMAN SUBJECTS EITHER WOULD OR WOULD NOT BE INVOLVED

- A. NO INDIVIDUALS WHO MIGHT BE CONSIDERED HUMAN SUBJECTS, INCLUDING THOSE FROM WHOM ORGANS, TISSUES, FLUIDS, OR OTHER MATERIALS WOULD BE DERIVED, OR WHO COULD BE IDENTIFIED BY PERSONAL DATA, WOULD BE INVOLVED IN THE PROPOSED ACTIVITY. (IF NO HUMAN SUBJECTS WOULD BE INVOLVED, CHECK THIS BOX AND PROCEED TO ITEM 7. PROPOSALS DETERMINED BY THE AGENCY TO INVOLVE HUMAN SUBJECTS WILL BE RETURNED.)
- B. HUMAN SUBJECTS WOULD BE INVOLVED IN THE PROPOSED ACTIVITY AS EITHER: NONE OF THE FOLLOWING, OR INCLUDING: MINORS, FETUSES, ABORTUSES, PREGNANT WOMEN, PRISONERS, MENTALLY RETARDED, MENTALLY DISABLED. UNDER SECTION 6. COOPERATING INSTITUTIONS, ON REVERSE OF THIS FORM, GIVE NAME OF INSTITUTION AND NAME AND ADDRESS OF OFFICIAL(S) AUTHORIZING ACCESS TO ANY SUBJECTS IN FACILITIES NOT UNDER DIRECT CONTROL OF THE APPLICANT OR OFFERING INSTITUTION.

4. DECLARATION OF ASSURANCE STATUS/CERTIFICATION OF REVIEW

- A. THIS INSTITUTION HAS NOT PREVIOUSLY FILED AN ASSURANCE AND ASSURANCE IMPLEMENTING PROCEDURES FOR THE PROTECTION OF HUMAN SUBJECTS WITH THE DHEW THAT APPLIES TO THIS APPLICATION OR ACTIVITY. ASSURANCE IS HEREBY GIVEN THAT THIS INSTITUTION WILL COMPLY WITH REQUIREMENTS OF DHEW Regulation 45 CFR 46, THAT IT HAS ESTABLISHED AN INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS AND, WHEN REQUESTED, WILL SUBMIT TO DHEW DOCUMENTATION AND CERTIFICATION OF SUCH REVIEWS AND PROCEDURES AS MAY BE REQUIRED FOR IMPLEMENTATION OF THIS ASSURANCE FOR THE PROPOSED PROJECT OR ACTIVITY.
- B. THIS INSTITUTION HAS AN APPROVED GENERAL ASSURANCE (DHEW ASSURANCE NUMBER GO-306) FOR AN ACTIVE SPECIAL ASSURANCE FOR THIS ONGOING ACTIVITY. ON FILE WITH DHEW. THE SIGNER CERTIFIES THAT ALL ACTIVITIES IN THIS APPLICATION PROPOSING TO INVOLVE HUMAN SUBJECTS HAVE BEEN REVIEWED AND APPROVED BY THIS INSTITUTION'S INSTITUTIONAL REVIEW BOARD IN A CONVENED MEETING ON THE DATE OF 10 JUN 84 IN ACCORDANCE WITH THE REQUIREMENTS OF THE Code of Federal Regulations on Protection of Human Subjects (45 CFR 46). THIS CERTIFICATION INCLUDES, WHEN APPLICABLE, REQUIREMENTS FOR CERTIFYING FDA STATUS FOR EACH INVESTIGATIONAL NEW DRUG TO BE USED (SEE REVERSE SIDE OF THIS FORM).

THE INSTITUTIONAL REVIEW BOARD HAS DETERMINED, AND THE INSTITUTIONAL OFFICIAL SIGNING BELOW CONCURS THAT:

EITHER HUMAN SUBJECTS WILL NOT BE AT RISK; OR HUMAN SUBJECTS WILL BE AT RISK.

5. AND 6. SEE REVERSE SIDE

7. NAME AND ADDRESS OF INSTITUTION

University of Virginia
School of Medicine
Charlottesville, Virginia 22908

8. TITLE OF INSTITUTIONAL OFFICIAL

John A. Owen, Jr., M.D.
Chairman, Human Investigation Committee

TELEPHONE NUMBER

804-924-2109

SIGNATURE OF INSTITUTIONAL OFFICIAL

DATE

June 20, 1980

CONSENT TO PARTICIPATE
IN A RESEARCH STUDY

I invite you to participate in a study of behaviors of new mothers. I am conducting this study as part of the requirement for the Master's Degree in Nursing from Virginia Commonwealth University in Richmond. I hope to learn more about how mothers act and feel about themselves during the first few days after their babies are born. You were selected for this study because you are at least 18 years old, have recently had a baby, and are able to have the baby in your room with you.

If you choose to participate in this study, I will ask you to complete a questionnaire. This will take you about 15 minutes. After you have finished the questionnaire, I will sit in your room for 30 minutes to see what you feel like doing. You can do whatever you would do if I wasn't there: sleep, make a phone call, watch TV, talk, anything you feel like doing. I will be there while your baby is in the room with you, but you do not have to do anything with your baby that you would not normally be doing at that time. During these 30 minutes, I won't be able to talk with you but can talk after the 30 minutes is over. If you have any questions after we are finished, you may ask me then.

Research studies often involve some risks. The only risk involved in this study would be a loss of your privacy during the 30 minute observation time. Although you will not benefit directly from this study, I hope that my study will help nurses know how to assist mothers better.

Any information that you share with me will be used responsibly and will be protected against release to unauthorized people. Your answers to the questionnaire will not be identified with your name. The questionnaire and my observations will not become a part of your hospital chart. Only myself and the three instructors helping me will see the results, and then only with your name separated. The results of this study may be published later, but not with any information that will identify you.

I am not able to pay you for your participation in this study. If you or your child should suffer any physical injury directly resulting from your participation in this study, which is extremely unlikely, no financial compensation for such things as lost wages, disability, or discomfort is available, but medical treatment that is not covered by your insurance will be provided free of charge. If you have any questions concerning financial compensation for injuries during the experiment, you should talk to me, Barbara Fleming at 293-5464.

Your decision whether or not to participate in this study will not affect your future care at this hospital, or the care of your baby. Even if you decide now to participate, you may stop and withdraw from the study at any time without hurting your or your child's future care at this hospital.

You are making a decision whether or not you will participate in this study. If you sign this form, you have agreed to participate based upon reading and understanding this form. If you have any questions, please ask me before signing. Thank you.

SIGNATURE: _____ DATE: _____

RESEARCHER: _____ WITNESS: _____

COUNSELOR RECORDINGS AND TESTS

Box 6184 • Acklen Station
Nashville, Tennessee 37212

May 14, 1980

Barbara W. Fleming
1204 Wellford Street
Charlottesville, VA 22903

Dear Ms. Fleming:

We are granting our permission for you to use the Tennessee Self Concept Scale as part of your research material. We request that you abide by copyright laws. Please purchase any material needed from us at the above address. A copy of our price list is attached.

Thank you,


Rosetta Mosley

Tennessee Self Concept Scale

Page 1

Item
No.

1. I have a healthy body	1
3. I am an attractive person	3
5. I consider myself a sloppy person	5
19. I am a decent sort of person	19
21. I am an honest person	21
23. I am a bad person	23
37. I am a cheerful person	37
39. I am a calm and easy going person	39
41. I am a nobody	41
55. I have a family that would always help me in any kind of trouble	55
57. I am a member of a happy family	57
59. My friends have no confidence in me	59
73. I am a friendly person	73
75. I am popular with men	75
77. I am not interested in what other people do	77
91. I do not always tell the truth	91
93. I get angry sometimes	93

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

2. I like to look nice and neat all the time..... 2
4. I am full of aches and pains..... 4
6. I am a sick person..... 6
20. I am a religious person..... 20
22. I am a moral failure..... 22
24. I am a morally weak person..... 24
38. I have a lot of self-control..... 38
40. I am a hateful person..... 40
42. I am losing my mind..... 42
56. I am an important person to my friends and family..... 56
58. I am not loved by my family..... 58
60. I feel that my family doesn't trust me..... 60
74. I am popular with women..... 74
76. I am mad at the whole world..... 76
78. I am hard to be friendly with..... 78
92. Once in a while I think of things too bad to talk about..... 92
94. Sometimes, when I am not feeling well, I am cross..... 94

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

7. I am neither too fat nor too thin.....	7
9. I like my looks just the way they are.....	9
11. I would like to change some parts of my body.....	11
25. I am satisfied with my moral behavior.....	25
27. I am satisfied with my relationship to God.....	27
29. I ought to go to church more.....	29
43. I am satisfied to be just what I am.....	43
45. I am just as nice as I should be.....	45
47. I despise myself.....	47
61. I am satisfied with my family relationships.....	61
63. I understand my family as well as I should.....	63
65. I should trust my family more.....	65
79. I am as sociable as I want to be.....	79
81. I try to please others, but I don't overdo it.....	81
83. I am no good at all from a social standpoint.....	83
95. I do not like everyone I know.....	95
97. Once in a while, I laugh at a dirty joke.....	97

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

8.	I am neither too tall nor too short.....	8
10.	I don't feel as well as I should.....	10
12.	I should have more sex appeal.....	12
26.	I am as religious as I want to be.....	26
28.	I wish I could be more trustworthy.....	28
30.	I shouldn't tell so many lies.....	30
44.	I am as smart as I want to be.....	44
46.	I am not the person I would like to be.....	46
48.	I wish I didn't give up as easily as I do.....	48
62.	I treat my parents as well as I should (Use past tense if parents are not living).....	62
64.	I am too sensitive to things my family say.....	64
66.	I should love my family more.....	66
80.	I am satisfied with the way I treat other people.....	80
82.	I should be more polite to others.....	82
84.	I ought to get along better with other people.....	84
96.	I gossip a little at times.....	96
98.	At times I feel like swearing.....	98

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

13.	I take good care of myself physically	13
15.	I try to be careful about my appearance	15
17.	I often act like I am "all thumbs"	17
31.	I am true to my religion in my everyday life	31
33.	I try to change when I know I'm doing things that are wrong	33
35.	I sometimes do very bad things	35
49.	I can always take care of myself in any situation	49
51.	I take the blame for things without getting mad	51
53.	I do things without thinking about them first	53
67.	I try to play fair with my friends and family	67
69.	I take a real interest in my family	69
71.	I give in to my parents. (Use past tense if parents are not living)	71
85.	I try to understand the other fellow's point of view	85
87.	I get along well with other people	87
89.	I do not forgive others easily	89
99.	I would rather win than lose in a game	99

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

14.	I feel good most of the time	14
16.	I do poorly in sports and games	16
18.	I am a poor sleeper	18
32.	I do what is right most of the time	32
34.	I sometimes use unfair means to get ahead	34
36.	I have trouble doing the things that are right	36
50.	I solve my problems quite easily	50
52.	I change my mind a lot	52
54.	I try to run away from my problems	54
68.	I do my share of work at home	68
70.	I quarrel with my family	70
72.	I do not act like my family thinks I should	72
86.	I see good points in all the people I meet	86
88.	I do not feel at ease with other people	88
90.	I find it hard to talk with strangers	90
100.	Once in a while I put off until tomorrow what I ought to do today	100

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

Subject # _____

DEMOGRAPHIC DATA

MOTHER:

Age - _____ Race - _____

Education - _____ Marital Status - _____

Parity - _____ Prenatal Care - _____

Length of Labor - _____ Type of Delivery - _____

I&D Medication _____

Postpartum Analgesic/Tranquilizers _____

Complications _____

INFANT:

Age - _____ Sex - _____

Weight - _____ Complications - _____

Vita

