THE EFFECT OF A HOSPITAL INITIATED POSTPARTUM SUPPORT GROUP ON THE SELF-ESTEEM OF PRIMARY CESAREAN DELIVERED MOTHERS AND THEIR PERCEPTIONS OF THEIR BIRTH EXPERIENCES

by

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ABSTRACT

Twenty-seven women who delivered by primary cesarean at LDS Hospital were studied to determine whether a hospital initiated postpartum support group made perceptions of birth and self-esteem more positive. Twelve women comprised the experimental group and attended a support group meeting lasting one hour on their third or fourth postpartum day. All the subjects completed two questionnaires the evening before their discharge. The support group did not significantly affect the cesarean delivered mothers' perceptions of their births or their self-esteem. However, mothers that attended the support group meeting did have a more positive perception of their sense of control during labor and delivery. Also, the support group seemed to make their perceptions of labor more positive. There is a need for further study of factors that may enhance the cesarean birth experience for families.

CONTENTS

Appendices

LIST OF TABLES

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CHAPTER I

INTRODUCTION

Twenty years ago women were relatively passive recipients of childbirth care. Few differences were apparent between women who delivered vaginally and those who delivered by cesarean; both were heavily medicated, separated from husbands and babies, and hospitalized for about a week. However, parents' expectations have been changing. Consumer activism has produced a trend toward informed, shared, family-centered birth (Lipson, 1982; Marut & Mercer, 1979). The consumer movement has stressed such factors as prepared childbirth, participation of the father or support person in the birth experience, decreased use of anesthesia and analgesia, and emphasis on early parent infant bonding.

Concurrently, the cesarean birth rate has increased in the last ten years to a mean of 15.2 percent (Placek & Taffel, 1980; Morrison, Wiser, McKay, Gookin & Douvas, 1982). The convergence of these two trends, informed, family-centered childbirth and an increased cesarean birth rate, has contributed to a negative reaction to cesarean delivery for some women (Affonso & Stichler,

1978; Lipson, 1982).

Purpose

The purpose of this study was to determine the effect of a hospital initiated postpartum support group interaction on the primary cesarean mother's perception of her birth experience and self-esteem. Caplan (1964) asserted that during a period of stress an individual has a heightened desire for help and is more susceptible to the influence of others. The researcher hoped to determine the efficacy of using a postpartum support group as one approach to helping mothers integrate birth experiences on a more positive level.

Problem Statement

The problem was to identify the effect of participation in an early postpartum support group on perceptions of the birth experience and self-esteem of primary cesarean mothers.

Conceptual Framework

Crisis intervention theory, as explicated by Aguilera and Messick (1982), provides the conceptual framework for this investigation. During a crisis situation, an individual faces a problem that he cannot solve with his previous coping mechanisms; therefore, a period of disequilibrium results. The goal of cri-

sis intervention is psychological resolution of the situation and return of functioning to the precrisis level or to an even more mature level of functioning.

Group therapy is an effective form of crisis intervention as social support facilitates coping with a crisis and adaptation to change (Cobb, 1976). A crisis group is composed of individuals who are unrelated and unknown to each other. They work with a therapist to resolve individual crises through group interaction. Thus, a generic approach to group intervention is utilized; the focus is on the particular kind of crisis rather than the psychodynamics of each individual.

The maternal-child nurse is in a unique position to act as a "therapist" because of her time-space closeness to patients and their families (Baird, 1976; Caplan, 1961; Donaldson, 1981). She is able to assess the effect of stressors on the patient's equilibrium and to initiate appropriate supportive intervention.

Aguilera and Messick identified the perception of the event, available situational supports, and coping mechanisms as "crisis-balancing factors." Therefore, members of the crisis group should explore the crisis-precipitating events, the crisis itself, past coping skills, situational supports, and present feelings that are preventing them from integrating the experience. The nurse can provide emotional support in terms of ego

support, clarification of the stressor event, modification of the environment, and anticipatory guidance (Cry & Wattenberg, 1965).

Expressing acceptance and empathy as well as clarifying the event and reinforcing reality provide ego support (Donaldson, 1981). Thus, the nurse can assist in the realistic perception of the event.

Modification of the environment refers to the patient's support system. The nurse needs to identify and reinforce familial support and assist in mobilizing the childbearing families' internal and external supports.

Finally, anticipatory guidance involves mobilizing the patient's coping strengths in advance of the full impact of the stressor (cesarean delivery). Teaching and environmental readiness for the postpartum period are included in anticipatory guidance. The patient and her family should be assisted in anticipating coming events, developing realistic expectations, and exploring coping resources.

Literature Review

Historical Overview

A brief review of the development of the use of the cesarean mode of delivery increases understanding of the relatively recent rise in the number of cesarean

deliveries. The origin of cesarean operations is grounded in folklore and mythology. Hemorrhage and massive infection made cesareans nearly always fatal (85-100% mortality rate) for the mother and fetus until the 20th century A.D. (Draft report, 1980). To avoid this high maternal mortality rate, internal version and extraction, operative forceps, early induction of labor for the delivery of a smaller baby, and fetal destruction were common practices in the 1800s (Draft report, 1980). Finally, by the end of the 19th century, the efficacy of cesareans received a boost with the initiation of the use of anesthesia, aseptic techniques as proposed by Lister, and suturing of the uterus (Draft report, 1980; Pritchard & MacDonald, 1980; Affonso, 1981).

In the 20th century two major modifications of the operative technique, entrance of the uterus extraperitoneally and placement of the incision in the lower uterine segment, helped to further reduce the maternal mortality rate (Pritchard & MacDonald, 1980). This resulted in decreased infection, decreased blood loss, and better healing.

However, in the 1950s, cesareans still remained the exception. By the 1960s, a decline in the mortality rate due to improved anesthesia, blood products, antibiotics and medical control of maternal illness

permitted more freedom of choice to perform a cesarean delivery (Draft report, 1980; Wiser et al., 1982). In addition to an increase in the safety of the operation, recognition of the potential detriment to fetal well-being by vaginal delivery or delay in delivery have contributed to the rise in the cesarean birth rate witnessed during the 1970s (Placek & Taffel, 1980; Wadhera & Nair, 1982).

Technological advances such as x-ray, ultrasound, hormonal tests, antepartum fetal monitoring, and amniotic fluid analysis may have helped to indicate the fetuses at risk who may need to be delivered surgically. Current predisposing risk factors for primary cesareans may be found within the following three groups:

1. maternal disease -- diabetes, chronic heart disease or hypertension, toxemia, kidney disease, or active herpes;
2. fetal condition -- Rh sensitivity, prolapsed cord, or other diagnoses of fetal distress, and prematurity; and
3. mechanical difficulties -- placenta previa, abruptio placenta, uterine anomalies, cephlopelvic disproportion, breech presentation, malpresentation, or conjoined twins (Mevs, 1977; Murray, 1981).

An increasing number of repeat cesareans, due to

the rise in primary cesareans, has also contributed toward the current high rate of cesarean deliveries.

In summary, at one time, the optimal goal was vaginal delivery because of ominous maternal morbidity and mortality rates associated with cesarean delivery. Hazardous effects of labor on the fetus had not been studied because methods for determining fetal distress had neither been developed nor implemented. However, with a dramatic drop in maternal morbidity and mortality and an increased emphasis on fetal well-being, cesarean birth is the method of choice today if a delay in delivery would compromise the mother, fetus, or both and if vaginal delivery cannot be safely accomplished (Pritchard & MacDonald, 1980).

The Psychological Impact

The emotional and psychological impact of cesarean childbirth has only recently been addressed in the literature (Affonso, 1977; 1981; Affonso & Stichler, 1978; 1980; Cohen, 1977; Conner, 1977; Donovan, 1978; Fawcett, 1981; Hedahl, 1980; Kehoe, 1981; Marut, 1978; Marut & Mercer, 1979; Mevs, 1977; Schlosser, 1978; Tilden & Lipson, 1981); research, however, is limited and is primarily descriptive. These studies are focused on recurrent maternal responses to a cesarean birth: relief at the end of labor, fears for self and baby,

depression, guilt, pain, self-blame, inadequacy, "negative" feelings, disappointment, jealousy of other women, "powerlessness," loss of autonomy, decreased self-esteem, and a change in body image.

Tilden and Lipson (1981), in an exploratory field study of 22 women, attempted to identify the variables affecting the psychological impact of cesarean delivery. Their data revealed that the quality and magnitude of the impact varied greatly depending on a number of antecedent, concurrent, and consequent variables surrounding cesarean birth. The antecedent variables include birth plans and expectations, the degree of trust felt towards the physician, the amount of time available to prepare for the cesarean delivery, and the perceived reason for the operative delivery. Tilden and Lipson found that if the woman was planning a natural delivery, she experienced a greater sense of loss, disappointment, and anger from the cesarean birth. Also, if the woman preconceptualized the birth experience as being within her control, implicit in natural childbirth, her sense of failure and guilt was greater.

The central antecedent variable was the woman's perception of why she needed the cesarean. Tilden and Lipson discovered that a woman's perception of the medical indication may either result in self-doubt and guilt about her performance or may make the cesarean

seem more justifiable.

The concurrent variables surrounding the surgical event include the atmosphere in the surgical suite, the presence of a support person, the type of anesthesia used, the loss of control experienced, the quality of the interaction with the infant at the time of birth, and the woman's recovery room experience. Tilden and Lipson discovered that reaction to these variables depended on whether she was treated more like a maternity patient or surgical patient.

Finally, Tilden and Lipson identified the woman's postoperative physical recovery, the amount of exhaustion felt, the amount and quality of the nursing support given, and her feelings toward her infant as consequent variables that influenced her feelings toward having cesarean delivery.

The impact produced by the interaction of these variables is dependent on the woman's coping skills, her ego strengths, developmental stage, social support system, perceived societal values, and her past experiences with crises (Caplan, 1964; Tilden & Lipson, 1981). Although not all women who experience a cesarean have negative perceptions, an unexpected cesarean can be a source of acute psychological stress (Affonso & Stichler, 1978; Lipson, 1982; Tilden & Lipson, 1981).

Marut and Mercer (1979) compared the perceptions

of 20 primiparous mothers who had cesareans with 30 primiparous mothers who had vaginal deliveries. All subjects were interviewed within 48 hours postpartum and completed a 29-item questionnaire. Cesarean mothers perceived the experience of giving birth as significantly different from those women who delivered vaginally. Marut and Mercer identified that cesarean mothers experienced decreased self-esteem, a greater sense of unreality, and negative feelings about their ineffective labors. Their perceptions centered on loss of control of the situation, fears during delivery, worry about the baby's condition, and the delayed time of bonding with the infant after the delivery. Cesarean mothers also tended to view the delivery as abnormal and having social stigma. The presence of husbands during the delivery was the only significant positive influence identified.

Cranley, Hedahl, and Pegg (1983) replicated Marut and Mercer's investigation and extended it to include multigravida and women experiencing a planned cesarean birth. Forty women who had vaginal deliveries, 39 who had emergency cesareans, and 43 who had planned cesareans comprised the sample. Cranley et al. also explored three variables in relation to women's perceptions of birth: the father's presence at delivery, perception of being in control, and feelings toward the infant. The subjects all completed three questionnaires

and participated in an interview two to four days after giving birth.

Cranley et al. (1983) found that the three groups had significantly different perceptions of the birth experience and that the emergency cesarean birth group had the most negative perceptions. In addition, the data supported the hypotheses that regional anesthesia, presence of husbands at delivery and greater participation in decision-making were associated with more positive perceptions. Also, women in the emergency cesarean group were unaware of the options available to them that could influence the birth experiences.

The previously identified negative reactions seem to center around three themes: a sense of unreality, grieving, and decreased self-esteem. Both the birth and the baby seem unreal to cesarean mothers. Affonso (1977) stressed that women undergoing unexpected cesareans are particularly vulnerable to forgetting events surrounding delivery. These "missing pieces" become a major part of the unreality felt. The father's presence in the delivery room makes it a more positive experience (Cohen, 1977; Hedahl, 1980; Affonso & Stichler, 1978; 1980; Fawcett, 1981; Marut & Mercer, 1979; Tilden & Lipson, 1981).

Secondly, discrepancies in maternal expectations and the actual birth event result in losses that require

grief work to resolve (Affonso, 1981; Cohen, 1977; Hedahl, 1980; Kehoe, 1981). Kehoe (1981) conducted an exploratory study of the differences in the frequency, type, and intensity of loss and grief experienced by 20 cesarean mothers and 16 vaginally delivered mothers. Cesarean mothers were found to have more frequent and intense grief responses.

Finally, the third major portion of negative feelings center on decreased self-esteem; women reported feeling that they failed (Affonso, 1981; Hedahl, 1980). Several factors contribute to decreased self-esteem. First, society views the cesarean delivery as a sign of weakness (Affonso, 1981; Marut & Mercer, 1979). Unmet expectations or personal goals may be a second cause of lowered self-esteem. More realistic expectations reduce this impact on self-esteem. A third factor evolves from the insult to a woman's body image as a result of the physical trauma of major surgery. A sense of failure also contributes to a poor self-image: a woman may feel that if she would have only tried a little harder, maybe she could have avoided a cesarean. In addition, cesarean mothers seem to get less positive feedback from friends and family. The last factor contributing to decreased self-esteem is perceived loss of control.

The cesarean mother must reconstruct the events surrounding the delivery, resolve her griefwork, and

improve her self-image in order to effect a positive resolution of the experience and to optimally assume the maternal role (Affonso, 1977; Marut, 1978; Marut & Mercer, 1980). Lipson and Tilden (1980) researched the cesarean mother's resolution of the childbearing experience and found that the resolution involved an intense psychological adjustment over an extended period of time postpartally. Lipson and Tilden asserted that association with and support of other cesarean mothers is a key factor in the adjustment. Cesarean support groups provide information in terms of experiential knowledge, peer emotional support, role models of those who have made positive adjustment, an opportunity to help others, and increased consumer consciousness and control within the health care system (Lipson & Tilden, 1982). Unfortunately, cesarean mothers often do not join a support group until several months postpartum or until a subsequent pregnancy when they realize that they have not resolved the previous cesarean birth experience.

Concerned professionals and lay people address the need for nurses to be supportive. However, although the literature suggests that psychological support from nurses facilitates adjustment to the cesarean delivery, research validating innovations in nursing care that might make the subjective experience more pleasurable and less ego-deflating are grossly lacking.

Crisis Theory

Hazardous situations or events within the life cycle produce a period of stress for everyone and a period of crisis for some. People strive to maintain a homeostatic state by constant utilization of coping mechanisms; if these mechanisms, however, are overpowered by a period of disequilibrium, a state of crisis results.

Bloom (1965) suggested that a crisis state can be identified by the significant presence of a stressful precipitating event and subjective cognitive and affective disruption lasting several days. The precipitating event is a problem or obstacle that the individual cannot solve as it requires a solution not previously encountered in one's life experience (Caplan, 1964; Rapoport, 1965a). The crisis is generally self-limited to one to six weeks.

The Chinese characters representing the word "crisis" mean both danger and opportunity (Aguilera & Messick, 1982). A crisis presents an individual with an opportunity for personal growth and maturation or with the danger of reintegration at a less functional and adaptive personality level. Caplan (1964) discussed the developmental phases of a crisis and factors influencing resolution. First, there is an increase in tension as the individual attempts to use previously

successful coping mechanisms. If there is no resolution and the stimuli or stressor is still present, tension continues to rise. This increased tension causes the individual to mobilize internal and external resources and redefine the situation so that it might be solved. However, there is also the possibility that the increased tension will not be resolved and will result in further disequilibrium. The outcome depends on the antecedent factors. External intervention, however, affects the results because during a crisis the individual has a heightened desire for help and is more susceptible to the influence of others.

With crisis theory the construct of ego development provides a conceptual framework for developmental or maturational crises (Caplan, 1964; Parad, 1965; Tilden, 1980). Ego development reflects an individual's coping behavior, instinct behavior, and conscious adaptive mechanisms. Erickson conceptualized the development of the ego as occurring during specific life stages. Developmental theories, such as Erickson's center around growth and a directional change as each successive life stage builds on the level achieved in the previous stage (Tilden, 1980).

After reviewing recent contributions in the literature concerning adult development, Tilden (1980) held that adult life consists of a series of crises and

transitions followed by brief plateaus. Crises are periods of ego instability precipitated by a pivotal life event, such as birth or death (Caplan, 1964). Ego instability produces a subjective feeling of uncertainty, insecurity, and anxiety.

Thus, the constructs of life crises and ego development theory provide a basis for studying maturational crises. Deutsch (1945) and Bibring (1961) originally identified pregnancy as a maturational crisis. In fact, the entire childbearing year is a series of maturational crises as the woman must work through several developmental tasks. During pregnancy, the woman must initially resolve psychological conflicts of earlier developmental stages -- especially, her relationship with her mother (Bibring, 1961; Deutsch, 1945). Next her tasks include incorporating the fetus; then separating the fetus from herself; and finally, establishing a relationship with the baby as a new person. Parenthood is the last maturational crisis of the childbearing year. The extent to which these developmental tasks are experienced as a crisis depends upon the emotional support available (Leifer, 1977).

Situational crises arise from the impact of an internal event or stressor on an individual. Again, the event itself, the individual's and the family's resources for coping with that event, and their definition or

perception of the event determines whether or not it constitutes a crisis. Perceptions are influenced by objective, cultural and subjective interpretations. A cesarean delivery can be an unanticipated stressor (Donaldson, 1981) which, when superimposed on the maturational crisis of pregnancy, can result in a major crisis period.

Hypotheses

Two hypotheses were tested:

1. Primary cesarean mothers who participate in a hospital initiated postpartum support group will have a more positive perception of the birth experience than those who receive no group support.
2. Primary cesarean mothers who participate in a hospital initiated postpartum support group will have a more positive perceived level of self-esteem than those who receive no group support.

Definitions

Primary Cesarean Mother

A primary cesarean mother was defined as either a primipara or multipara who had experienced her first cesarean delivery.

Cesarean Support Group

A cesarean support group was considered a group of cesarean delivered mothers who were unknown and unrelated to each other who met with a nurse group leader to work together toward the resolution of the childbearing experience through group interaction and support.

Perception of the Birth Experience

Perception of the birth experience was defined as subjective interpretation of the birth event as a result of integration of the stimulus (the cesarean birth) with past knowledge and experience.

Self-Esteem

Self-esteem was defined as personal judgment of worthiness as experienced in the attitudes the individual held toward herself.

Assumptions

The following assumptions were made in this project:

1. The cesarean mother is motivated to resolve her feelings about the birth experience.
2. Supportive intervention during the immediate postpartum period is critical to the resolution of the childbirth experience.

3. The primary cesarean mother may have negative perceptions of the birth experience; hence, there exists the need to modify them.

4. The primary cesarean mother is able to modify her feelings immediately postpartum in accordance with her understanding of the situation.

CHAPTER II

METHODOLOGY

Design

A static group comparison design was chosen to test two hypotheses. This design, which is preexperimental in nature, involved the comparison of a group which participated in a cesarean support group and one which did not in order to establish the effect of the support group (Figure 1).

This design controls for all threats to internal validity except for selection and motality. Since subjects were not randomly assigned to groups there was no way of certifying that the groups were equal, except for the intervening variable (Campbell & Stanley, 1963). Rather than randomly assigning individuals to two different groups at the same time, two time periods with one group at each time period was necessary to facilitate larger group size. Also, it prevented interaction between the two groups. Therefore, this design did not control for the threat to internal validity of selection.

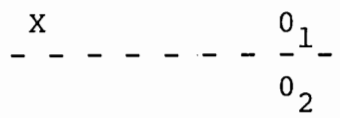

Figure 1. Static group comparison design.

The threat to mortality was controlled in this design because data collection for each individual took place over a period of two days. Therefore, the problem of differential drop-out within each group was minimized or nonexistent.

Sample

A nonprobability convenience sample of 27 primary cesarean-delivered mothers, including minors, was drawn over a two-month period at LDS Hospital. The first month, 15 mothers who experienced a primary cesarean delivery constituted the control group. Data were collected during the third or fourth postpartum day.

The experimental group of 12 mothers was drawn during the second month. They participated in a cesarean support group session on the third or fourth postpartum day. Data were collected on the evening following the group session.

Instruments

A 29-item questionnaire (Appendices A and B) measuring attitudes about the labor and delivery experience was completed by each of the subjects. The questionnaire was adapted by Marut and Mercer (1979) from a 15-item questionnaire developed by Samko and Schoenfeld to measure subject's attitudes toward the Lamaze child-

birth experience. Marut and Mercer made the adaptation to enhance the content validity for use with cesarean delivered mothers. Each item on the questionnaire has a scale of one to five; the higher the rating, the more favorable or positive the experience is viewed. The correlation coefficient reliability (Cronbach's alpha) for Marut and Mercer's adapted questionnaire was .83 for internal consistency (Marut & Mercer, 1979).

Two forms (A and B) of Marut and Mercer's questionnaire were used in this study. Form A is the original questionnaire. Form B is a modification made by Cranley (1983) for women who had no labor before their cesarean birth. Items 1, 3, 4, 7, 11, 13, 16, 19 and 23 measured perceptions of preoperative procedures and were considered analogous to the labor items on the original scale.

The subject's self-esteem was measured by the Tennessee Self-Concept Scale (TSCS)(Fitts, 1965)(Appendix C). This instrument consists of 100 Likert-type statements that measure self-concept and self-esteem in terms of the individual's perceived identity, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self, and social self. The overall level of self-esteem is measured by the total positive score, the most important single score. Persons with high total scores tend to like themselves and feel that they

are persons of value and worth.

Extensive normative data are available for all scores on the TSCS. The original group from which the norms were developed was a broad sample of 626 people (Fitts, 1965). The test-retest reliability coefficients as reported by Fitts cluster mostly in the .80 to .90 range and are shown in Table 1. Samples from other populations do not differ appreciably from these norms.

Procedure

All mothers delivering by primary cesarean were contacted by the researcher on the second postpartum day. After discussing the purpose of this investigation and answering any questions asked by the mother, written consent was obtained prior to participation. Pertinent information for the data sheet (Appendix D) was obtained from the subject's hospital chart.

During the first data collection month, the researcher asked the subjects in Group I, the control group, to complete the two questionnaires described above on the third or fourth postpartum day.

During the second research month, the researcher invited the mothers in Group II (experimental group) to participate in a short cesarean support group session. These sessions lasted about one hour. Mothers were encouraged to share their perceptions of the

Table 1

Means, Standard Deviations, and Reliability Coefficients Tennessee Self Concept Scale (N=60)

Score	Mean	Standard Deviation	Reliability
Self-criticism	35.54	6.70	.75
Total positive	345.57	30.70	.92
Row 1	127.10	9.96	.91
Row 2	103.67	13.79	.88
Row 3	115.01	11.22	.88
Column A	71.78	7.67	.87
Column B	70.33	8.70	.80
Column C	64.55	7.41	.85
Column D	70.83	8.43	.89
Column E	68.14	7.86	.90
D Score	120.44	24.19	.89

birth experience, to identify any negative feelings, to discuss the available support system, and to discuss plans for the immediate postpartum period at home. The researcher was present to facilitate the group interaction and to provide information and support as necessary. Mothers who had more than one cesarean delivery were also present to provide insight and support to the members of the group. The primary cesarean mothers were asked to complete the questionnaires on the evening of the fourth postpartum day.

Data from the questionnaires completed by the two groups were analyzed to identify the differences between the two groups.

Data Analysis

Analysis of the data was performed at the University of Utah Computer Center using the Statistical Package for the Social Sciences program (Nie, Hull, Jenkins, Steinbrenner & Bent, 1970). The level of confidence for all statistical tests was set at the .05 level (Runyon & Haber, 1977).

Descriptive statistics were computed to describe and summarize the data. Chi-square analysis and paired *t*-tests were used to evaluate any significant differences between the subjects in the sample. The Mann-Whitney-U test, a nonparametric alternative to the *t*-

test, was used to evaluate hypothesis one. The one-tailed *t*-test was used to evaluate differences in self-esteem, hypothesis two.

Human Subjects Considerations

Permission to conduct this study was granted by the human subjects review committees of both the University of Utah and LDS hospitals. The Assistant Director of Nursing, Maternal/Newborn Nursing, and the postpartum head nurse were also consulted prior to implementation.

Written informed consent was obtained after the subjects were provided with sufficient information and an opportunity to consider whether or not to participate. The mothers were provided with an explanation of the purpose of the research of what participation in the support group involved. The mothers were told that the questionnaires dealt with their attitudes and feelings about the delivery experience and with their views of themselves as persons.

Further explanation was provided to the mother regarding the amount of time the support group meeting involved and how long it would take to complete the two questionnaires. She had the right to stop participating at any time. Confidentiality was maintained by coding the data. No names were used in reporting the results.

CHAPTER III

RESULTS AND DISCUSSION

Descriptive Statistics

Demographic data were gathered from 27 mothers. Descriptive statistical procedures, frequencies, means, medians, standard deviations, and ranges were performed on these data.

The mother's demographic characteristics are summarized in Table 2. The age range was 21 through 39 years with a mean of 29.7 years. There were 12 primiparas in the sample and the mean number of living children was 1.59. The mean length of labor was 6.63 hours; five subjects had no labor. The labor of 12 subjects was augmented with pitocin. These data reveal no significant difference between the control and experimental groups in terms of the subject's age, parity, length of labor, or augmented labor.

The occurrence (percent frequencies) of complications of pregnancy and complications during labor are summarized in Table 3. Chi-square analysis for the complications of pregnancy, pre-eclampsia ($p = .56$; $df = 1$) and diabetes ($p = .66$; $df = 2$), reveal no difference

Table 2

Means, Standard Deviations, Ranges and Variance:

Demographic Data of Cesarean Mothers (N=27)

Variable	Mean	Standard Deviation	Range	Separate Variance Estimate 2-tailed prob.
Age	28.7	5.45	21-39	
Group 1 (n=15)	28.5	5.17		.198
Group 2 (n=12)	31.2	5.61		
Parity (before delivery)				
Term	1.6	2.12	0-7	
Group 1	1.5	2.26		.875
Group 2	1.7	2.02		
Premature	.1	.27	0-1	
Group 1	.1	.35		.164
Group 2	.0	.00		
Abortions	.6	1.15	0-5	
Group 1	.9	1.39		.104
Group 2	.2	.62		
Living Children	1.6	1.97	0-7	
Group 1	1.6	2.06		.831
Group 2	1.5	1.93		
Length of Labor	6.6	5.23	0-15	
Group 1	6.4	4.73		.810
Group 2	6.9	5.99		
Augmentation of Labor		Degrees Freedom: 1		Significance: .7950

Table 3

Percent Frequencies Demographic Data Regarding the Intrapartum Period (N=27)

Variable	Frequency (%)
Complications of Pregnancy	
Pregnancy induced hypertension	18.5
Diabetes (Class A)	3.7
Diabetes (Class D)	3.7
Bleeding	7.4
Renal infection	3.7
Multiple pregnancy	3.7
Complications of Labor	
Abnormal presentation	44.4
Late decelerations	37.0
Variable decelerations	48.1
Decreased variability	29.6
Meconium fluid	22.2
Other:	
Bleeding	3.7
Eclampsia/preeclampsia	7.4
Fetal tachycardia	7.4
Fetal bradycardia	3.7
Prolapsed cord	3.7

between the two groups. The complications of labor consisted primarily of indications of fetal distress. Twenty of the cesareans were emergency deliveries and seven were planned, although the decision was made within 24 hours of the delivery. The reasons stated on the patients' charts for performing the cesareans included presentation (37.0%), fetal distress (29.6%), cephlopelvic-disproportion (14.8%), and others (active herpes, bleeding, previa, hydrocephalus, and failed induction -- 3.7% each). Twenty-four of the 27 women received regional anesthesia. The 27 subjects were delivered by 19 physicians; the mean number of deliveries by each physician was 1.42 with a range of one to three deliveries. There were few postpartum complications -- three subjects were treated for pre-eclampsia and three for sepsis.

Table 4 summarizes demographic data describing the infants that were delivered by the mothers in this sample. The percent frequency of neonatal complications appears in Table 5. Only five babies required care in the newborn ICU.

Hypothesis One

Hypothesis one stated:

> Primary cesarean mothers who participate in hospital initiated postpartum support groups will have a more positive perception of the birth experiences than those who receive no group support.

Table 4

Means, Standard Deviations and Ranges:

Infant Demographic Data

(N=27)

Variable	Mean	Standard Deviation	Range
1 min Apgar score	6.6	2.15	1-9
Group 1 (n=12)	6.3	2.23	4-9
Group 2 (n=15)	6.7	2.38	1-9
5 min Apgar score	8.3	1.40	4-9
Group 1	8.3	1.45	4-9
Group 2	8.1	1.88	5-9
Gestational Age	39.1	1.46	36-42
Group 1	38.7	1.46	36-42
Group 2	39.75	0.87	38-41
Weight (grams)	3240.0	650.84	1680-4630
Group 1	3172.0	836.46	1680-4630
Group 2	3325.0	310.70	2880-4170

Table 5

Percent Frequencies Neonatal Complications

(N=27)

Variable	Frequency (%)
Pr/AGA	7.4
Group 1 (n = 15)	7.4
Group 2 (n = 12)	.0
Pr/LGA	3.7
Group 1	3.7
Group 2	.0
T/SGA	7.4
Group 1	7.4
Group 2	.0
Meconium aspiration	11.1
Group 1	3.7
Group 2	7.4
Other	
hypoglycemia	3.7
Group 1	3.7
Group 2	.0
hyponatremia	3.7
Group 1	3.7
Group 2	.0
bruising	3.7
Group 1	.0
Group 2	3.7

Table 5 continued

Variable	Frequency (%)
renal failure	3.7
Group 1	0.0
Group 2	3.7
hydrocephalus	0.0
Group 1	0.0
Group 2	3.7

This hypothesis was analyzed by the Mann-Whitney U Test. Each questionnaire item was tested to determine if the two groups differed significantly. Table 6 includes the questionnaire items that reflected a significant probability level (≤ 0.05) or approached significance (≤ 0.10).

These items reflect the areas in which Marut and Mercer (1979) identified the greatest difference between cesarean and vaginally delivered mothers: a sense of unreality about the delivery, negative feelings about the ineffective labor, loss of control, and the feeling state during delivery. Thus a few of the data seem to lend support to the hypothesis that a support group can positively influence a mother's perception of the birth experience.

Items one and four, dealing with negative feelings about the ineffective labor, approach the level of significance at $\underline{U} = 53.5$, $\underline{p} = 0.67$ and $\underline{U} = 64.0$, $\underline{p} = 0.109$, respectively. Perceptions of predelivery pain ($\underline{U} = 59.0$, $\underline{p} = 0.69$) and of awareness of events during delivery ($\underline{U} = 62.0$, $\underline{p} = 0.093$) also approached the level of significance. These findings suggest that the mothers are able to alter their perceptions in accordance with their understanding of the situation as it was clarified for them during the support group session.

The women's perceptions of control, Items 7, 10

Table 6

Questionnaire Items that Differentiated Group I Subjects from Group II Subjects

Items	n_1, n_2	U value	p-values (1-tail)
(1) Success with breathing and relaxation	15, 11	53.5	0.067
(4) Relaxation during labor/predelivery procedures	15, 12	64.0	0.109
(7) Control during labor/predelivery procedures	15, 11	45.0	0.027
(10) Consider self useful and cooperative member of obstetric team	15, 12	56.0	0.051
(14) Awareness of events during delivery	15, 12	62.0	0.093
(16) Remember labor/predelivery procedures as painful	15, 12	59.0	0.069
(23A) Choices about interventions during labor	9, 8	15.0	0.023

and 23A were significantly influenced by group support (U = 45.0, p = 0.02; U = 56.0, p = .05; and U = 15.0, p = 0.02, respectively). Thus a support group's influence upon cesarean mothers perceived sense of control may be particularly important. The data from the research of Marut and Mercer (1979) and Cranley (1983) suggest the importance of control over the birth experience in effecting a more positive perception of the birth.

Therefore, although hypothesis one was not generally supported by the data, some of the data do support it. Several limitations may have influenced the significance of the difference between the groups. Marut and Mercer noted that a forced-choice scale diminished the mothers' negative response to labor and delivery experiences. Thus, the single use of a questionnaire without employing an open-ended interview may not have allowed maximal expression of the mother's feelings.

Also, another possible limitation was the time during which the questionnaire was administered. Completing the questionnaires immediately after the support group meeting may not have allowed full assimilation of the possible influence of the group. Finally, a larger sample size would be desirable for future research to increase the validity of the findings.

Hypothesis Two

Hypothesis two stated:

> Primary cesarean mothers who participate in hospital initiated postpartum support groups will have a more positive perceived level of self-esteem than those who receive no group support.

This hypothesis was not supported by the data. There were no significant differences between groups for the total p score, the most important indicator of overall self-esteem. Only one of the ten subscores, perceived behavior of self, approached significance at $p = 0.062$. The data for this variable are summarized in Table 7.

Qualitative analysis of the interview data in Marut and Mercer's study (1979) suggested that cesarean mothers had a decrease in self-esteem while vaginally delivered mothers had an increase in self-esteem. However, the data for this study do not differ from the norms (Table 1) established by the self-esteem measurement tool that was utilized in this investigation.

Again, the analysis of the difference in self-esteem between the two groups may have been limited by the time when the questionnaire was administered in relationship to the time that the support group met. There may not have been adequate time for the effect of the group interaction to affect the mother's self-esteem.

Furthermore, only one support group session was

Table 7

Means, Standard Deviations and 1-tailed Probability of Separate Variance Estimate for Perceived Behavior (N=27)

Group	Mean	Standard Deviation	t- value	1-tailed p
Group 1	118.4667	12.95		
			1.59	0.62
Group 2	111.6667	9.26		

held. Perhaps more than one or even a series of sessions (6-10) may have allowed the women an opportunity to establish rapport and to further evaluate their responses to the birth -- and to increase self-esteem.

Another limitation may have been the instrument used. Perhaps a scale needs to be developed that measures self-worth but is directly related to the childbearing experience.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this research was to determine the effect of a hospital initiated postpartum support group upon the primary cesarean mother's perception of the birth experience and her self-esteem. Supportive intervention was assumed to be critical to the positive resolution of the childbirth experience for the cesarean mother. Thus, it was believed that the mother could modify her feelings in accordance with understanding of the birth experience.

Recent research has shown that cesarean delivered mothers have a significantly different and more negative perception of the birth experience than vaginally-delivered mothers. Although further research is needed to validate that cesarean delivered mothers also experience decreased self-esteem, qualitative analysis of subjective data suggest that this occurs.

The goal was to determine the efficacy of using an immediate postpartum support group as one approach

to helping mothers integrate birth experiences on a more positive level. Research validating innovations for improving nursing care to cesarean mothers is needed.

The sample consisted of 27 primary cesarean mothers who delivered at LDS Hospital. All the mothers completed the two questionnaires. Twelve of the mothers constituted the experimental group and attended a postpartum support group meeting last one hour during the third or fourth postpartum day. This occurred prior to the completion of the questionnaires.

The first hypothesis stated that primary cesarean mothers who participated in a hospital initiated post-partum support group will have a more positive perception of the birth experience than those who received no group support. Only three of the 29 items measuring perceptions showed any significant difference between the groups; four approached significance(≤ 0.10). Analysis of these seven items suggests that the support group positively affected the mother's perceptions in areas that according to the literature have been found to be most significantly different or negative in comparison with vaginally delivered mothers.

The second hypothesis dealt with the mothers' perceived level of self-esteem. There was no significant difference between the groups. In addition, the mean self-esteem for the total sample was not less than

the established norms for the instrument used (TSCS).

Conclusions

These findings suggest that a postpartum support group may have a positive effect on the cesarean mother's perception of the birth experience. Previous investigators have suggested the importance of reviewing the birth experience with women in the early postpartum period. The postpartum support group not only provides the mother a chance to review her birth experience, but it also provides an opportunity for the mother to relate to others who have experienced a similar delivery. A hospital initiated postpartum support group may prove to be an inexpensive, effective intervention that could make a significant difference for cesarean mothers; although further research is needed to validate usefulness.

The support group did not have any significant effect on the mother's perceived self-esteem. However, future research is needed to elucidate the impact of giving birth, especially by cesarean section, on a woman's perceived self-esteem.

Recommendations

1. A larger sample size might provide a greater degree of discrimination between the groups.

2. Random assignment to groups would increase the strength of the experimental design.

3. A sample drawn from a hospital where mothers deliver primarily without conduction anesthesia and thus have different expectations than this sample (drawn from a hospital that predominantly utilizes epidural anesthesia in labor) may also provide a greater degree of discrimination.

4. Repeat cesarean mothers should be included in a larger study.

5. A combination of questionnaires and open-ended interviews may allow a greater expression of feeling.

6. The questionnaires and interviews should perhaps take place two weeks to a month after the delivery to determine if the additional time has allowed a greater impact from the support group.

7. More support group sessions may make a difference.

8. Further study is needed to determine the effect of cesarean births on the mother's perceived self-esteem.

9. Further study is warranted so that nursing can determine factors that would enhance the cesarean birth experience for families.

APPENDIX A

QUESTIONNAIRE MEASURING ATTITUDES ABOUT LABOR AND DELIVERY (FORM A)

Form A Code #_____

Attitudes About Delivery Experience

Please circle the number that best describes the feeling state referred to in each question:

	Not at all		Moderately		Extremely
1. How successful were you in using breathing or relaxation methods to help with contractions?	1	2	3	4	5
2. How confident were you during delivery?	1	2	3	4	5
3. How confident were you during labor?	1	2	3	4	5
4. How relaxed were you during labor?	1	2	3	4	5
5. How relaxed were you during the delivery?	1	2	3	4	5
6. How pleasant or satisfying was the feeling state you experienced during delivery?	1	2	3	4	5
7. How well in control were you during labor?	1	2	3	4	5
8. How well in control were you during delivery?	1	2	3	4	5
9. To what extent did your experience of having a baby go along with the expectation you had before labor?	1	2	3	4	5

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Form A Code #_____

	Not at all		Moderately		Extremely
10. To what extent do you consider yourself to have been a useful and cooperative member of the obstetric team?	1	2	3	4	5
11. How useful was your partner in helping you through your labor?	1	2	3	4	5
12. How useful was your partner in helping you through delivery?	1	2	3	4	5
13. To what degree were you aware of events during labor?	1	2	3	4	5
14. To what degree were you aware of events during delivery?	1	2	3	4	5
15. How unpleasant was the feeling state you experienced during delivery?	1	2	3	4	5
16. Do you remember your labor as painful?	1	2	3	4	5
17. Do you remember your delivery as painful?	1	2	3	4	5
18. How scared were you during delivery?	1	2	3	4	5
19. Did you worry about your baby's condition during labor?	1	2	3	4	5
20. Did you worry about your baby's condition during delivery?	1	2	3	4	5

Form A Code #_____

	Not at all		Moderately		Extremely
21. Did the equipment used during labor bother you?	1	2	3	4	5
22. Was the delivery experience realistic as opposed to dream-like?	1	2	3	4	5
23. Did you have choices about interventions, i.e., examinations or treatments during labor?	1	2	3	4	5
24. Did your partner (or other person) review your experience with you?	1	2	3	4	5
25. Did you feel better after reviewing the labor and delivery experience?	1	2	3	4	5
26. Were you pleased with how your delivery turned out?	1	2	3	4	5
27. Were you able to enjoy holding your baby the first time?	1	2	3	4	5
	8 hrs/longer		2 hours		immediately
28. How soon after delivery did you touch your baby?	1	2	3	4	5
29. How soon after delivery did you hold your baby?	1	2	3	4	5

APPENDIX B

QUESTIONNAIRE MEASURING ATTITUDES ABOUT LABOR AND DELIVERY (FORM B)

Form B Code #_____

Attitudes About Delivery Experience

Please circle the number on each scale that best describes the feeling state referred to in each question:

	Not at all		Moderately		Extremely
1. How successful were you in using the breathing or relaxation methods to help relieve tension before delivery?	1	2	3	4	5
2. How confident were you during delivery?	1	2	3	4	5
3. How confident were you before going to the delivery or operating room?	1	2	3	4	5
4. How relaxed were you before delivery?	1	2	3	4	5
5. How relaxed were you during delivery?	1	2	3	4	5
6. How pleasant or satisfying was the feeling state you experienced during delivery?	1	2	3	4	5
7. How well in control were you during predelivery procedures?	1	2	3	4	5

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Form B Code #_____

	Not at all		Moderately		Extremely
8. How well in control were you during delivery?	1	2	3	4	5
9. To what extent did your experience of having a baby go along with the expectations you had before delivery began?	1	2	3	4	5
10. To what extent do you consider yourself to have been a useful and cooperative member of the obstetric team?	1	2	3	4	5
11. If partner was present, how useful was he/she in helping you through anesthesia? Not present_____	1	2	3	4	5
12. If partner was present, how useful was he/she in helping you through delivery? Not present _____	1	2	3	4	5
13. How confident were you when getting the anesthesia?	1	2	3	4	5
14. To what degree were you aware of events during delivery?	1	2	3	4	5
15. How unpleasant was the feeling state you experienced during delivery?	1	2	3	4	5

Form B

Code #_____

	Not at all		Moderately		Extremely
16. Do you remember your predelivery procedures as painful?	1	2	3	4	5
17. Do you remember your delivery as painful?	1	2	3	4	5
18. How scared were you during delivery?	1	2	3	4	5
19. Did you worry about your baby's condition before delivery?	1	2	3	4	5
20. Did you worry about your baby's condition during delivery?	1	2	3	4	5
21. Did the equipment used during delivery bother you?	1	2	3	4	5
22. Was the delivery experience realistic as opposed to dream-like?	1	2	3	4	5
23. How relaxed were you during predelivery procedures (enema, catheterization, IV, shave and scrub)?	1	2	3	4	5
24. Did your partner (or other person) review your delivery experience with you?	1	2	3	4	5
25. Did you feel better after reveiwing the delivery experience?	1	2	3	4	5

Form B

Code #_____

	Not at all		Moderately		Extremely
26. Were you pleased with how your delivery turned out?	1	2	3	4	5
27. Were you able to enjoy holding your baby the first time?	1	2	3	4	5

	8 hrs/longer		2 hours		immediately
28. How soon after delivery did you touch your baby?	1	2	3	4	5
29. How soon after delivery did you hold your baby?	1	2	3	4	5

APPENDIX C

TENNESSEE SELF CONCEPT SCALE

INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

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

You will find these response numbers repeated at the bottom of each page to help you remember them.

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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

Page 2

	Item No.
2. I like to look nice and neat all the time	[redacted]
4. I am full of aches and pains	[redacted]
6. I am a sick person	[redacted]
20. I am a religious person	[redacted]
22. I am a moral failure	[redacted]
24. I am a morally weak person	[redacted]
38. I have a lot of self-control	[redacted]
40. I am a hateful person	[redacted]
42. I am losing my mind	[redacted]
56. I am an important person to my friends and family	[redacted]
58. I am not loved by my family	[redacted]
60. I feel that my family doesn't trust me	[redacted]
74. I am popular with women	[redacted]
76. I am mad at the whole world	[redacted]
78. I am hard to be friendly with	[redacted]
92. Once in a while I think of things too bad to talk about	[redacted]
94. Sometimes, when I am not feeling well, I am cross	[redacted]

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

Page 3

	Item No.
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

Page 4

		Item No.
8.	I am neither too tall nor too short	
10.	I don't feel as well as I should	
12.	I should have more sex appeal	
26.	I am as religious as I want to be	
28.	I wish I could be more trustworthy	
30.	I shouldn't tell so many lies	
44.	I am as smart as I want to be	
46.	I am not the person I would like to be	
48.	I wish I didn't give up as easily as I do	
62.	I treat my parents as well as I should (Use past tense if parents are not living)	
64.	I am too sensitive to things my family say	
66.	I should love my family more	
80.	I am satisfied with the way I treat other people	
82.	I should be more polite to others	
84.	I ought to get along better with other people	
96.	I gossip a little at times	
98.	At times I feel like swearing	

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

		Item No.
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

		Item No.
14.	I feel good most of the time	
16.	I do poorly in sports and games	
18.	I am a poor sleeper	
32.	I do what is right most of the time	
34.	I sometimes use unfair means to get ahead	
36.	I have trouble doing the things that are right	
50.	I solve my problems quite easily	
52.	I change my mind a lot	
54.	I try to run away from my problems	
68.	I do my share of work at home	
70.	I quarrel with my family	
72.	I do not act like my family thinks I should	
86.	I see good points in all the people I meet	
88.	I do not feel at ease with other people	
90.	I find it hard to talk with strangers	
100.	Once in a while I put off until tomorrow what I ought to do today	

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

APPENDIX D

DEMOGRAPHIC DATA

Code #_____

1. Age: _____ (yrs)

2. Race: _____ Caucasian (1)
_____ Black (2)
_____ Other (3)

3. Physician: _____

4. Parity: ___ ___ ___ ___

5. Complications of pregnancy: _____
_____

6. Length of labor: _____ (hrs) (rounded to nearest whole number)

7. Augmentation: yes_____ no_____

8. Complications of labor: _____
_____

9. Cesarean: _____emergency _____ elective

10. Reason: _____
_____

11. Anesthesia: _____

12. Postpartal complications: _____
_____

Baby

13. Complications of fetus: _____
_____

14. Apgar: 1 min_____ 5 min_____

15. Sex: Male_____ Female_____

16. Weight: _____ gms

17. Appropriateness for gestational age: _____/gest. age _____

18. Complications of neonate: _____
_____

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