THE SELF-CONCEPT OF PRIMIGRAVIDAS IN THE LAST MONTH OF PREGNANCY

A THESIS
SUBMITTED IN PARTIAL FULLFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE
IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

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MAY, 1974

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September 14 19 73

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ACKNOWLEDGMENTS

The author expresses deep appreciation to all those who made this study possible and to those who provided the motivation to complete it well.

A special expression of thanks goes to the three faculty advisors, Dr. Opal White, Margaret Swinburne, and Christina Graf who were diligent in their assistance and astute in their criticisms.

Sincere gratitude and appreciation is due also to Virginia Doster, the author's sister, who devotedly spent many unselfish hours proofreading, editing, and typing this paper. It is hard to imagine a finished product without her help and support.

Thanks are also due to those women who participated in this study.

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CHAPTER I

INTRODUCTION

With the coming of Christ, motherhood took on new dimensions, and until Freud's time the lofty position of mothers remained veiled in holiness and crowned with halos. The world began looking upon motherhood with critical eyes, however, as Freud described the impact of early emotional experiences on the personality. Just how much influence does a mother hold over her child, and how much does she influence her child's future? How much do her own feelings and emotions determine what manner of person her child shall be? Man, indeed, began to realize that the relationship between mother and child was a powerful one.

If the mother is the target of such speculations, the question arises as to how she perceives herself as she progresses through the stages to becoming a mother. What attitudes and beliefs does she hold about herself as she takes on this very important role? Do carrying the heavy burden of child care and meeting society's standards of motherhood cause changes in the way she sees herself?

Much has been written concerning the emotional changes women undergo during pregnancy and delivery. Little has

been done, however, to determine the woman's beliefs and attitudes about herself at these times or to investigate how her self-concept relates to the way she mothers her child. This study attempted to provide an initial step in that direction.

Statement of Problem

This study was designed to describe the self-concept of primigravidas in the last month of pregnancy. The primary aims of this study, therefore, were to conduct an exploratory study into the self-concept of primigravidas as it exists in the last month of pregnancy and to provide initial information that can be used for further exploration of the self-concept in pregnancy and motherhood.

Limitations

The researcher identified the following factor as limitations in this study: The participants were chosen to be as homogeneous and free from pathology as possible; however, it was recognized that such factors as family crises and past experiences unknown to the researcher may have influenced the individual participants in the study.

Delimitations

Because the study was a descriptive one, the target population was limited to subjects with certain character-

istics as a means of reducing the number of variables present and to provide for greater homogenity.[1] The following criteria were used in selecting participants: 1) Primigravidas between the ages of 18-30 who attended a prenatal clinic. 2) Primigravidas whose husbands planned to be in attendance during the last month of pregnancy, during labor, and after delivery. 3) Primigravidas with a history of a normal pregnancy. 4) Primigravidas in the last month of pregnancy.

Definitions

One of the first problems besetting a researcher is the precise definition of each term investigated. For the purpose of this paper, the researcher worked within the limits of the following stated definitions of terms:

Self-Concept: attitudes, feelings, thoughts, and beliefs one has about oneself.

Primigravida: a woman who is pregnant for the first time.

Last month of pregnancy: two weeks before the estimated date of delivery.

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[1]Faye Abdellah and Eugene Levine, Better Patient Care Through Nursing Research (New York: MacMillan Company, 1964), p. 344.

Assumptions

For the purpose of this study, the following assumptions were made: 1) Self-concept can be measured. 2) Pregnancy constitutes a crucial time in the life of a woman.

CHAPTER II

RELATED LITERATURE AND RESEARCH

Self-Concept

The self or self-structure has been given much attention in the last few years.[1] The emphasis on ego psychology and interest in the individual and his personality make-up have contributed to this focus on self and self-concept.[2] Some studies have been conducted that indicate a person's self-concept influences his behavior and emotions.[3,4] In addition some of these studies have shown that changes in self-concept produce changes in behavior and in one's reaction to others.[5,6] For example, a study

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[1]Ruth C. Wylie, The Self-Concept (Lincoln: University of Nebraska Press, 1961), p. 2.

[2]Sidney Jourard, Personal Adjustment (New York: The MacMillan Company, 1968), p. 303.

[3]S. Coopersmith, "Self-Esteem and Need Achievement as Determinants of Selective Recall and Repetition," J. of Abdn. Soc. Psy., Vol. LX (1960), pp. 310-317.

[4]M. M. Helper, "Parental Evaluations of Children and Children's Self-Evaluations," J. of Abdn. Soc. Psy., Vol. XXII (1958), pp. 400-405.

[5]S. M. Jourard and R. M. Remy, "Perceived Parental Attitudes - the Self and Security," J. of Consul. Psy., Vol. XIX (1955), p. 264-366.

[6]M. Manis, "Personal Adjustment, Assumed Similarity to Parents, and Inferred Parental Evaluations of Self," J. of Consul. Psy., Vol. XXII (1958), pp. 481-485.

by Davis indicated that the way an individual views himself influences the occupational role he chooses.[1] Also, Meleis found a high positive correlation between the way women perceived themselves and their effectiveness in family planning.[2]

The development of self-concept and its influence on the person's adaptation to the world without and the world within has been discussed by several authors recently. Their attention has been given to the growth and reorganization of the personality as a result of a developmental crisis.[3,4,5,6] It appears that one's self-concept is

[1]Anne J. Davis, "Self-Concept, Occupational Role Expectations and Occupational Choice in Nursing and Social Work," Nursing Research, Vol. XVIII, No. 1 (January-February, 1969), pp. 55-59.

[2]Afa Ibranhim Meleis, "Self-Concept and Family Planning," Nursing Research, Vol. XX, No. 3 (May-June, 1971), pp. 229-235.

[3]Lawerence H. Schwartz and Jane Linker Schwartz, The Psychodynamics of Patient Care (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1972), p. 204.

[4]Theodore Lidz, The Person: His Development Throughout the Life Cycle (New York: Basic Books, Inc., 1968), pp. 117-126.

[5]Doris Cook Gutterley and Gloria Ferraro Donnelly, Perspectives in Human Development Nursing Throughout the Life Cycle (Philadelphia: J. B. Lippincott Company, 1973), pp. 218-226.

[6]Erik H. Erikson, "Growth and Crisis of the 'Healthy Personality,'" Psychological Issues, Vol. I, No. 1, Monograph No. 1 (New York: International Universities Press, 1959), p. 89.

particularly vulnerable to change at these times of crisis, since at these times the individual is forced to see himself in a new way.[1,2,3] Likewise, according to both Wylie and Combs, the manner in which developmental crises are resolved and new roles accepted is influenced by one's self-concept.[4,5]

In light of the importance of self-concept in all developmental crises, it would seem profitable to explore the self-concept of women experiencing the developmental crises of pregnancy.

Self-Concept and Pregnancy

The special tasks that have to be solved in pregnancy and motherhood include the complexity of developmental shifts that must occur in a woman in order for her to make smoothly the transition from wife to wife and mother.[6]

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[1]G. Bibring, "Some Considerations of the Psychological Processes in Pregnancy," The Psychoanalytic Study of the Child, Vol. XIV (New York: International Universities Press, 1959), pp. 113,121.

[2]Arthur W. Combs and Donald Snygg, Individual Behavior (New York: Harper and Row, 1959), p. 303.

[3]Wylie, p. 27.

[4]Combs, p. 156.

[5]Wylie, pp. 136-137.

[6]Sylivia Brody, Ph.D., Patterns of Mothering (New York: International Universities Press, Inc., 1956), p. 22.

The first pregnancy requires particular attention, for it usually presents a more critical experience to the mother than subsequent pregnancies,[1,2] profoundly altering her life, bringing new sensations and awareness.[3,4] Not only does her pregnancy confirm her identity of femininity and her concept as a creative person,[5,6] but also presents a time for reevaluation of the self and affirmation of new roles.[7] In addition the emotional course of pregnancy is largely responsible for the psychological environment of the child, and because having a child might confirm or undermine the meaning of the marriage, it may stabilize or disrupt the primary social unity, the family.[8]

The marked bodily and social changes that occur in pregnancy require changes in self-concept, because the

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[1]Lidz, p. 94.

[2]E. James Anthony and Therese Benedeck, Parenthood: Its Psychology and Psychopathology (Boston: Little Brown and Company, 1970), pp. 148-151.

[3]Helene Deutsch, The Psychology of Women, Vol. II (New York: Grune and Stratton, 1945), p. 210.

[4]Joseph Rheingold, The Fear of Being a Woman (New York: Grune and Stratton, 1964), p. 510.

[5]Anthony, p. 117.

[6]Lidz, p. 443.

[7]Schwartz, pp. 223-234.

[8]Anthony, p. 150.

pregnant woman's idea of the way she looks and appears to others shifts quite drastically.[1,2] Reorganizing the self-concept is not an easy task for the pregnant woman and requires constant reassessment of her bodily changes and reassessment of these changes.[3]

Norris emphasized that there is a need to study the body-image of maternity patients and what it means in terms of acceptance of the infant and influence on family integration.[4] However, there is a paucity of studies of the self-concept in pregnancy, which seems quite surprising in view of the previously mentioned current emphasis on ego psychology and the interest in developmental psychology.

The few studies found dealing with the self-concept of obstetric patients have utilized exclusively projective techniques, such as the Thematic Apperception Test or interviews, with equivocal results. For example, Gunter, in a study involving prematurity, was unable to establish TAT "self dimension" differences (inner life, body image, sexuality) between mothers of premature infants and those

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[1]Schwartz, p. 204.

[2]Rheingold, pp. 59-60.

[3]Schwartz, p. 204.

[4]Catherine Norris, "The Professional Nurse and Body Image," Behavioral Concepts and Nursing Intervention (Philadelphia: J. B. Lippincott, 1970), p. 50.

of normal infants.[1] Grimm, on the other hand, found habitual aborters to be more dependent and to have poorer emotional controls than control group mothers.[2]

Kapp and Graham, by means of ratings obtained through interviews, reported that their abnormal subjects evidenced more negative attitudes and relations toward their mothers than did the controls.[3]

Another problem which has not been systematically explored is the effect of pregnancy on personality variables. In one study involving twenty-eight normal deliveries, McConnell and Daston showed that there are significant changes in the body image following delivery, e.g., decreasing Rorschach penetrations scores.[4] McDonald and Parham also found that both their normal and abnormal groups achieved reliably lower scores on the MMPI neurotic

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[1]L. Gunter, "Psychopathology and Stress in the Experience of Mothers of Premature Infants," American Journal of Obstetrics and Gynecology, XXCVI (1963), p. 333.

[2]E. Grimm, "Psychological Investigation of Habitual Abortion," Psychosomatic Medicine, XXIV (1962), p. 369.

[3]F. T. Kapp and V. T. Graham, "Some Psychologic Factors in Prolonged Labor Due to Inefficient Uterine Action," Comprehensive Psychiatry, IV (1963), p. 9.

[4]O. L. McConnell and P. G. Daston, "Body Image Changes in Pregnancy," Journal Projective Techniques, XXV (1961), p. 451.

and psychotic scales after delivery.[1] A study by McDonald and Gynther revealed that their abnormal group's perception fluctuated more than the normal group in an analysis of pre to post delivery changes in self-perception.[2]

Some studies were found concerning the self-concept of unwed mothers.[3,4,5] However, no studies using a validated instrument were found dealing with the self-concept of normal pregnant women.

Rubin stressed the importance for nurses to understand maternal emotions and behavior in order to enhance nursing care and foster healthy development of the mother and child.[6] In view of this need to make an initial step in

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[1]Robert L. McDonald and K. J. Parham, "Relation of Emotional Changes During Pregnancy to Obstetric Complications in Unmarried Primigravidae," American Journal of Obstetrics and Gynecology, XC (1964), p. 195.

[2]R. L. McDonald and M. D. Gynther, "Relations Between Maternal Anxiety and Obstetric Complications," Psychosomatic Medicine, XXV (1967), p. 357.

[3]C. W. Boston and K. L. Kew, The Self-Concept of the Unmarried Mother in the Florence Crittenton Home (Nashville, Tennessee: Unpublished master's thesis, University of Tennessee, 1964).

[4]Robert L. McDonald and Malcolm D. Gynther, "Relations Between Self and Parental Perceptions of Unwed Mothers and Obstetric Complications," Psychosomatic Medicine, Vol. XXVII, No. 1 (1964), pp.31-36.

[5]McDonald and Parham, p. 195.

[6]Reva Rubin, "Maternity Care in Our Society," Nursing Outlook, Vol. II, No. 7 (November, 1961), pp. 519-521.

the direction of study into the effects of self-concept on pregnancy and the effects of pregnancy on self-concept, the researcher has attempted to describe the self-concept of pregnant women in the last month of pregnancy.

To determine what self-concept is like in pregnancy seemed necessary before further investigation could be pursued.

It was recognized that pregnancy is experienced as a sequence of transformations, especially during the first pregnancy, and that these changes are experienced in different ways during the trimesters of pregnancy.[1] The various shifts, however, will usually have occurred at least by the last month of pregnancy.[2] In the third trimester, the body becomes more and more a burdensome weight.[3] The situation and impending event is obvious;[4] the inner conflicts and inner struggles reach a climax;[5] and the final proof of the woman's ability to create, withstand crisis, and mother is at hand.[6]

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[1]Anthony, p. 216.

[2]Anthony, p. 221.

[3]J. P. Greenhill, Obstetrics (Philadelphia: W. B. Saunders Company, 1951), p. 319.

[4]Anthony, p. 224.

[5]Deutsch, p. 210.

[6]Anthony, p. 224.

CHAPTER III

METHODOLOGY

Design

The study was a descriptive one; therefore, the results were simply reported.[1] Graphs depicting the results of each of the subject's test scores were included. Tables were made to report the scores on each of the scales for the subjects. Mean scores and standard deviations for each scale of the test were computed and reported in order to give some information about the tendency of the scores as a whole.[2]

POPULATION

Setting

The subjects for the study came from women attending a prenatal clinic at the Northwest Texas Hospital in Amarillo, Texas. The hospital is supported by a hospital district and contains 289 hospital beds. The clinic is conducted on an outpatient basis biweekly. Anyone seeking prenatal care may attend the clinic. The fee is on a

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[1]Abdellah, p. 708.

[2]Allen L. Edwards, Statistical Analysis, 3rd ed. (New York: Holt, Rinehart and Winston, 1969), pp. 55-56.

sliding scale, with patients who qualify for indigency receiving care without pay. The clinic includes laboratory facilities and prenatal classes, and it is staffed by an obstetrician, medical students, a licensed vocational nurse, and nursing students. The patients come once a week in the last month of pregnancy for a routine check and prenatal classes.

Selection and Description of the Sample

The subject population consisted of ten women pregnant for the first time and within two weeks of their due date. The subjects were selected according to the following criteria:

1) an age range of 18-30 years
2) attendance of the prenatal clinic at Northwest Texas Hospital
3) presence of the husband planned during the last month of pregnancy, labor, and delivery
4) a history of normal pregnancy
5) two weeks from the date due to deliver.

Subjects were chosen from the records of the clinic. The first ten primigravidas who met the criteria were approached when they attended the clinic and asked to participate in the study.

Development of Test Instrument

The Tennessee Self Concept Scale was used for this Study by permission of its developer, William H. Fitts, Ph.D.[1] The scale was used to obtain an independent index of self-concept. The scale was designed as a counseling aid and research tool for the study of the self-concept and consisted of 100 self-descriptive statements which the subject used to portray her own picture of herself.[2] The instrument, designed as a research tool for study of the self-concept, was first published by Counselor Test and Recordings in 1965.

The subject rated each statement as it applied to herself on a 5 point true-false scale. Scoring was objective and automatic through use of carbon papers in the combination packet.[3] Time required to administer the scale was 10 to 20 minutes.

The instrument has been validated with subjects having an age of 12 or higher and having at least a 6th grade reading level.[4] The instrument has been used in a

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[1]Permission letter in Appendix B.

[2]Sample of T.S.C.S. in Appendix B.

[3]Sample of packet in Appendix C.

[4]William H. Fitts, Ph.D., Tennessee Self Concept Scale Manual (Nashville: Counselor Recordings and Tests, 1965), p. 1.

limited way with normals to date. Reliability of individual scores range from 0.64 to 0.92 with overall reliability of 0.90 based on 60 college students over a two week period.[1]

The test consisted of 30 interrelated scores which gave a multidimensional picture of the self-concept. Only 17 of the interrelated scores were reported in this research, however. The 17 scales are the most descriptive of the self-concept and apply to the purposes of this study whereas the scores on the empirical scales and the time scores which were not considered were developed to compare the subjects' self-concepts with that of deviant groups.[2] Because that comparison of deviant groups was not in keeping with the purposes of this study, those scales were omitted. The distribution subscores were also omitted, because they are simply a reporting of the number of 5's, 4's, 3's, 2's, and 1's chosen on the test and are of no partical value to this study.

The meaning and importance of the 17 scales that were reported are as follows:

> The Self-Criticism (SC) scale indicates an ability or inability to be open and critical of the self in a healthy way.

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[1] Fitts, p. 17.

[2] Fitts, p. 6.

The True-False Ratio (T/F) measures response set or response bias and indicates whether the subject's approach to the task involves any strong tendency to agree or disagree regardless of item content.

The Net Conflict Scores measure the extent to which an individual's responses to positive items differ from, or conflict with, her responses to negative items in the same area of self-perception.

The Total Conflict Scores, if high, indicate confusion, contradiction, and general conflict in self-perception. Low scores have the opposite interpretation.

The Total Positive Score reflects the overall level of self-esteem.

The Row 1 P Score consists of "what I am" items. Here the individual describes her basic identity -- what she is as she sees herself.

The Row 2 P Score indicates the degree of self-satisfaction about the self she perceives.

Row 3 P Score comes from those items that say "this is what I do" and measures the individual's perception of her own behavior.

Column A represents the physical self. Here the individual is presenting her view of her body, her state of health, her physical appearance, skills,

and sexuality.

Column B describes the self from a moral, ethical frame of reference.

Column C reflects the individual's sense of personal worth, her feeling of adequacy as a person apart from her body, or her relationship with others.

Column D reflects one's feelings of adequacy, worth, and value as a family member.

Column E is another "self as perceived in relation to others" and reflects the person's sense of adequacy and worth in her social relationships.

The Variability Scores provide a simple measure of variability or inconsistency from one area of perception to another. The Total V represents the amount of variability for the entire record.

The Column Total V measures and summarizes the variations within the columns.

The Row Total V is a sum of the variations across the rows.

The Distribution Score (D) is a summary score and can be interpreted as a measure of another aspect of self-perception-- certainty about the way one sees herself.[1]

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[1]Fitts, pp. 2-3.

Administration of the Test Instrument

The ten experimental subjects were approached when they attended the clinic and asked to participate in the study in the following manner:

1) The researcher identified herself as a student working on a research paper.
2) The subjects were told that participation involved answering 100 items.
3) Anonymity was assured.
4) The subjects were told that one purpose of the study was to increase knowledge about pregnant women.

The instructions for taking the Tennessee Self Concept Scale were reviewed. The instructions were also printed in the test.[1]

Identification of the Testing Instrument was by assigned numbers to preserve the privacy of the subjects.[2]

The same instrument was administered to each subject.

The researcher began in November, 1972, reviewing the records of the clinic for subjects and obtained the ten subjects by April, 1973.

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[1]Sample of directions in Appendix B.

[2]Florence Downs, "Ethical Inquiry in Nursing Research," Nursing Forum (January, 1967), pp. 12-30.

TECHNIQUE OF TREATMENT OF DATA

To obtain an objective measure of the self-concept and to report the results obtained, the researcher treated the data in the following manner:

First, the score sheets were tallied according to the instructions in the Tennessee Self Concept Manual.[1] The scores obtained were then charted on the profile sheets provided in the combination packets.[2]

Second, a table depicting the subjects' actual scores on the 17 scales was compiled.

Third, the mean and standard deviation for each scale were computed, first by adding the scores and dividing by the number of scores to obtain the mean or central tendency of the scores. The standard deviation for each scale was then computed by subtracting the mean from each score to obtain the deviation score. The deviation scores were then squared, summed, and divided by 9 (N-1). The square of this value was obtained and recorded as the standard deviation for that scale. A table was made of these scores.

The computations were performed by the researcher.

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[1]Fitts, pp. 5-6.

[2]Example of Profile Sheet in Appendix B.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF FINDINGS

The actual scores obtained from the 10 test subjects were reported in Table 1.

The mean and standard deviation of the scores on each of the 17 scales were computed and reported in Table 2. The mean scores were also reported on a profile sheet.

Because it was the purpose of this study to describe the self-concept of the primigravidas, no further attempts were made to compare the results with other groups or perform computations beyond that of reporting the scores and the measures of central tendency and variability.

Table 1 represents the 10 subjects' actual scores on each of the 17 scales. Table 2 represents the mean scores and standard deviations for each of the 17 scales. Table 3 represents normative values for the T.S.C.S.

Table 3 represents the means and standard deviations of the normative group on the T.S.C.S.

TABLE 1

PRIMIGRAVIDAS' SCORES ON THE TENNESSEE SELF CONCEPT SCALE

	SC	T/F	Net Con-flict	Total Con-flict	Total	Rows		
						1	2	3
1	31	7.4	11	35	377	135	130	112
2	49	2.5	55	61	317	92	118	103
3	46	2.7	58	58	348	142	110	96
4	48	2.1	19	53	323	131	87	105
5	47	5.8	-7	35	361	123	119	119
6	24	18.0	-7	25	371	130	111	130
7	37	78.0	6	22	378	130	125	123
8	36	3.5	0	28	308	119	91	98
9	46	5.7	-12	30	319	110	106	103
10	49	5.6	-22	22	262	117	96	99

TABLE 1--Continued

Columns					Variability			
A	B	C	D	E	Total	Col. Tot.	Row Tot.	D
81	69	72	85	70	46	24	22	130
65	66	54	65	63	2	31	21	116
82	78	62	70	66	74	46	28	208
68	58	67	72	58	72	46	26	129
76	69	70	70	76	46	28	18	154
68	72	71	80	80	44	26	18	125
68	79	76	85	70	34	15	19	119
59	63	64	58	64	39	28	11	78
61	72	60	58	68	33	16	17	165
61	70	55	62	64	0	0	0	82

TABLE 2

MEAN AND STANDARD DEVIATIONS OF PRIMIGRAVIDAS' TENNESSEE SELF CONCEPT SCALE

SCORE	MEAN	STANDARD DEVIATIONS
Self-Criticism	41.0	8.77
T/F	13.3	23.23
Net Conflict	9.9	22.85
Total Conflict	36.9	14.92
Total Positive	336	34.96
Row 1	134	18.97
Row 2	109	14.41
Row 3	108.8	37.09
Col. A	68.9	8.12
Col. B	69.6	6.34
Col. C	65	12.16
Col. D	70.5	10.15
Col. E	69.9	64.87
Total Variability	44	20.91
Col. Total V	26	13.86
Row Total V	18	4.65
D	130	38.35

TABLE 3

MEANS, STANDARD DEVIATIONS OF NORMATIVE GROUP
TENNESSEE SELF CONCEPT SCALE*

SCORE	MEAN	STANDARD DEVIATIONS
Self-Criticism	25.54	6.70
T/F	1.03	.29
Net Conflict	-4.91	13.01
Total Conflict	30.10	8.21
Total Positive	345.57	30.70
Row 1	127.10	9.96
Row 2	103.67	13.79
Row 3	115.01	11.22
Col. A	71.78	7.67
Col. B	70.33	8.70
Col. C	64.55	7.41
Col. D	70.83	8.43
Col. E	68.14	7.86
Total Variability	48.53	12.42
Col. Total V	29.03	9.12
Row Total V	19.60	5.76
D	120.44	24.19

*Fitts, p. 14.

A discussion of the scores obtained on each of the scales follows.

The scores on the Self-Criticism Scale ranged from 24 to 49 with 41 as a mean. One score fell below the normative line on the graph[1,2] and could be considered to indicate defensiveness on the part of the subject. The remaining scores were well within the limits of the scale and could be said to indicate a normal, healthy openness and capacity for self-criticism on the part of the subjects.

The True-False Ratio Scores, which measure response set or response bias, were all above the 99th percentile with the mean being 13.3 and the range of scores from 2.1 to 78.0. These high results can be treated purely as a measure which has meaning only in terms of empirical validity and can be used in this sense to differentiate patient from non-patient group. It can also be considered, from the framework of self-theory and from this approach, a high T/F Score indicates the individual is achieving self-definition or self-description by focusing on what she <u>is</u> and is relatively unable to accomplish the same thing by eliminating or rejecting what she is <u>not</u>. Low T/F Scores would mean the exact opposite, and scores in the middle

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[1]See #6, Table 1.

[2]See Table 3 for scores of normative group.

would indicate that the subject achieves self-definition by a more balanced employment of both tendencies -- affirming what is self and eliminating what is not self.

These high T/F Scores might simply reflect the narcissistic quality of the state of pregnancy and not be an indicator of pathology in itself. The increased libidinous feelings aroused during pregnancy, as self-centered as they may seem, increase the woman's pleasure in bearing her child, stimulate her hopeful fantasies, and diminish her anxiety. It seems indeed a normal phenomenon for the pregnant woman to be focusing on herself, her bodily functions, the child within her, and be relatively unable to focus on the external environment.

The Net Conflict Scores are an operational measure of conflict and measure the extent to which a person's response to positive items differ from or conflict with her responses to negative items in the same area of self-perception. Thus, any difference between P and N reflects contradiction or conflict. The Net Conflict Scores indicate the directional amount of conflict.

There are two different kinds of conflict:

1. Acquiescence Conflict. This phenomenon occurs when the P Scores are greater than the N Scores. This yields a positive score or number. In this case the subject is

overaffirming her positive attributes.

2. Denial Conflict. Here the N Scores are higher than the P Scores, yielding a minus number of score. This means the subject is over-denying her negative attributes in relation to the way she affirms her positive characteristics.

The subjects' scores on this scale were above the 20th percentile with a mean of 9.9 and a range from -22 to 158. The mean fell within the 90th percentile. Although the mean was within the normative limits of the scale, it was high enough to imply that the subjects generally were overaffirming their positive attributes. Although the tendency of the scores on the Net Conflict Scale was toward the positive end of the scale, there were four scores that yielded a minus number.[1] This indicated that these subjects were dealing with conflict by over-denying their negative attributes and concentrating on eliminating the negative.

These scores indicate some conflict during the last month of pregnancy, which the subjects dealt with in different ways. Those who used overaffirmation may have been doing so in order to handle feelings of inadequacy or doubt about their ability to give birth and to be a mother.

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[1]See 5, 6, 9, 10, Table 1.

On the other hand, they may have felt extremely excited and proud of the impending birth of their child and felt that the event would, in fact, affirm them as women. Those who concentrated on denying their negative attributes may have had the same doubts about themselves but handled those doubts by eliminating them from their awareness. These women may have been more pessimistic about their child's birth. This conflict would not seem surprising in view of the many pressures and anxieties of the last trimester. It is stressed that the Conflict Score was not deviant from the norm.

The foregoing Net Conflict Scores were concerned only with the directional trends in the P-N measure of conflict. The Total Conflict Score determines the total P-N conflict in a subject's self-perception by summing P-N discrepancies regardless of sign.

The mean scores on the Total Conflict Scale were within the 75th percentile of the scale. The mean score was 36.9 and the range of scores between 22 and 61. These scores were not abnormally high. High scores on this scale indicate confusion, contradiction, and general conflict in self-perception. Low scores have the opposite interpretation.

The fact that little or no conflict was shown may indicate coping mechanisms were operating on the part of the

subjects.

The Total Positive Score is the most important single score on the scale and reflects the overall level of self-esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. Low scores indicate doubt about self-worth and anxiety and depression about the self.

The primigravidas' Total Scores indicated a tendency toward the 50th percentile with a mean of 336 and range between 262 and 378. Four scores fell below the normative line on the scale,[1] indicating the presence of some anxiety and depression. The other scores indicated that the primigravidas generally felt worthwhile with a moderate amount of self-esteem.

In view of the characteristic depression and anxiety experienced by some women during the last month of pregnancy, the two slightly low scores do not seem to reflect any pathological depression.

It is generally believed, however, that if a woman has been prepared for motherhood, has a fair relationship with her own mother, and wants her child, she should be able to meet the conflicts and anxieties of this period

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[1]See 2, 8, 9, 10, Table 1.

without serious damage to her self-esteem. In fact, her self-esteem may be enhanced by successful handling of these conflicts. Several factors, nonetheless, may contribute to some loss of self-esteem accompanied by moderate depression and anxiety.

One of these factors is the self-absorption typical of the third trimester, which may result in the primigravida feeling isolated and alone in her experience. This is especially true if her husband does not understand and turns away from or condemns her.

Moreover, in the last month, fear of death and concern over the baby's welfare may also arouse feelings of anxiety, and accompanying loss of control over the circumstances add to the depression and anxiety. At the same time, bodily discomforts and appearance add other disagreeable aspects, which cause some women to feel humiliated and degraded. Medical invasion of privacy also contributes to these feelings. In addition, the struggle for a new identity and concern over one's ability to perform necessary functions may also arouse anxiety.

The Row Scores indicate the positive description made about the self. The subjects' scores on Row 1 yielded a mean of 134 which fell within the 60th percentile on the scale. The range was 92 to 142. Generally the scores indicated a positive identity and feeling about the self.

Two scores fell below the 10th percentile,[1] indicating some doubts about identity, although they were not extremely low.

As has been previously stated, the woman who, prior to pregnancy, was relatively certain about her identity would probably weather the conflicts concerning a new identity fairly well. The identity-role conflict aroused by the first pregnancy, however, would provide some rationale for those women who scored lower on this scale.

Row 2 consists of items where the individual describes how she feels about the self she perceives. In general, this score reflects the level of self-satisfaction or self-acceptance.

The mean score on this scale was 109 with a range of scores from 87 to 130. These scores fell within the 10th and 95th percentile, which is within the normative range. The subjects' scores indicate that the subjects were experiencing self-satisfaction and self-acceptance.

These scores indicated that although there may be some doubt about identity as reflected in two of the Row 1 scores, the primigravidas generally felt satisfied with the selves they perceived. Perhaps this reflects the generally held belief in our society that doubts and anxieties are

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[1]See 2, 9, Table 1.

expected during pregnancy and do not reflect on the worth of the person.

The score on Row 3 comes from those items that say "this is what I do, or this is the way I act." Thus, this score measures the individual's perception of her own behavior, or the way she functions.

The mean of the scores on Row 3 was 108.8 and within the 20th percentile on the scale. The range of scores was 96 to 130. This was one of the lower mean scores obtained, although it was not abnormally low. These scores might reflect some anxiety over a new role and the ability to function within it. There is also a slowing down of movement and loss of energy experienced in the last month of pregnancy because of the heavy, cumbersome body. The low scores could reflect some feelings about this condition.

The Column Scores also indicate positive descriptions made about the self. In Column A, the individual is presenting her view of her body, her state of health, her physical appearance, skills, and sexuality.

The subjects' scores on Column A ranged from 59 to 82 with a mean score of 68.9. The mean score fell within the 20th percentile on the scale. Although the scores tended toward the lower limits of the norm, only three scores fell

below the 10th percentile.[1] The primigravidas maintained a relatively positive view of their bodies, state of health, appearance, and sexuality at this time. A low score on this scale might also reflect dissatisfaction over an awkward, cumbersome appearance. The husband's response to the woman as a sexual partner might also affect this score.

Column B describes the self from a moral, ethical frame of reference. Moral worth, relationship to God, feelings of being a "good" or "bad" person, and satisfaction with one's religion or lack of it are included.

The subjects' scores on Column B ranged from 63 to 79 with a mean score of 69.6 which fell within the 40th percentile. Two scores fell below the normative line[2] and indicated some doubts about the self as a moral or ethical being. The other subjects, however, seemed satisfied with themselves in relation to religion and morals.

Low scores might be expected on this scale if the woman has some negative feelings toward her child which she cannot reconcile. Guilt might be generated if she has a strong desire for the baby to die or if she has become pregnant to please her husband and is experiencing hateful feelings toward him.

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[1] See 9, 10, Table 1.

[2] See 4, 7, Table 1.

In addition, a person who has not been religious often begins to think of her child's need for religion and attempts to reconcile some of her own moral conflicts in order to provide her child with a religious framework. Fear of death during delivery might also arouse questions about her moral worth and her relation to God.

Column C reflects the individual's sense of personal worth, her feeling of adequacy as a person and her evaluation of her personality apart from her body, her relationship to others, or her moral self.

The subjects' scores ranged from 54 to 76 on this scale with a mean score of 65 which fell on the 50th percentile line of the scale. The scores indicate that the subjects as a whole described feelings of worth and adequacy as persons. The relationship of this score to others on the scale was not known by the researcher; however, it would seem in keeping with the Total P Scores and perhaps reflects a general confidence at this time, despite conflicts and doubts in other areas of self perception.

Column D reflects one's feelings of adequacy, worth, and value as a family member. It refers to the individual's immediate circle of associates.

The subjects' scores reflect a mean of 70.5 with a range from 58 to 80. The mean fell within the 55th percentile on the scale. Most of the subjects were achieving a

sense of adequacy, worth, and value as a family member. Anthony notes that there is a great cultural pressure on growing girls and young women to consider maternity necessary for individual fulfillment and adult status.[1] The ability to have a child and start one's own family is highly prized in American society, and much reinforcement is given by the family of the expectant mother for carrying a wouldbe grandchild, son, daughter, niece, or nephew. Feelings of adequacy as a family member would, indeed, then be an expected outcome of such reinforcement and increased status in the family.

Column E depicts another "self as perceived in relation to others" category, but pertains to "others" in a general way. It reflects the person's sense of adequacy and worth in her social interaction with other people in general.

The mean score for Column E was 69.9 and the range of scores from 58 to 80. The mean fell with the 55th percentile on the scale. The subjects generally were also describing themselves as feeling adequate and worthwhile in interactions with people in general.

This score might reflect the general social attitude toward women who are pregnant in terms of the extra consid-

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[1]Anthony, p. 102.

eration, special privileges, and special attention given to them at this time. The score may simply mean, however, that the women generally felt adequate socially before pregnancy and continue this feeling of adequacy in spite of a more dependent and isolated position.

The Variability Scores provide a simple measure of the amount of variability, or inconsistency, from one area of self-perception to the other.

The Total Variability represents the total amount of variability for the entire record and is a measure of how variable the person's concept of herself is. High scores mean that the person's self-concept is so variable from one area to another as to reflect little unity or integration. High scoring persons tend to compartmentalize certain areas of self and view these areas quite apart from the remainder of self. Well integrated people generally score below the mean on these scores but above the first percentile.

The subjects' mean scores on this scale were 44 and within the 39th percentile on the scale but slightly below the mean of 48. The range of scores was from 0 to 72. As a whole, these scores indicated that the subjects' self-concepts reflected a degree of unity and integration. In other words, their self reports were consistent from one area to the next, although they remained flexible enough to incorporate all aspects of the self into a unified self

picture.

The Column Total Variability Score measures and summarizes the variations within the columns. The Row Total Variability measures variations across the rows. These scores further break down the Total Variability Score so that the aspect of the self-concept that is most variable can be pinpointed. The Column Total V measures variability in those areas dealing with the external self (physical self, moral-ethical self, personal self). The Row Total V deals with those areas internal to the self (Identity, Self-satisfaction, Behavior).

Again, the subjects scored between the 30th and 40th percentiles on this scale. The mean for the Column Total V was 26. The mean for the Row Total V was 18. The range of scores on the Column Total V was from 0 to 46 and on the Row Total V was 0 to 28.

These scores confirm the results of the Total V scores.

The final score reported is the Distribution Score (D), which is a summary score of the way one distributes her answers acorss the five available choices in responding to the items on the scale. It is also interpreted as a measure of still another aspect of self-perception -- certainty about the way one sees herself. High scores indicate that the subject is very definite and certain in

what she says about herself, while low scores mean just the opposite. Low scores are found also at times with people who are defensive and guarded.

The mean D Score obtained was 130 with a range of scores from 78 to 208. The mean score fell within the 68th percentile on the scale, indicating that the subjects generally were very definite and certain in what they said about themselves.

Two scores fell below the 10th percentile.[1] These subjects were less certain about the way they saw themselves and may also have been defensive and guarded in their descriptions.

This score may have more to do with the subjects' usual manner of responding to items about the self than with the variable of pregnancy. More study and comparison of prepregnant to pregnant scores are needed to interpret this score.

The results of this study indicated that, in general, the primigravidas were experiencing a degree of self-esteem and personal worth. They generally described themselves in an open manner and also displayed a capacity for healthy self-criticism. While, as a whole, the primigravidas were achieving self-definition or self-description by focusing

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[1]See 8 and 10, Table 1.

on what they were and were relatively unable to eliminate or reject what they were not; they tended to overaffirm their positive attributes. A high degree of internal conflict was not evidenced, however. In general the scores reflected a positive identity and feelings of self-satisfaction and self-acceptance.

Interestingly enough, however, the women scored themselves lower on their perception of their own behavior or the way they functioned while maintaining a relatively positive view of their bodies, state of health, appearance, and sexuality.

The subjects tended to be satisfied with themselves morally and ethically and to describe themselves as worthwhile and adequate. At the same time, they tended to describe themselves as experiencing a sense of adequacy, worth, and value as a family member and as a person interacting with others. In addition, they tended to reflect unity and integration in their self-descriptions.

Care must be taken when speculating about these findings. There is no data to collaborate how the variable of pregnancy influenced the scores, nor is there a way of knowing how the primigravidas would have described themselves before pregnancy.

No generalization can be made, particularly in view of the very small number of subjects. Many variables may have

influenced the self-picture, none of which were explored in the study or held constant, e.g., the values the women and their families placed on childbearing, the circumstances surrounding the pregnancy, and the life experiences of the participants. The findings, therefore, were descriptive of this population only, and, with this in mind, the researcher felt that some speculation as to the findings were warranted. Some discussion of the possible meaning of the scores to pregnancy can be found in the preceding paragraphs; however, attention is again drawn to the unusually high T/F Ratio Scores. It would be enlightening to compare these scores with other groups and to gather more data from pregnant women on this score. Speculations can be made that the high scores were a measure of the primigravidas' conflict over "letting go" of the infant. The mechanism of incorporation could have been working here in that the women tried to resolve the conflict by inclusion and were unable to use exclusion to a significant degree.

Other than the conclusions that can be drawn from this deviant score, the findings tended to indicate that pregnancy is a serene and stable time in the lives of most of the women. Some authors corroborate this point and even point out that neurotic women may appear less neurotic

during pregnancy.[1,2]

Similarly, Freud, impressed by the emotional calmness of pregnant women, considered pregnancy as a period during which the woman lives in the bliss of her basic wish being gratified.[3]

Perhaps the point to be emphasized and explored further is the following statement by Anthony:

> Only if the psychosexual organization of the woman is loaded with conflicts toward motherhood do actual conditions stir up deeper conflicts and disturb the psychophysiologic balance of pregnancy.[4]

In the light of this statement, it would be wise to detect those women with severe conflicts in order to help them work out problems that would hinder or harm the course of their pregnancy.

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[1]Anthony, p. 41.

[2]Duetsch, p. 52.

[3]Anthony, p. 137.

[4]Anthony, p. 142.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study emphasized the need for new and improved ways to assess the mental health and emotional state of pregnant women. The importance of a healthy self-perception at such a critical time has implications not only for the course of pregnancy, but also for the family equilibrium and mental health of the infant after delivery.

Nurses, long having been critical figures in assessing the physical state of parturient women, are in a key position to detect psychological problems especially associated with poor self-concept. There is much a nurse can do in terms of anticipatory guidance and counseling to help the mother with role transition, with accepting her feelings about the baby and her pregnancy, and with her feelings about herself as a person. Sharing feelings with another person often helps one to be more accepting of himself, and the nurse is in an ideal position to foster this sharing of feelings.

The office nurse or primary nurse practioner, also, has a golden opportunity to talk about the baby as a separate being growing inside the mother, to support the

mother's own struggle with her feelings, and to teach the family concerning the needs of the mother and baby.

Moreover, a tool for assessing the crucial area of self-perception would help the nurse know what areas needed the most attention and where to concentrate her efforts. Such a tool was used by the researcher in this study. The tool is an objective measure of self-concept and was used to assess the mental state of the primigravidas in the last month of pregnancy. More data needs to be collected, however, in order to generalize the results to other pregnant women and to establish a norm from which the nurse could identify deviations and toward which she could direct her efforts.

Although the form of the T.S.C.S. used in this research was not meant for a counseling aid, the Counseling Form could be used in working with women who deviate from the norm once the norm is established. A major recommendation for additional research in this area, consequently, would be to use the T.S.C.S. with a larger population of women prior to pregnancy, at several times during the pregnancy, and after delivery.

This data would not only help to establish a norm, but also would supply data for further research. This research might involve the effect of certain variables on the self-concept in pregnancy. Such variables that could be explored

are methods of nursing care during pregnancy and delivery. This information might detect those things a nurse does that are most enhancing to the self-concept.

Another question in need of exploration is the effect of general anesthesia on the role transition process. In other words, is a mother more likely to accept her baby and feel proud about her accomplishment if she has participated consciously in the delivery process?

This knowledge about the effect of certain variables on their patients' self-concepts would help nurses recognize the implications of their patients' attitudes about their pregnancy and aid the nurse in aiming care toward therapeutic ends. Nurses need to be sensitive to their patients' perceptions of themselves and others, especially as it influences the patients' ability to use a critical situation such as pregnancy for further growth and mobilization of innate human resources.

Moreover, an evaluation of the patient's self-concept after delivery and the puerpurem could be used to evaluate the care given and provide some feedback for the nurses as to the effectiveness of her intervention.

The influence of a mother's self-concept and the way she mothers her child would also bear investigation.

APPENDIXES

APPENDIX A

PERMIT FROM AGENCY

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Tx. 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Tx. 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE NORTHWEST TEXAS HOSPITAL

GRANTS TO JEANIE HENAGER

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

THE SELF-CONCEPT OF PRIMIGRAVIDAS
IN THE LAST MONTH OF PREGNANCY

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date September 5, 1972

Signature of Agency Personnel

Jeanie Henager
Signature of Student

Opal H. White
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original-Student; first copy-agency; second copy-TWU College of Nursing.

White/jmm/9/17/70

APPENDIX B

PERMISSION LETTER FOR INSTRUMENT

DIRECTIONS FOR THE T.S.C.S.

SAMPLE TENNESSEE SELF CONCEPT SCALE - FITTS

dede wallace center
nashville mental health center · 2410 white avenue · nashville, tennessee 37204 · phone 297-9571

January 21, 1971

Jeanie Heneger, R.N., B.S.
Chief of Clinical Nursing
The Kilgore Children's Psychiatric Center
and Hospital Incorporated
1200 Wallace Boulevard
Amarillo Medical Center
Amarillo, Texas 79106

Dear Miss Henegar:

I was glad to receive your letter of January 4 forwarded to me by the publisher of the TSCS. Your request for information about the scale has already been handled by the publisher. Your thesis project sounds like an interesting one and a valuable contribution. I will certainly look forward to seeing your results and hope you can send a copy of your thesis when it is finished.

I am sending our lates Reference List of TSCS studies and you should find two of them in particular (Boston & Kew and Cole, Garrett, & Meade) relevant. Also enclosed are two free monographs which we have published from TSCS studies. I am sorry we are out of Monograph 3. We are presently in preparation on 3 more monographs. They should be available by the end of March.

Good luck with your study.

Sincerely,

William H. Fitts

William H. Fitts, Ph. D.
Director of Research

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	

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

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

AND R.

TENNESSEE SELF CONCEPT SCALE — ANSWER SHEET

ITEM NO.	PAGES 5 AND 6	ITEM NO.	PAGES 3 AND 4	ITEM NO.	PAGES 1 AND 2
13	1 2 3 4 (5)	7	1 2 3 4 (5)	1	1 2 3 4 (5)
14	1 2 3 4 (5)	8	1 2 3 4 (5)	2	1 2 3 4 (5)
15	1 2 3 4 (5)	9	1 2 3 4 (5)	3	1 2 3 4 (5)
16	(1) 2 3 4 5	10	1 2 3 4 (5)	4	(1) 2 3 4 5
17	1 2 3 4 (5)	11	(1) 2 3 4 5	5	(1) 2 3 4 5
18	(1) 2 3 4 5	12	(1) 2 3 4 5	6	(1) 2 3 4 5
31	1 2 3 (4) 5	25	1 2 3 4 (5)	19	1 2 3 4 (5)
32	1 2 3 4 (5)	26	1 2 3 4 (5)	20	1 2 3 4 (5)
33	1 2 3 4 (5)	27	1 2 3 4 (5)	21	1 2 3 4 (5)
34	(1) 2 3 4 5	28	1 2 3 4 (5)	22	(1) 2 3 4 5
35	1 2 3 4 (5)	29	1 2 3 4 (5)	23	(1) 2 3 4 5
36	1 2 3 4 (5)	30	(1) 2 3 4 X	24	(1) 2 3 4 5
49	(1) 2 3 4 5	43	1 2 3 4 (5)	37	1 2 3 4 (5)
50	1 2 3 4 (5)	44	(1) 2 3 4 5	38	1 2 3 4 (5)
51	(1) 2 3 4 5	45	1 2 3 4 (5)	39	1 2 3 4 (5)
52	1 2 3 4 (5)	46	1 2 3 4 (5)	40	(1) 2 3 4 5
53	1 2 3 4 (5)	47	(1) 2 3 4 5	41	(1) 2 3 4 5
54	(1) 2 3 4 5	48	1 2 3 4 (5)	42	(1) 2 3 4 5
67	1 2 3 4 (5)	61	1 2 3 4 (5)	55	1 2 3 4 (5)
68	1 2 3 4 (5)	62	1 2 3 4 (5)	56	1 2 3 4 (5)
69	1 2 3 4 (5)	63	1 2 3 4 (5)	57	1 2 3 4 (5)
70	1 2 3 4 (5)	64	1 2 3 4 (5)	58	(1) 2 3 4 5
71	1 2 3 4 (5)	65	1 2 3 4 (5)	59	(1) 2 3 4 X
72	1 2 3 4 (5)	66	(1) 2 3 4 5	60	(1) 2 3 4 5
85	1 2 3 4 (5)	79	1 2 3 4 (5)	73	1 2 3 4 (5)
86	1 2 3 4 (5)	80	1 2 3 4 (5)	74	(1) 2 3 4 5
87	1 2 3 4 (5)	81	1 2 3 4 (5)	75	1 2 3 4 (5)
88	1 2 3 4 (5)	82	1 2 3 4 (5)	76	(1) 2 3 4 5
89	1 2 3 4 (5)	83	(1) 2 3 4 5	77	1 2 3 4 (5)
90	(1) 2 3 4 5	84	1 2 3 4 (5)	78	(1) 2 3 4 5
99	1 2 3 4 (5)	95	1 2 3 4 (5)	91	(1) 2 3 4 5
100	1 2 3 4 (5)	96	1 2 3 4 (5)	92	1 2 3 4 (5)
		97	1 2 3 4 (5)	93	1 2 3 4 (5)
		98	1 2 3 4 (5)	94	1 2 3 4 (5)

NAME

53a

BY:
RECORDINGS AND TESTS
ACKLEN STA.
TENN. 37212

H. FITTS 1964

OF:

	A PHYSICAL SELF						COLUMN B MORAL-ETHICAL SELF						C PERSONAL SELF												COLUMN E SOCIAL SELF						CRITICISM				ROW TOTALS
1.		P-2	P-3	N-4	N-5	N-6																							91	92	93	94	POSITIVE P + N	
	5	(5)	(5)	1	1	1			(5)	1	1	1			(5)	1	1	1			(5)	1	✗	1		5		1	(1)	1	5	(5)	(5)	(5)		
IDENTITY		4	4	2	2	2	4		4	2	2	2	4	4	4	2	2	2	4	4	4	2	2	2	4	4	4	2	2	2	4	4	4	4	--	-
THE	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
IS	2	2	2	4	4	4	2	2	2		4	4	2	2	2	4		4	2	2	2	4	4	4	2		2		4			2	2	2		
	1	1	1			5			1				1												1		1					1	1	1	-15	
	P																																			
	P + N 2	P − N 0					P + N 20	P − N					P +		−			+	3d	− N 1			+		−											
ROW 2.	P-7	P-8	P-9	N-10	N-11	N-12				N- 8	N-29	N-30									N				79P	80F	81				96	97	98			
	(5)	(5)	(5)	(1)	1	1				(1)	(1)		(5)	5			1		(5)	(5)	(5)		(1)	1	(5)	(5)	(5)		1			(5)	(5)	(5)		
	4	4	4	2	2	2	4	4	4	2	2	2	4	4	4		2	2	4	4	4	2	2	2	4	4	4		2	2	4	4	4	4		
SELF SATISFACTION	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
HOW HE	2	2	2	4	4	4	2	2	2	4	4		2		2	4	4	4	2	2	2	4	4		2	2	2	4		4	2	2	2	2		
ACCEPTS HIMSELF	1	1	1	5					1	5	5		1		5		5					5			1	1	1	5			1	1	1	1	8	17
	P			N																																
	÷		−				P + N		− N				+		−			+		−			+		−										
ROW 3.	P-14	P-15	N-16	N-17			P-31	P-32	P-33							N-52	N-53	N-54										N-88	N		100						
	(5)	(5)	1	(1)	1		5	(5)	(5)	1	(1)		5	(5)	5	(1)	(1)	1											(1)	1	(5)					
BEHAVIOR	4	4	4	2	2	2	(4)	4	4	2	2	2	4	4	4	2	2	2	4	4	4	2	2	2	4	4	4	2		2	4	4				
HOW HE	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	=			
ACTS	2	2	2		4		2	2	2		4	4		2		4	4	4	2	2	2	4	4	4	2	2	2	4	4		2	2				
	1			5				1	1		5	5		1		5	5				1	5	5	5	1	1	1	5	5		1	1				
										N															P											
			−				P +		−				P		−										P +		−								

5396

COLUMN TOTALS

- TOTAL POSITIVE (ΣP + N)
- Σ (Algebraic) P − N
- Σ Non-(Algebraic) P − N
- V. (Range of P + N Cell Scores)

Total Positive or P + N →

→ Total Net Conflict (P − N)

Row V.

→ Total Conflict

→ Col. Tot. V.

DISTRIBUTION OF RESPONSES

NUMBER OF 5'S + 4'S [4 3 5 1] 3'S 2'S + 1'S [0 2 + 2 4] = 90 T/F = 66/24 = [2.01]

SELF CRITICISM RESPONSES 9 0 0 0 1 = 10

TOTALS 24 1 0 0 35 = 100

D 1.24 + .1 + 0 + .50 = [2.01]

EMPIRICAL SCALES

DP = ___ − ___ = ___

GM = ___

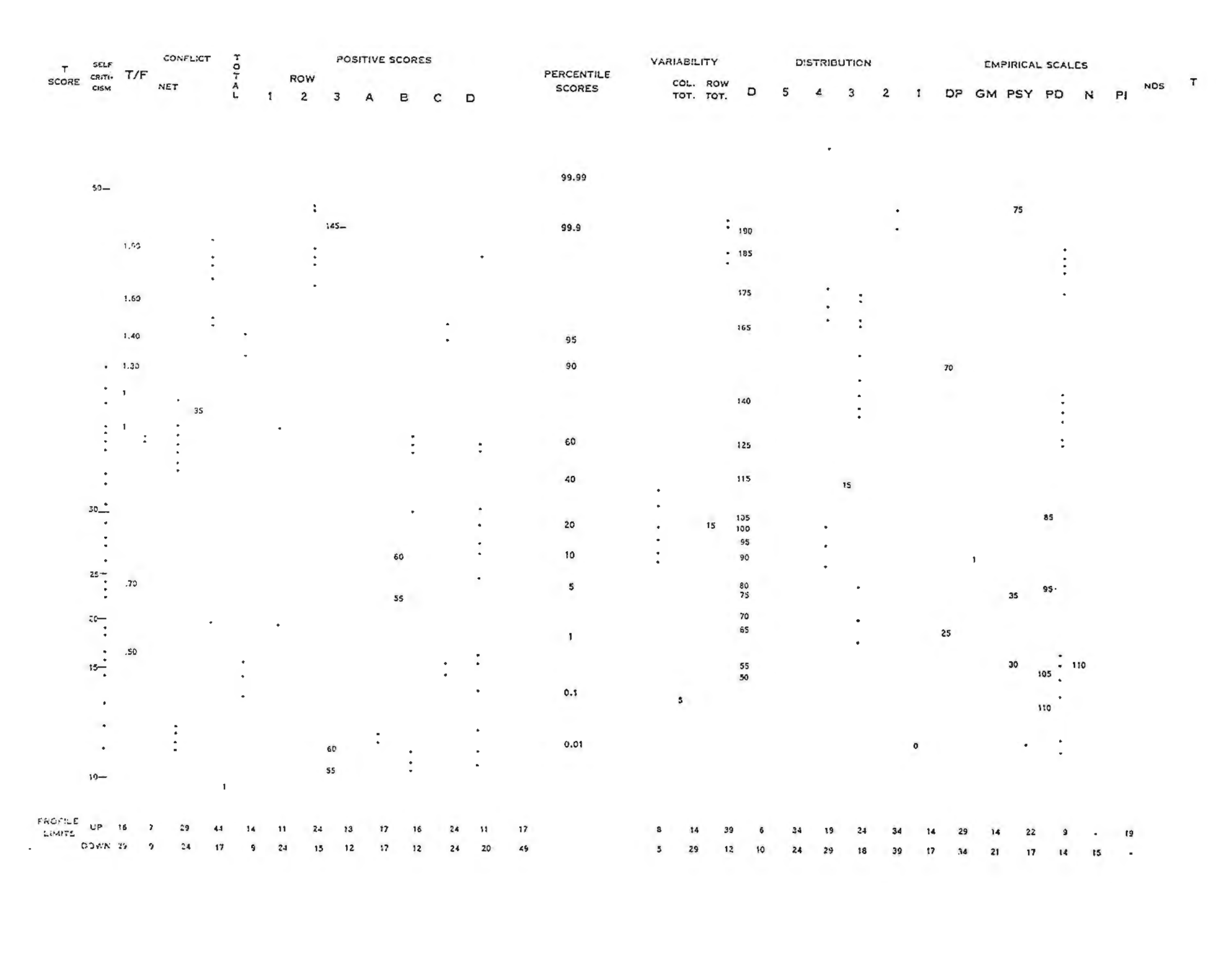
PSY = (100 + ___) − (___) = ___

PD = ___ − ___ = ___

N = ___ − ___ = ___

PI = ___

*PUBLISHED BY:
COUNSELOR
BOX 6184, ACKLEN STA
NASHVILLE, TENN. 37212


T SCORE
SELF CRITICISM
T/F
CONFLICT
NET
TOTAL
POSITIVE SCORES
ROW
1
2
3
A
B
C
D
PERCENTILE SCORES
99.99
99.9
95
90
60
40
20
10
5
1
0.1
0.01
VARIABILITY
COL. TOT.
ROW TOT.
DISTRIBUTION
D
5
4
3
2
1
EMPIRICAL SCALES
DP
GM
PSY
PD
N
PI
FSN
T
PROFILE LIMITS
UP
DOWN

APPENDIX C

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