SELF-ESTEEM OF PRIMIPARAS FOLLOWING VAGINAL AND CESAREAN BIRTHS

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DEDICATION

TO RACHEL,

whose cesarean arrival launched me
headlong into this venture;

TO ELIZABETH,

whose cesarean arrival was the
fulfillment of a dream;

TO LESLIE,

who shares everything with me, good or bad,
inspiring or discouraging,
you are always there.

TO ALL CESAREAN MOTHERS,

in hope that your cesarean child's birth-day
is the happiest day of your lives.

Lehayim!

ACKNOWLEDGMENTS

TO JANE:

I never could have done it without you!

Thank you.

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CHAPTER 1

INTRODUCTION

The birth of a first child can be both an exhilarating and an exhausting emotional experience for many expectant parents. Almost all women make extensive preparations in anticiaption of the birth. They formulate expectations of the self and the experience. One of these expectations concerns the labor and delivery process. Many couples attend classes to learn about and to prepare for an active part in the birth. The goal is for a healthy baby, born via a normal, uncomplicated vaginal delivery.

For a variety of reasons, an increasing number of women are unable to have vaginal deliveries. Approximately 15% to 20% of deliveries are now by cesarean section (Affonso, 1981; Boyd & Mahon, 1980). An unexpected cesarean birth can be emotionally devastating for a new mother (Cohen, 1977). Months of preparation are seemingly destroyed in a matter of minutes or hours. The mother's expectations for normalcy may be shattered. The literature suggests that she may experience feelings of guilt, failure, disappointment, resentment, anger,

or frustration following an unexpected cesarean delivery (Donovan, 1978). The literature also implies that these feelings may lead to a decrease in self-esteem of the new mother (Bampton & Mancini, 1973). Rubin (1968) stated:

> When we consider the high values placed on a person's capacity to use himself in action to accomplish what he wishes to do when and where he intends to do it, we can estimate and understand to some degree what happens experientially when he succeeds or fails. In fact, it is possible to consider a personal success or personal failure in terms of the congruence between intent or expectation of self and the effectiveness of functional control. Certainly, self respect is measured in these terms. (pp. 21-22)

It would appear, then, that an unexpected cesarean delivery and its aftermath can be an emotionally, as well as physically, trying time for the new mother. The impact of this unplanned event has ramifications in terms of the new mother's self-respect, or self-esteem, and in terms of unfulfilled expectations.

Problem of Study

The problem of this study was to determine if there was a difference in the level of self-esteem in primiparous women who had vaginal deliveries and those who had unexpected cesarean births.

Justification of Problem

In the past few years, there has been an increasing interest in the health care field on the part of the consumer. Many consumers have begun to demand more information, more education, and more participation in their care. This has been especially true in the area of childbirth (Marut & Mercer, 1979). A wealth of information (books, and other similar literature, films, classes, support groups) is available for expectant parents (Donovan, 1978). The direction of much of this information has been toward "prepared" or "natural" childbirth, resulting in an uncomplicated, normal, vaginal delivery (Bampton & Mancini, 1973; Conklin, 1977).

Frequently, couples prepare together for the childbirth experience. They anticipate a shared experience. In contrast, a primary cesarean birth usually precludes choice of participation. Parents are often not prepared for this situation (Donovan, 1978). Cesarean birth is infrequently or briefly discussed in prenatal classes. Lay and nursing literature regarding cesarean childbirth is limited.

Research regarding cesarean birth is also limited. Marut and Mercer (1979) found, in comparing perception of vaginal and cesarean births, that cesarean mothers were less satisfied with the birth experience than mothers who delivered vaginally. These authors concluded that

> further study is warranted so that nursing practice can consider more explicitly those factors that can enhance social attitudes about Cesarean birth to make it a more pleasurable and less ego-deflating experience. (Marut & Mercer, 1979, p. 265)

In an article entitled "Best Laid Plans," Hott (1980) related her study which involved a prepartum and postpartum comparison of self and spouse in primary Lamaze couples who shared delivery and those who did not. Women who were not able to share the childbirth experience with their husband due to a cesarean were generally found to have lower postpartum self-preparation. Hott (1980) concluded that

> A labor that leads to a cesarean section may be particularly damaging to the self-system and difficult to integrate. . . . It is difficult to readjust to think of oneself as an imperfect human being whose body image is now changed by the surgery of a cesarean delivery. The feelings that accompany it are painful and include loss of self-esteem. (p. 25)

Lowered self-esteem may result in depression. This, in turn, may interfere with the ability of the mother, regardless of delivery method, to relate to her infant. Lesh (1978) stated

> the crippling effects of early maternal rejection can hardly be exaggerated . . . 50,000-70,000 [children] neglected, battered and exploited annually; 150,000 placed in foster homes. (p. 54)

At a time when prepared childbirth and the participation of both parents in labor and delivery are being stressed, nurses need to further examine the effect of a cesarean birth on the family, especially the mother. Nursing has the opportunity to participate in the antepartum period of the mother's pregnancy, as well as during the intra and postpartum periods, providing many occasions for assessment. Nursing's responsibility lies in the identification of factors that possibly may be detrimental to the mother's pregnancy, delivery, recovery, and to the maternal/infant relationship. Recognition of these factors is the initial step in planning appropriate nursing interventions.

Conceptual Framework

In 1890, William James (James, 1904) became one of the earliest to write on the self. James developed the I/Me dichotomy. The self is divided into the self as the knower--the I, and the self as known--the Me.

> In its widest possible sense, a man's Me is the sum total of all that he can call his, not only his body and his psychic powers, but his clothes and his house, his wife and his children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank account. All these things give him the same emotions. If they wax and prosper, he feels triumphant; when they dwindle and die away, he feels cast down, not necessarily in the same degree for each thing, but in much the same way for all. (James, 1904, p. 177)

The Me is further divided into three parts: its constituents, the feelings and emotions they arouse (self-appreciation), and the act to which they prompt (self-seeking and self-preservation). The constituents are then subdivided into three parts: the material Me, the social Me, and the spiritual Me. The material Me includes the body, the family, the home, material possessions, and things that would result in intense grief if lost. The social Me is manifest in the recognition one receives from others, for example, fame or honor. "A man has as many social selves as there are individuals

who recognize him (James, 1904, p. 179). The lack of recognition is not a pleasant state.

> No more fiendish punishment could be devised, were such a thing physically possible, than that one would be turned loose in society and remain absolutely unnoticed by all the members thereof. (James, 1904, p. 179)

The spiritual Me is defined as "the collection of the states of consciousness, psychic facilities and disposition taken concretely" (James, 1904, p. 181). This includes states such as thinking, feeling, deciding, and desiring.

The I portion of the dichotomy is more difficult to describe. It is the I, the knower, the "pure ego," "that which at any given moment <u>is</u> conscious, whereas the Me is only one of the things it is conscious of" (James, 1904, p. 195). The I is the <u>Thinker</u> in each person.

Upon self-examination, the I knowing the Me, one is left with a sense of what one could be and an evaluation of what one is. This is the derivation of the "equation" James used to determine self-esteem.

$$\text{Self-esteem} = \frac{\text{Success}}{\text{Pretension (Aspirations)}}$$

(James, 1904, p. 187)

James identified three possible influences upon self-esteem. First, he concluded that human aspirations and values have an essential role in determining whether an individual regards himself-herself favorably. Achievements are measured against one's aspiration for any given area of behavior. If achievement approaches or meets aspirations in a valued area, the result is high self-esteem; if there is wide divergence, the individual regards himself poorly (Coopersmith, 1967). The second area of influence in regard to self-esteem is that men/women achieve a sense of their general worth by employing communal standards of success and status.

> We may weigh our own worth in the balance of praise and blame as easily as we weigh other people--though with difficulty quite as fairly. There is no reason a man should not pass judgment on himself quite as objectively and well as on anybody else . . . he may still truly know his own worth by measuring it by the outward standard he applies to other men. (Coopersmith, 1967, p. 30)

The third area of influence is the value placed on the extentions of the self, described earlier as the Me.

The present study integrated James' concept of self-esteem in examining level of self-esteem in mothers delivered vaginally and by cesarean. The expectant mother arrives in labor with a set of expectations (aspirations).

Her perceptions of the experience as successful or unsuccessful are determined to a large degree by how well her expectations are fulfilled, leading to a potential variance in her self-esteem.

Assumptions

The following assumptions were made:

1. Self-esteem is present in each person.

2. Self-esteem is basic to an individual's healthy functioning and to interpersonal relationships.

3. Self-esteem is directly related to the satisfaction of an individual's aspirations.

4. The level of an individual's self-esteem can be measured through the administration and completion of a written tool.

5. It is desirable to have a successful childbirth experience.

6. Mothers generally anticipate a normal, uncomplicated vaginal delivery.

Hypothesis

The following hypothesis was tested:

Primiparous women who have been delivered by unexpected cesarean section will have lower self-esteem

than those who have had a normal vaginal delivery, as measured by their scores on the Rosenberg Self-Esteem Scale.

Definition of Terms

For the purposes of this study, the following terms were defined.

1. Self-esteem--"A personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself" (Coopersmith, 1967, p. 5). Rosenberg (1965) defined high self-esteem as a feeling of respect and self-worth that the individual holds for himself and low self-esteem as a feeling of self-rejection, self-dissatisfaction, or self-contempt. The level of self-esteem is determined through the scores obtained by the administration of a written tool, the Rosenberg Self-Esteem Scale. Self-esteem is presented on a continuum of -6 through +6, with -6 representing the highest level of self-esteem, +6 representing the lowest level of self-esteem.

2. Primiparous woman--one who has given birth to her first child.

3. Normal vaginal delivery--the uncomplicated birth of an infant through the vagina.

4. Cesarean section/birth/delivery--the removal of the infant by means of an incision into the uterus, by way of the abdominal wall.

5. Unexpected cesarean section/birth/delivery--on admission to the hospital, the pregnant woman anticipates a normal labor and delivery. After her admission, circumstances arise leading to surgical delivery that was not foreseen or planned.

Limitations

The following limitations were made:

1. No control was made for age, education, race, religion, or marital status.

2. No control was made for self-esteem levels prior to delivery.

3. No control was made for varying experiences within the health care system.

4. No control was made for variation in policy and procedure at the two separate hospitals.

5. No data were collected more than 5 days post-delivery.

6. Non-random selection of subjects limited generalizability.

Summary

The incidence of cesarean childbirth has been increasing in recent years. An unexpected cesarean birth has many potential psychological ramifications. Of specific interest to this study was the concept of self-esteem and its importance in regard to the childbirth experience. The conceptual framework for this study was based on James' work, which initially described the components of the self and the overall importance of self-esteem. James defined self-esteem as a ratio of success to aspirations. In light of the increasing rate of cesarean deliveries, the psychological aspects demand further study with regard to the self, parent/child interaction and relationships, and the family. This study examined the concept of self-esteem in women who had a vaginal delivery compared to those who had an unexpected cesarean delivery.

CHAPTER 2

REVIEW OF LITERATURE

The review of literature for this study has been divided into two major sections. The first section includes discussion of aspects of self and self-esteem. The second section discusses various aspects of cesarean childbirth. In preface, some of the earliest discussion of self occurred with Aristotle's distinction between the physical and nonphysical aspects of human functioning. One central concept of non-physical existence was soul, often used to

> refer to the core of the non-physical or psychic, that part which is essential and unique in mental functioning. This notion has much in common with what later theorists meant by "the self." (Gergen, 1971, pp. 5-6)

The French philosopher, Rene Descartes, elaborated further. Descartes' (cited in Gergen, 1971) dictum was "I think, therefore I am" (p. 6). According to Gergen, Descartes reasoned that since the reality of thinking was undeniable, so was the existence of the thinker, or the I. This notion of I, the thinking, knowing, cognizing entity, became one direct predecessor of the concept of self in psychology.

Self/Self-Esteem

There are many contributors to the area of self and self-esteem. This section includes a review of the major theorists and researchers.

William James

James (1904) was one of the earliest to write on the self, as previously described in the conceptual framework. Briefly, James developed the I/Me dichotomy where the self is divided into the self as the knower--the I, and the self as known--the Me. Upon self-examination, the I knowing the Me, one is left with "a sense of what we could be and an evaluation of what we are" (James, 1904, p. 187). James (1904) derived an equation to represent self-esteem:

$$\text{Self-esteem} = \frac{\text{Success}}{\text{Pretensions (aspirations)}}$$

(p. 187).

James concluded, in part, that human aspirations and values have an essential role in determining whether an individual regards himself favorably. Achievements are measured against one's aspirations in a valued area, with subsequent increase or decrease or self-esteem.

Calvin H. Cooley

Cooley (1902/1956) is best known for his work in the aspect that James called the Social Me. Cooley believed that the individual, the self, must be considered within the context of society. Cooley's major contribution was that of the "looking glass self," where an individual's conception of himself is determined by the perception of other people's reactions to him (Wells & Marwell, 1976). According to Cooley (1902/1956):

> A self idea of this sort seems to have three principal elements: the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification. . . . The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imprinted sentiment, the imagined effect of this reflection upon another's mind. (p. 185)

One does not see oneself as others see him, but as he imagines they see him. Although Cooley did not deal explicitly with self-esteem, he included self-feeling as an aspect of his looking glass self, and he postulated a need for protecting the self against negative influences (Wells & Marwell, 1976)

George H. Mead

Mead's (1934) thoughts rested upon a few basic ideas which were refined and integrated over many years. Like James and Cooley, Mead saw the self as a social phenomena, a product of interactions in which the person experienced himself as reflected in the behavior of the other (Wells & Marwell, 1976). The development of a self is a social process; it is not present at birth, but arises in the process of social experience and activity.

> The individual possesses a self only in relation to the selves of the other members of his social group; and the structure of his self expresses or reflects the general behavior pattern of this social group to which he belongs just as does the structure of the self of every other individual belonging to this social group. (Mead, 1934, p. 164)

Mead distinguished between the "I," the functioning spontaneous part of the self, and the "me," the part of the self that reflects upon, judges, and evaluates the person. Self attitudes are unique in this regard, in that the person holding the attitude and the object toward whom the attitude is held are the same.

Mead believed that language is an essential part of the development and operation of the self, as a symbol-using or symbol-dependent process (Mead, 1934).

> The transformation of the biologic individual to the minded organism, or self, takes place . . . through the agency of language, which presupposes the existence of a certain kind of society and certain physiological capacities in the individual organism. (Mead, 1934, p. xx)

> It is the same agency of language which on this theory makes possible the appearance of the self. (Mead, 1934, p. xxiii)

> Mead finds the distinguishing trait of selfhood to reside in the capacity of the minded organism to be an object to itself. . . . Thus again, it is only in a social process that selves, as distinct from biological organisms, can arise--selves as beings that have become conscious of themselves. (Mead, 1934, pp. xxiii-xxiv)

Mead did not deal explicitly with self-esteem, because he was primarily concerned with the process by which the self developed. He did, however, discuss the effects of self-evaluation, and the tendency of people to "self-realization." Mead proposed that man has innate drive for not only self-enhancement but superiority in relation to others.

Karen Horney

Horney (1950) believed that an individual is born with certain intrinsic potentialities, which eventually develop into the "real self." The elements of the real self include:

> The clarity and depth of his own feelings, thoughts, wishes, interests; the ability to tap

> his own resources, the strength of his will power; the special capacities or gifts he may have; the faculty to express himself, and to relate himself to others with his spontaneous feelings. (Horney, 1950, p. 17)

The culmination of this is that the individual will ultimately find his set of values and his aims in life. He will grow toward self-realization (Horney, 1950).

Ideally, an individual needs favorable conditions for this growth. He needs an atmosphere of love and warmth so that he will have a feeling of security and the freedom enabling him to have his own feelings and thoughts and to express himself. He needs guidance and encouragement, as well as

> healthy friction with the wishes and wills of others . . . if he can grow <u>with</u> others, in love and friction he will also grow in accordance with his real self. (Horney, 1950, p. 18)

The growth of the real self may be affected by a variety of adverse influences, from indifference to over-protection, causing basic anxiety where the child has a sense of insecurity and apprehension. The world is conceived as potentially hostile; he is isolated and helpless. Rather than developing the real self, he develops ways to cope with the anxiety/helplessness. For Horney, self-realization/self-alienation involved the degree of discrepancy between the real self and the actual self (Wells & Marwell, 1976).

Carl Rogers

Rogers (1951) presented a theory of personality and behavior that is basically phenomenological in character. The "end point" of personality development is seen as a basic congruence between the phenomenal field of experience and the conceptual structure of the self. If achieved, the situation would represent freedom from internal strain and anxiety, and freedom from potential strain; would represent the maximum in realistically oriented adaptation, which would mean the establishment of an individualized value system having considerable identity with the value system of any other equally adjusted member of the human race (Rogers, 1951).

Rogers' theory consisted of 19 propositions with regard to the formation of the self. The most simple way to present them is to list them as follows. According to Rogers (1951):

> Every individual exists in a continually changing world of experience of which he is the center. (p. 483)
>
> The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality." (p. 484)
>
> The organism reacts as an organized whole to this phenomenal field. (p. 486)

> The organism has one basic tendency and striving--to actualize, maintain, and enhance the experiencing organism. (p. 487)
>
> Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced in the field as perceived. (p. 491)
>
> Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism. (pp. 492-493)
>
> The best vantage point for understanding behavior is from the internal frame of reference of the individual himself. (p. 498)
>
> A portion of the total perceptual field gradually becomes differentiated as the self. (p. 497)
>
> As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed--an organized, fluid but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with values attached to these concepts. (p. 498)
>
> The values attached to experiences, and the values which are a part of the self structure, in some instances are values experienced directly by the organism. In some instances values are introjected or taken over from others, but perceived in distorted fashion as if they had been experienced directly. (p. 498)
>
> As experiences occur in the life of the individual they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived

relationship to the self structure, (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self. (p. 503)

Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self. (p. 507)

Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual. (p. 509)

Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences which consequently are not symbolized and organized into the "gestalt" of the self structure. When this situation exists, there is a basic or potential psychological tension. (p. 510)

Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self. (p. 513)

Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself. (p. 515)

Under certain conditions, involving primarily complete absence of any threat to the self structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences. (p. 517)

> When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others as separate individuals. (p. 520)

> As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system--based so largely upon introjections which have been distortedly symbolized--with a continuing organismic valuing process. (p. 522)

Ultimately, value systems emerge which

> are unique and personal for each individual, and which are changed by the changing evidence of organic experience, yet which are at the same time deeply socialized. (Rogers, 1951, p. 523)

The result is a fully functioning individual characterized by self-regulation and self-direction. The effective individual relies on his total organismic valuing process to guide him toward need satisfaction, self-actualization, and adequate behavior.

Abraham Maslow

Maslow (1970) formulated what he termed a "holistic-dynamic theory of motivation" (p. 35). He described a multitude of needs, ordered from lowest to highest: physiological needs, safety or security needs, needs for love and belonging, esteem needs, and need for self-actualization. Each need must be satisfied before one can attain the next level. In regard to the esteem

needs, Maslow (1970) stated:

> all people in our society (with a few pathological exceptions) have a need or desire for a stable, firmly based, usually high evaluation of themselves, for self-respect or self-esteem, and for the esteem of others. (p. 45)

These needs are classified into two groups. The first is a desire for strength, achievement, adequacy, mastery and competence, confidence "in the face of the world," and for independence and freedom. Second, this group includes needs for reputation or prestige (defining it as respect or esteem from other people), status, fame and glory, dominance, recognition, attention, importance, dignity, or appreciation (Maslow, 1970).

Satisfaction of the self-esteem needs leads to feelings of self-confidence, worth, strength, capability, adequacy, and of being useful and necessary in the world. Failure to satisfy these needs produces feelings of inferiority, weakness, and helplessness, which in turn give rise to either basic discouragement or else compensatory or neurotic trends (Maslow, 1970). Maslow also pointed out that more is being learned of the dangers of basing self-esteem on the opinion of others rather than on real capacity, competence, and adequacy to the task.

> The most stable and therefore most healthy self-esteem is based on deserved respect from others rather than on external fame or celebrity, and unwarranted adulation. (Maslow, 1970, p. 46)

The ultimate goal of need satisfaction is for self-actualization, "man's desire for self-fulfillment, namely to the tendency for him to become actualized in what he is potentially" (Maslow, 1970, p. 46). Maslow gave an example:

> A musician must make music, an artist must paint, a poet must write, if he is to be ultimately at peace with himself. What a man can be, he must be. (p. 46)

William Fitts

Fitts (1971) extended Maslow's concept of self-actualization--the individual's development or realization of innate abilities and potentials. Fitts' work tries to establish the relationship between the self-concept and rehabilitation (ultimately self-actualization). Fitts (1971) described the self-concept as "the frame of reference through which the individual interacts with his world" (p. 3). The self-concept is learned by each person through his lifetime of experiences with himself, with other people, and with the realities of the external world (Fitts, 1971).

Three principal parts or "subselves" comprise the self. These are the self as object (Identity Self), the self as doer (Behavioral Self), and the self as observer and judge (Judging Self). The Identity Self is the most basic aspect of the self-concept, asking "Who Am I?" It consists of the labels and symbols assigned to the self by the individual to describe himself and establish his identity. As one develops, more labels are added both by others and himself which help to describe the self. For example, one thinks of himself or herself in a number of ways: I am Janet . . . a wife . . . a mother . . . a daughter . . . a nurse . . . a student . . . a neighbor . . . a church member . . . creative . . . friendly . . . compassionate. . . etc. (Fitts, 1971).

The Behavioral Self functions freely in a child--he does whatever he is prompted to do by internal and external stimuli. The consequences of his behaviors determine whether they will be continued or not. They also determine whether new behaviors are abstracted, symbolized, and integrated into his Identity Self (Fitts, 1971).

The interaction between the Identity Self and the Behavioral Self and their integration into the total self-concept involves the third subself, the Judging Self. The Judging Self functions as an observer, standard setter, dreamer, comparer, and most of all, evaluator. It also serves as a "mediator" between the other two selves.

> This evaluative tendency of the self is a primary component of self-perception and provides the material or sustenance for self-esteem which is a primary concern for most people. (Fitts, 1971, p. 17)

The standards which the Judging Self applies depend on the extent to which self-actualization values are operating in relation to other conflicting values and the progress one has already made toward self-actualization (Fitts, 1971). Whatever the specific standards utilized by the Judging Self, they are applied in two ways: an absolute manner and in a relative or comparative manner. Thus, the Judging Self determined one's satisfaction with self or the extent to which one can live with and tolerate himself (Fitts, 1971).

Esteem is derived from two sources, the self and other persons. Esteem is earned as one achieves certain goals, operates by certain values, or measures up to

certain standards. The goals, values, and standards may be internal and/or external. They may be established and regulated and applied by the Judging Self and/or others. Generally, values, goals, and standards are initially incorporated from others: esteem can be earned only by measuring up to the demands and expectations of others. Thus, the initial source of self-esteem is esteem from others (Fitts, 1971). It was contended that esteem

> emanates from the self whenever the Behavioral Self engages in self-actualizing behavior--when one is meeting one's own physiological needs, protecting one's self, loving and otherwise actualizing one's abilities. (Fitts, 1971, p. 22)

Fitts related that complete understanding or measurement of any person's self-concept would require consideration of his unique set of subselves, for example: Physical Self, Moral-Ethical Self, Personal Self, Family Self, Social Self, Work Self. The degree of internal consistency between and within these subselves is related to their effective integration with the total self. There are any number of subselves that comprise our esteem. These are also variable: "As individuals view themselves and as self-concepts are measured or viewed by others, a wide range of variability occurs" (Fitts,

1971, p. 23). Other facets of the subselves affecting esteem include degree of differentiation, or clarity, content, form, and conflict. The esteem value of the total self is a composite of the esteem values attached to the individual's subselves (Fitts, 1971).

Research Studies in Self-Esteem

In spite of the large and varying amount of literature concerning self, self-concept, and self-esteem there are few empirical studies measuring the concept. Fitts (1971) related that the

> greatest difficulty in measuring the self-concept results from the fact that the person's self-concept is private, personal, and not directly observable. (p. 39)

Another difficulty lies in the fact that many researchers have devised their own instruments rather than using existing instruments, making the data difficult to collate and integrate. "As far as the instruments, little is known in regard to the psychometric characteristics--reliability, validity or normative data" (Fitts, 1971, p. 40). The major researchers have been Rosenberg (1965) and Coopersmith (1967). The works of these men represent their attempts to develop theories of self-esteem based on empirical studies of self-esteem.

Morris Rosenberg. One of the major purposes of Rosenberg's (1965) study was to learn how different social experiences, stemming from membership in groups characterized by different values, perspectives, or conditions of existence, would bear upon levels of self-esteem and upon values. Rosenberg described many of the social conditions associated with increased and decreased self-esteem. Data regarding the social conditions and self-esteem itself were obtained through the use of an attitude survey administered to 5,024 high school students.

Rosenberg (1965) defined self-esteem as "a positive or negative attitude toward a particular object, namely, the self" (p. 30). Rosenberg (1965) described high and low self-esteem more specifically:

> When we speak of high self-esteem, then we shall simply mean that the individual respects himself, considers himself worthy; he does not necessarily consider himself better than others, but he definitely does not consider himself worse; he does not feel that he is the ultimate in perfection, but on the contrary, recognizes his limitations and expects to grow and improve. . . . Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, self-contempt. The individual lacks respect for the self he observes. The picture is disagreeable, and he wishes it were otherwise. (p. 31)

In general, Rosenberg found that social class is only weakly related and ethnic group affiliation is unrelated to self-esteem. It appears that the broader social context does not play as important a role in interpreting one's own successes as has often been assumed. Of significance is the fact that Rosenberg found the amount of paternal attention and concern was related to self-esteem. The amount of paternal attention and concern differs between social class, religion, and ethnic group. Adolescents who have a closer relationship with their fathers are higher in self-esteem than those with more distant relationships (Rosenberg, 1965).

Also of importance were Rosenberg's findings relating self-esteem to religion and order of birth. In regard to religion, it was found that social prestige in the community at large has little influence on self-esteem. Jews, who are lower in the hierarchy of general social prestige, are more inclined to be higher in self-esteem than either Catholics or Prostestants. This apparently results largely from the great amount of interest and attention that Jewish children, especially boys, receive from their parents. Within

the family itself, only children and particularly only male children are higher in self-esteem.

One of Rosenberg's major contributions was the instrument he developed. Rosenberg utilized a cross-sectional sample survey approach, with all information obtained from a single score, through use of a single instrument. The Self-Esteem Scale provided researchers with an instrument simple to administer, requiring a small amount of time for completion (Rosenberg, 1965). Rosenberg's work provided a basis for future research.

Stanley Coopersmith. Coopersmith (1967) was concerned with the conditions contributing to the development of self-esteem. Coopersmith posed a more specific question:

> What differentiates the antecedent conditions and personal characteristics associated with the occurrence of high self-esteem from those associated with less favorable self-appraisals? (Coopersmith, 1967, p. 236)

The basis for Coopersmith's study was the belief that self-esteem is significantly associated with personal satisfaction and effective functioning. Self-esteem was defined as

> a personal judgment of worthiness that is expressed in the attitudes the individual

> holds toward himself. It is a subjective experience which the individual conveys to others by verbal reports and other overt expressive behavior. (Coopersmith, 1967, p. 50)

Coopersmith elaborated on his definition: "the definition centers upon the relatively enduring estimate of general self-esteem rather than on more specific and transitory changes" (p. 50). Momentary, situational, limited shifts in self-evaluation were not considered in the study. Coopersmith also considered that self-esteem varied across different areas of experience and according to age, sex, and other role-defining conditions. Coopersmith recognized that his study dealt largely with esteem related to achievement and family experiences.

A third consideration of his definition is the clarification of "self-evaluation." The term refers to a

> judgmental process in which the individual examines his performance, capacities and attributes according to his personal standards and values and arrives at a decision of his own worthiness. (Coopersmith, 1967, p. 7)

These attitudes may be defined in the same way as attitudes directed toward other objects: an orientation toward or away from some object or event and a

predisposition to respond favorably or unfavorably toward these and related objects and events. The individual may not be aware of his/her attitudes toward himself/herself, but they will nonetheless be expressed in the voice, gestures, and performance (Coopersmith, 1967).

Coopersmith divided the observation of self-esteem into two parts:

> a subjective expression (the individual's self-perception and self-description) and the behavioral expression (behavioral manifestations of the individual's self-esteem which are available to outside observers. (Wells & Marwell, 1976, pp. 32-33)

Four groups of variables were projected as determinants of self-esteem: success, values, aspirations, and defenses.

> The process of self-judgment derives from a subjective judgment of success, with that appraisal weighted according to the value placed upon different areas of capacity and performance, measured against a person's personal goals and standards and filtered through his capacity to defend himself against presumed or actual occurrences of failure. The degree of self-esteem an individual actually expressed would thus reflect the extent to which his successes approached his aspirations in areas of performance that were personally valued, with his defenses acting to define and interpret what is "truly" valued, the "actual" level of aspiration, and what is regarded as "successful." (Coopersmith, 1967, p. 242)

Coopersmith chose to study the self-esteem of preadolescents of "middle class background who were male, white and normal" (Coopersmith, 1967, p. 8). The overall design was carried out in a series of four interrelated studies: selection of subjects, clinical evaluation of subjects, laboratory experiments of observation and measurement of the subjects's behavior, and identification of the "antecedents of self-esteem" through the use of interviews and questionnaire administration to the subject and his mother. A 50-item Self-Esteem Inventory was used; the sample size was 85. Coopersmith's findings about the antecedents of self-esteem can be summarized in terms of three conditions:

> total or nearly total acceptance of the children by their parents, clearly defined and enforced limits, and the respect and latitude for individual action that exist within the defined limits. (Coopersmith, 1967, p. 236)

Coopersmith concluded that parents of children with high self-esteem are concerned and attentive toward their children, that they structure the worlds of their children along lines they believe to be proper and appropriate, and that they permit relatively great freedom within the structures they have established. There were some general relationships observed between

childrearing practices and the formation of self-esteem. These relationships indicate that (a) definite and enforced limits were associated with high self-esteem; (b) that families which established and maintained clearly defined limits permitted greater deviation from conventional behavior, and more free individual expression; (c) that families which maintained clear limits utilized less drastic forms of punishment; and (d) that families of children with high self-esteem exerted greater demands for academic performance and excellence (Coopersmith, 1967).

Limits and rules were likely to have enhancing and facilitating effects. Well-defined limits provided the child with a basis for evaluating his present performance as well as facilitating comparisons with prior behavior and attitudes. Imposition of limits served to define the expectations of others, the norms of the group, and the point at which deviation from them is likely to evoke positive action; enforcement of limits gives the child a sense of what is real and significant, contributes to self-definition, and increases the likelihood that the child will believe that a sense of reality is attainable (Coopersmith, 1967).

Coopersmith found that individuals with high self-esteem reared under strongly structured conditions tended to be more, rather than less, independent and creative. It appears that children reared within definite limits are also more likely to be socially accepted as peers and leaders by their associates, and more capable of expressing opinions and accepting criticism. It is suggested that there is a relationship between parental self-esteem and the child's self-esteem, indicating that unconscious identification and conscious modeling may underlie the self-evaluations of many individuals. High parental self-esteem and acceptance directly related to the child's self-esteem (Coopersmith, 1967).

Aspects of Cesarean Childbirth

The amount of literature and other information available to expectant mothers and fathers is abundant. There are many books written on pregnancy and childbirth, available through bookstores, private organizations, mail-order, even at the grocery store. Popular magazines frequently have articles addressing pregnancy and childbirth. Those who experience a normal uncomplicated labor and delivery are generally able

to find what they need to know or want to learn through the available literature.

Donovan and Allen (1977) independently found that cesarean families have been largely ignored by the entire childbirth movement. Childbirth literature also tended to neglect cesarean parents. The amount of literature written on cesarean delivery is limited. Much of it is on a highly technical, scientific level, dealing with the procedure itself, with statistics regarding the procedure, or with physiological aspects. Medically, there is little written in regard to the emotional or psychological aspects of cesarean delivery.

Nursing literature had almost nothing published about cesarean childbirth until approximately 1977. Since then, several articles have been published, but again, a portion is in regard to physical care of the mother, or the procedure itself. The remaining material has increasingly begun to discuss the psychological-emotional needs of cesarean parents. Presently, there have been only two professional level books printed about cesarean childbirth. Only a few research studies have been conducted with cesarean patients and/or their families.

Information available to the lay public is limited, as well. There are few publications available which specifically address cesarean delivery (Appendix A). Most of these have been written by lay persons arising from personal experience. The wide availability of general childbirth information is in direct contrast to the limited cesarean information.

Historical Aspects of Cesarean Childbirth

The cesarean birth procedure is considered one of the oldest surgical procedures in time. Young (cited in Affonso, 1981) referred to it as:

> The oldest in the history of medicine and without doubt, the greatest; the oldest in that the history of its origin is lost in the midst of antiquity, and the greatest in that it is the only operation in which two lives are concerned. (Young, cited in Affonso, 1981, p. 4)

The allusion to the removal of an unborn child from its mother by opening the abdomen has existed for many hundreds of years; however, it is difficult to trace the actual origin of the cesarean mode of birth. It is best referenced in ancient mythological, classical, and religious writing.

Mythology provides a number of references to abdominal birth: Asclepius, the Greek god of sleep,

was said to have been cut from the body of his slain mother, Coronis, by Apollo, his father. Zeus removed the fetus, Dionysus, from the belly of the dying Semele; Virgil tells that Lichas was cut out of his dead mother's womb. In the Far East, it is said that Buddha was delivered from his mother's flank (Affonso, 1981). One of the most popular beliefs focused on the Romans. In the Seventh Century, B.C., the second king of Rome, Numa Pompilius, codified the Roman law. Called Lex Regia, it decreed that the baby be removed from every woman who died in late pregnancy, in order for the mother and child to be buried separately. Later, under the rule of the emperors, the Lex Regia became known as the Lex Caesarea, or Cesarean Law, consequently resulting in the procedure being called the cesarean section or operation (Brian, 1976).

Although the authenticity of the Lex Regia account is questionable, it is probable that the term cesarean was derived from the Latin verb caedare, meaning to cut, implying birth by means of cutting. The Latin word for children delivered by being cut from their dead mothers was caesones (Affonso, 1981). The legend that the operation gained its name from the abdominal

birth of Julius Caesar is highly questionable. At the time of Caesar's birth, approximately 100-75 B.C., until well into the 19th Century, the operation was invariably fatal. It is known from Caesar's letters to his mother, Aurelia, that she lived for many years after his birth (Affonso, 1981; Brian, 1976; Donovan, 1978). In regard to the references to abdominal delivery Pritchard (1976) noted that no such operation was ever mentioned by Hippocrates, Galen, Paulus, Celsus, Soranus, or any other medical writer of the period. According to Pritchard (1976),

> If the cesarean delivery were truly in use at that time, it is surprising that Soranus, whose extensive work written in the second century A.D. covers all aspects of obstetrics, does not refer to it. In Genesis 2:21, it is written, "And the Lord God caused a deep sleep to fall upon Adam, and he slept: and He took one of his ribs, and closed up the flesh instead thereof." Are we to conclude from this statement that general anesthesia and thoracic surgery were known in pre-Mosaic times? It would probably be just as logical to draw conclusions about the beginnings of cesarean section from the myths and fantasies that have come down to us. (p. 922)

The religious laws of the Egyptians in 3000 B.C. and of India in 1500 B.C. dictated cesarean delivery of a dead pregnant woman (Brian, 1976). The Jews referred to cesareans as early as 140 B.C. in passages of the Talmuc. Christians regarded cesarean birth as

having the merit of saving the souls of the children because they could be removed from their mother's womb and be baptized (Affonso, 1981). Literary works described other cesarean births. Robert II, King of Scotland, was said to have been born by cesarean after his mother was thrown from a horse. King Edward VI of England, only son of Henry VIII, was born by cesarean following a long labor. His mother, Jane Seymour, died several days later (Affonso, 1981; Brian, 1976). Shakespeare gives an example of cesarean birth; in Macbeth, he described Macduff as being "from this mother's womb untimely ripped" (Affonso, 1981, p. 6).

Many legends existed, but the first documentation of an intentional cesarean performed on a living woman was dated 1610, by the surgeon, Trautmann. The woman eventually died because the uterus was left unsutured and became infected. It was, however, considered a significant medical accomplishment for the time because the woman supposedly lived for 25 days after the procedure (Affonso, 1981). Regardless of its origins, cesarean delivery remained one of the most terrifying consequences of childbearing until well into the 19th Century. In Paris between 1750-1800, 24 cases of

cesarean delivery were performed without a single maternal survival. In the early 1800s, the mortality recorded from cesarean birth was greater than 75%, mounting to 85% in Great Britian and Ireland in 1865, nearing 100% on occasion (Affonso, 1981; Brian, 1976; Pritchard, 1976).

Several events altered the course of cesarean birth toward a brighter path. In 1876, a new technique known as the "Porro operation" advocated a cesarean delivery be followed by complete removal of the uterus, fallopian tubes and ovaries, with only the lower cervical stump left intact. Although this procedure did result in major reduction of maternal mortality, it cost the woman her future reproductive capabilities (Affonso, 1981). In 1882, a German surgeon, Max Sanger, introduced the technique of suturing the uterine wall (Wertz & Wertz, 1977). Incredibly, it had been believed that sutures in the uterus were superfluous as well as harmful (Pritchard, 1976). The technique became known as the "classical cesarean section" because it consisted of a longitudinal entry into the upper fundus of the uterus and remained the cesarean method of choice for many years. The development of the Porro and Sanger

techniques occurred at a time when Lord Lister introduced antiseptic procedures and was experimenting with the precursors of anesthesia. Lister's work unquestionably contributed to decreased maternal mortality (Affonso, 1981; Brian, 1976). A major achievement for modern obstetrics has been the development of the low, transverse entry into the uterus. The placement of the incision in the lower uterine segment avoided the highly vascular, contractile portion of the upper uterus, lessening the danger of hemorrhage. The transverse entry avoided the peritoneal cavity as well, reducing the hazards of infection (Affonso, 1981).

Over the years, technological improvements have made cesarean delivery a life-preserving measure, rather than one of certain death. Although now considered one of the safest surgical procedures, cesarean delivery does entail some risk. The overall safety has increased greatly through the years, lowering the mortality to the present .01-.03% (Hausknecht & Heilman, 1978; Meyer, 1979; Stichler & Affonso, 1980). However, the maternal mortality and morbidity rates with cesarean birth still remain higher than those associated with vaginal delivery. The inherent risks of surgery and anesthesia still remain (Mevs, 1977).

Incidence of and Indications for Cesarean Birth

Over the past years, the incidence of cesarean childbirth has been rising. The actual numbers vary, depending on the source. Kehoe (1981) related that the rate for primary deliveries prior to 1971 was as low as 2.64-4.0%, with the total rate for both primary and repeat cesareans ranging from 4.7-8.0%. In a report submitted to the Department of Health, Education, and Welfare (DHEW), Marieskind (1979) found that from 1968 until 1977, the rate of cesarean births increased by 156%. The rate in 1977 was 12.8%, with individual institutions reproting rates of up to 25%. Affonso (1981) reported that the National Institute of Health found that the rate of cesarean births increased to 14.7% in 1978. The Canadian cesarean rate has also climbed: 13.9% in 1979 with some facilities reporting rates as high as 30%.

A variety of factors has been identified as contributing to the rising incidence of cesarean deliveries. Marieskind's (1979) extensive report identified 11 principal factors that may be contributory. They are given here in order of significance; however, one must recognize that many factors may often combine to increase

the cesarean rate. The reason most frequently given by physicians for the cesarean increase was the threat of a malpractice suit if a cesarean was not done and a "less-than-perfect" baby resulted. Such a threat encourages the practice of "defensive obstetrics." The most common indication for a cesarean in North America was a previous cesarean delivery, despite strong evidence that many women who have had a previous cesarean can safely have a vaginal birth. Lack of training and experience in uncomplicated obstetrics, together with a heavy reliance on sophisticated equipment, such as electronic fetal monitors, prepare many young physicians poorly to handle uncomplicated labor and birth.

Physicians believe cesarean delivery gives a "superior outcome," that is, a healthier baby. However, the decline in newborn illness and death rates that has been attributed to the use of cesarean section and electronic fetal monitoring has not been shown and does not acknowledge influences such as better nutrition, improved prenatal care, and neonatal intensive care units. Indications for cesarean delivery have changed and expanded. A lack of consistency among

individual physicians and hospitals concerning the need for cesarean section has led to greater surgical intervention in cases of cephalopelvic disproportion (CPD), labor difficulties, breech presentation, and fetal distress. An attitude of acceptance for the cesarean trend may itself foster more cesareans.

Shifts are occurring in maternal age, fertility, and the number of children born to each women. Older women and those having their first baby comprise a larger proportion of the childbearing population, and these groups are more likely to have cesareans. If the policy of routine repeat cesareans is followed, it will likely ensure another cesarean for subsequent pregnancies. Fewer children are being born, further promoting the "premium baby concept." Economic factors may be involved, including the lesser amount of time required for a cesarean birth (versus waiting out a labor), longer hospital stay, fewer empty hospital beds, higher fees, and guaranteed insurance coverage. These factors combine to favor the "more profitable, in this case, surgical, approach while at the same time providing no incentives to persist with a vaginal delivery" (Marieskind, 1979, pp. 12-13).

Greater use of technological procedures for fetal assessment such as electronic fetal monitoring, ultrasound, amniocentesis, oxytocin challenge tests, nonstress tests, and induction of labor may contribute to more cesareans. Some physicians who rely heavily on obstetrical technology may also intervene surgically more often than other physicians. "Bigger babies" is a commonly given, not unsubstantiated, reason for more cesareans. The average birth weight rose only 2 ounces in the United States during the years that the cesarean rate doubled. More cesareans are done now for very low birth weight babies, however, in an attempt to save their lives by delivering them with the least possible trauma. Women with severe medical conditions, such as diabetes and chronic hypertension, are now able to carry their pregnancies to term or nearly term, and cesarean delivery is often the delivery of choice for these women. The incidence of Herpes virus II is increasing. Because the newborn can be infected while passing through the birth canal, cesarean section is necessary in women with active Herpes infections.

The indications for a cesarean fall into two general categories--maternal and fetal. Maternal indications for cesarean delivery include the following: previous cesarean section (accounting for 30-50% of all cesarean deliveries), placenta previa, chronic or pregnancy-induced hypertension, Herpes virus II infection, CPD, "failure to progress," uterine dystocia or inertia, prolonged rupture of membranes, or previous pelvic surgery. Fetal indications include fetal distress, malpresentation or malposition of the baby, prolapsed cord, abruptio placentae, diabetes in the mother, and Rh disease. Lay persons and health care professionals alike recognize these factors as indications for cesarean delivery. Many of today's health care professionals as well as parent/consumers are concerned about the rapidly rising incidence of cesarean deliveries. The possible factors for the increased incidence of cesarean birth have been presented earlier. Many are concerned that the cesarean rate is rising, that too many are done too quickly, perhaps unnecessarily, Donovan (1978), however, looked at this increased incidence from a different point of view.

> First, take a walk through an old graveyard. How many of these headstones belong to women who

> died in childbirth? And those smaller markers of babies who died at birth: how many of them could have been saved if their mothers had been able to have a safe cesarean delivery? Second, before all cesareans are written off as "unnecessary," let us ask if the increase in the number of cesareans will also decrease infant mortality, brain damage, retardation and learning disabilities. (p. 192)

While some cesareans may be done unnecessarily, there is no doubt that modern obstetrical technology has made cesarean delivery a safe, alternative method of childbirth.

Psychophysiologic Considerations

As the expectant mother progresses through pregnancy, she prepares for the childbirth experience in many ways. She formulates expectations of childbirth based on her experiences and perceptions, on information she receives from available books or other sources, from health care providers, from friends and family, from the mass media. One of these expectations concerns the labor and delivery process. The pregnant woman generally anticipates a normal uncomplicaated vaginal delivery. She expects a healthy infant. Many women, along with their husbands or partners, seek information about and active participation in the birth process.

In order to do this, many expectant parents attend childbirth classes. These classes generally teach parents what to expect in the course of a normal uncomplicated labor and delivery. The childbirth classes usually do not mention cesarean birth more than briefly. The couple who anticipates a normal childbirth experience may hear what an instructor says about cesareans but the implications do not strike home. They think "It will happen to someone else--not to me." Approximately one couple will experience a cesarean delivery out of every five to six couples who attend classes (Donovan, 1978; Hausknecht & Heilman, 1978).

Physically, a woman who undergoes a cesarean birth follows a different course than one who has a vaginal delivery. Initially, the conduct of labor is different: it may not happen at all if surgery is indicated early enough, it may become a critical emergency, or it may last for hours before surgery is considered. Rather than experiencing an exhilarating climax at the end of labor, the woman is suddenly subjected to another stressful situation. Affonso and Stichler (1980) found that most women (in a study group of 105) had been told about the reality of a cesarean birth less than 2 hours

before the surgery took place. Affonso and Stichler (1980) stated:

> Two hours is certainly insufficient time to grasp all the events occurring and then rally one's resources for optimal coping. Many women said they felt overwhelmed by everything happening around them and that the sensory bombardment increased their anxiety. (p. 468)

As a result of the cesarean operation, the mother automatically incurs a longer, more painful recovery and a longer hospital stay. She may develop complications, such as hemorrhage or infection. She must undergo the procedures and discomforts associated with anesthesia and major abdominal surgery. The woman must also learn to deal with her new role as a mother, with postpartum discomforts and with an infant at a time when she may not feel ready or capable. Cesarean women are both surgical patients and postpartum patients. As Enkin (1977) stated, "having a section <u>is</u> having a baby" (p. 100). It is first and foremost the birth of a baby. Affonso and Stichler (1981) stated that:

> It is generally accepted that every physiological event has the capacity to generate feelings and perceptual reactions in the individuals who are forced to cope with the situation. The process of birth is one life experience that leads to multiple emotional and perceptual responses. (p. 39)

One must recognize that vaginally delivered mothers will also have postpartum adjustments and discomforts. The author of the present study is not attempting to minimize these adjustments and discomforts in any way. One must be aware, however, that cesarean mothers have not only had a baby, but major abdominal surgery as well.

Psychologically, the cesarean mother undergoes a different experience than a woman who delivers vaginally. Primary cesareans most often occur after a period of time in labor, for one of the indications discussed previously. The woman is often exhausted and/or sedated. If she has not been prepared to the possibility of a cesarean delivery, she may be frightened or overwhelmed by the rapid course of unknown and unexpected procedures. Due to general anesthesia or sedation, it may be hours before the new mother becomes aware of the particulars about the baby. Medications and anesthesia blur memory and perceptions, leaving incomplete or perhaps false impressions that will linger in her memory.

In a study of women's perceptions and feelings about their labor and delivery experience, Affonso

(1977) found unexpectedly that many women could not completely reconstruct their childbirth experience. They became very concerned about certain events that they either did not understand or could not remember from their labor and delivery. Affonso labeled these components of their experience which had been repressed or forgotten or in some other way made unavailable as "missing pieces." Certain situations which appear to make women more vulnerable to encountering missing pieces in their childbirth experience were identified. These included a long, or rapid labor, and medications administered.

Affonso (1977) recognized any high risk condition and unfulfilled expectations as contributory. Affonso (1977) stated:

> especially women who encounter an unexpected cesarean section are vulnerable to forgetting certain important areas of their childbirth experience. (p. 163)

Affonso (1977) further stated that:

> women who have discrepancies between their expectations of labor and delivery and the actual outcomes may fail to integrate and remember large portions of the birth experience. (p. 163)

This certainly applies to cesarean mothers. In order to move forward into parenting, it is necessary for

the mother to be able to reconstruct the birth experience. Both medical personnel and the family must provide the woman with the factual data she is seeking. Suggestions for assisting these women were offered by Affonso.

What happens, then, to a woman who has attended prepared childbirth classes and been promised a uniquely fulfilling experience? What becomes of her dreams and expectations when she must undergo an unexpected cesarean delivery? In a study comparing primiparas' perceptions of vaginal and cesarean births, Marut and Mercer (1979) found that satisfaction with the birth experience was significantly lower among cesarean mothers and among those who had general anesthesia. The cesarean group tended to view their deliveries as abnormal and having social stigma. Marut and Mercer's findings seem to indicate that a cesarean birth has a negative impact on the mother's perceptions of her labor and delivery experience.

Cranley, Hedahl, and Pegg (1983) undertook a replication and extension of Marut and Mercer's (1979) study of women's perceptions of vaginal and cesarean deliveries. Of a sample of 122 women, 40 had vaginal

deliveries, 39 had unexpected or emergency cesareans, and 43 had a planned cesarean delivery. Questionnaires and interviews were completed 2 to 4 days postpartum. Findings revealed that women who had emergency cesareans had the least positive perceptions of the experience than either the planned cesarean group or vaginal delivery group. Another finding showed that women who were attended at delivery by a significant other had a more positive perception of the experience than those who were not. The study also showed that women who had a cesarean birth with regional anesthesia viewed their experience more positively than those who had general anesthesia. Affonso and Stichler (1980) published an article based on an indepth study of women's perceptions and feelings in response to their recent cesarean deliveries. Feelings about having a cesarean included: anxiety, fear, worry and concern about the baby and self, and the surgery (92%); feelings of frustration, anger, disappointment or depression (52%); and feelings of happiness and/or relief (30%).

Pain was also identified as one of the main sources of fear and anxiety associated with the childbirth

experience. McCaffery (1979) described four psychological factors which can influence one's perceptions of and reactions to pain. Past experiences with pain can increase fear and discomfort, particularly in one facing a cesarean delivery and who may be experiencing a high level of anxiety about the impending surgery and the anticipation of the postoperative pain. The second factor is knowledge and understanding on cognitive levels. How much a person knows about the cause, implications, and duration of pain will influence his/her response to pain and even its intensity and existence (McCaffery, 1979). Incomplete or inaccurate information not only influences the meaning and existence of a painful sensation but also affects the level of anxiety during the period of anticipation of pain. Mevs (1977) indicated that anxiety and fear may result during preparation for unexpected cesareans, an added stress on the woman already involved in a serious, stress-producing situation. Affonso and Stichler (1978) have noted that the woman who has a cesarean may have limited time to obtain accurate information and then organize and process it to achieve an understanding of her own situation.

The third factor, also identified by Kehoe (1981), is powerlessness, occurring when a person is faced with a situation over which he believes he has little control. He/she may cease to seek further information about the predicament (McCaffery, 1979). A woman undergoing a primary cesarean delivery may perceive her situation as one where she is powerless to alter the mode of delivery.

The fourth factor McCaffery identified is the presence, attitudes, and feelings of others. When a patient is in pain or fears pain, the simple presence of another person may influence the behavioral responses of the subjective experience. The presence of someone may reduce loneliness and anxiety resulting from pain. A high degree of anxiety or fear may cause the patient to perceive a greater sensation of pain (McCaffery, 1979). Pain, then, appears to have a potentially dramatic effect on the mother's perception of her childbirth experience.

In regard to the presence and support of another person, Affonso and Stichler (1978) found that the woman in their study felt abandoned in the operating room as preparations were being made for the surgery. The

women "overwhelmingly expressed a need for human contact in the cesarean environment, especially verbal contact and touch" (Affonso & Stichler, 1978, p. 93). The importance of the presence of a supportive significant person has been identified in virtually all the sources regarding childbirth, cesarean and otherwise. In many settings, the support person is asked to leave when the decision is made to do a cesarean. At a time when she needs support and reassurance, the laboring woman is separated from her husband or other significant other.

DeGarmo (1978) conducted a study regarding fathers' and mothers' feelings about sharing the childbirth experience. DeGarmo contrasted fathers who decided not to be present at delivery with fathers who participated in order to uncover differences in their characteristics, their motives, and the amount of positive meaning they derived from the experience. The mothers in each group were interviewed to determine if their feelings on the subject correlated with the feelings of the respective fathers. Using the Osgood Semantic Differential, DeGarmo found that fathers who witnessed childbirth found more positive meaning in the experience

while mothers demonstrated overwhelming support for the father's presence during delivery. While the study did not involve couples who had cesarean deliveries, it substantiates the need for support for the cesarean mother.

In 1980, Hott conducted a study which involved pre and postpartum comparison of self-image of 47 primiparous Lamaze couples who shared delivery and those who did not. All couples had completed Lamaze classes. Thirty-four couples were able to share the delivery as planned; 13 were unable to do so due to complications resulting in cesarean delivery. Hott found that the couples who were not able to share the delivery experience perceived self and various ideal concepts lower prenatally and postnatally than those couples who shared delivery. The women in Hott's study who experienced the crisis of an operative or anesthetized delivery had definite changes in their concept of the ideal woman (part of Hott's instrument). In discussing implications for nursing, Hott (1980) stated:

> Nurses need to help strengthen a couple's self-image at a critical time in family growth when their self-concept has been particularly threatened because their plans to share this experience have been foiled. . . . It is essential

> that nurses and other health professionals anticipate the lowered self-concept of disappointed Lamaze couples by increasing couples' involvement in decision-making as well as self- and newborn care when they are emotionally and physically able to take on these essential responsibilities. (pp. 25-26)

In an unpublished master's thesis discussing two factors affecting the cesarean delivered mother (father presence at the delivery and postpartum teaching), Gainer and Van Bonn (1977) found that the father's presence at the cesarean delivery positively influenced the mother's delivery satisfaction. Affonso and Stichler (1978) found that if the father was not allowed to participate, he may experience anger, disappointment, grief or relief, as well.

Another significant feeling identified in Affonso's (1981) study was that of loss. Loss associated with childbirth has three aspects: loss or threatened loss of a valued object or person (such as the baby), loss or threatened loss of expectations or values, and loss or threatened loss of some aspect of the self. Women who had expectations of a vaginal delivery perceived loss when a cesarean was deemed necessary. Affonso found that perception of loss was intensified when the woman had taken some type of prepared childbirth classes.

Other losses identified were the inability to participate in or witness the birth of the baby, loss of a significant other (in that the father was not allowed to attend the birth), loss of control over the events which affected the self and loss of immediate interaction with the baby. One of the most striking losses was identified as "loss of womanliness," of feelings of inadequacy, guilt or failure due to not "having a baby the natural way."

> Women criticized themselves by referring to the self as a failure for not being able to achieve what was perceived to be a minimum expectation of the female sex--that of conceiving and bringing forth the infant through a normal vaginal delivery. (Affonso, 1981, p. 47)

Grace (1978) defined grief as

> the mechanism through which feelings of loss are acknowledged; the ways in which the lost object provided gratification are examined, and new patterns of gratification are developed. (p. 18)

Grief response accompanies a loss. Benoliel (1976) described the usual grieving process in the following stages: period of numbness or shock, feelings of anger and fear, sense of helplessness and a wish to be helped, and feelings of despair and emptiness, sometimes coupled with guilt or shame. The last stage is comprised of

a renewal of hope and reorganization or behavior to cope with the reality of the consequences associated with the loss.

Birdsong (1981) reviewed the cesarean birth literature which revealed that many of the reported feelings experienced by cesarean mothers can be interpreted as loss and grieving. In accordance with Affonso (1981), Birdsong (1981) related that:

> Feelings of loss and grieving in cesarean mothers are, in order of frequency of occurrence: failure, anger, depression, fear, guilt, pain, self-blame, "negative feelings," shame, sadness, fatigue, feeling abnormal, withdrawal, defeat, blaming of others, shock and disbelief, anticipation of losing one's life or health or the life or health of the baby, bitterness, powerlessness, abandonment, loneliness, disinterest in one's environment, numbness, a sense of loss of control, and helplessness. (p. 191)

Lay authors have also identified these negative responses to cesarean childbirth (Donovan, 1978; Rozdilsky & Banet, 1975; Vestal, 1978; Wilson & Hovey, 1980). The literature indicates that while the specific object of the cesarean mother's grief often varies, it is invariably related to her perception of her performance during childbirth (Birdsong, 1981). Affonso and Stichler (1978) noted that certain grieving behaviors were often observed in women who had unexpected cesarean births

because they did not have enough time to prepare for the event. Such behaviors included anger, depression, and a need to work through and relive their childbirth experience.

Schlosser (1978) related her personal experience with an emergency cesarean for placenta previa, and her feelings of guilt, failure, disappointment, and resentment. She mentioned that her negative feelings lasted 3 months and were resolved only after she saw a chart by Clark and Affonso (1976) relating behavioral reactions to grief during the childbirth experience. Recognizing the grief process enabled Schlosser (1978) to work through her feelings. Her experience as a nurse taught her how to physically care for cesarean mothers. Her experience as a cesarean mother opened channels for their emotional support, as well.

Research Studies Relating Cesarean Childbirth and Self-Esteem

There are few studies specifically dealing with cesarean childbirth and self-esteem. Self-esteem and self-concept have been mentioned numerous times in various articles and books regarding cesarean childbirth, but usually this is no more than a few sentences

or a paragraph at the most. Hall (1980) conducted an investigative study regarding the self-concept of primiparas who had emergency cesarean deliveries. The study was also to provide baseline data for further investigation of the self-concept as it relates to childbirth preparation and motherhood. Using Fitts' Tennessee Self-Concept Scale, Hall tested a sample of 10 primiparous women who experienced emergency cesarean delivery. The results showed that all of the subjects were experiencing a sense of value and self-worth. None of the subjects indicated feelings of depression or low levels of self-esteem. The subjects apparently were not experiencing depression or feelings of inadequacy. These findings are contrary to those of Cohen (1977), Conner (1977), Marut (1978), and Marut and Mercer (1979), as well as contrary to the findings of Cox and Smith (1982) in a later study.

Cox and Smith (1982) related that

> much of the evidence for the negative impact of cesarean delivery on the mother's self-esteem is based on empirical observation rather than research. (p. 311)

The purpose of their study was to test whether the empirical evidence could be demonstrated through

research: to determine whether women who had cesarean deliveries had lower self-esteem than women who delivered vaginally. Through the use of the Rosenberg Self-Esteem Scale (Rosenberg, 1965) completed 1 month postpartum, Cox and Smith obtained data from 76 cesarean mothers and 78 vaginally delivered mothers. A significantly lower level of self-esteem was found in the group with cesarean deliveries.

Lipson and Tilden (1980) studied the function of cesarean support groups and the experiences of 21 women who participated in them. Data were obtained through group observation and individual interviews, revealing that the quality and magnitude of impact of a cesarean delivery varies tremendously according to the interaction of a number of variables. Lipson and Tilden (1980) stated:

> The subjective experience of any crisis depends on the integration of individual coping skills and ego strengths, one's unique perception of the crisis based on such intrapsychic factors as developmental stage and symbolic meaning of the crisis, and quality of the social support system. (p. 601)

Variables found to be crucial to the subject's cesarean birth experience included the woman's plans and expectations for natural childbirth, her relationship with

her doctor, the amount of time she had to prepare for the surgery, the reason for the cesarean, the extent of her labor, the presence of her husband during the surgery and recovery period, her contact with the infant, and any medical complications.

> Psychological integration of a life event such as childbirth involves (1) cognitive processes through which the event is reconstructured; (2) affective processes, through which the feelings associated with the event emerge into consciousness and are recognized; and (3) integrative processes, through which the feelings and memories are placed in the broader perspective of the person's life. (Lipson & Tilden, 1980, p. 601)

Through their data collection, Lipson and Tilden became aware of five phases of assimilation required for the resolution of the cesarean childbirth experience. The time frames given are an approximate average amount of time required for the completion of each phase, each varying with the individual.

Phase one encompasses the immediate postoperative hours, described as a period of shocked numbness, a sense of suspended animation, lasting approximately 21-24 hours. It is a time when the body's defense mechanisms take over and "operate to keep the emotionally overwhelming stimuli within manageable limits" (Lipson & Tilden, 1980, p. 602). Phase two, the initial

postpartum days, extends over the hospital stay of 5 to 7 days.

> The qualities of numbness and "just coping" . . . gradually are replaced by intense feelings of disappointment at the loss of the happy, natural delivery that had been anticipated. (Lipson & Tilden, 1980, p. 602)

A number of feelings described were relief, guilt, anger, disappointment, or envy of others who delivered vaginally. In addition to coping with these feelings, the new mother must also begin caring for her new baby. Phase two is also primarily a time of physical coping, with her energies channeled into such tasks as ambulation, pain control, elimination, resumption of eating, and attempting to sleep. The women of Lipson and Tilden's (1980) study also reported "feeling highly sensitive to the amount and quality of support given them by postpartum nurses during this period" (p. 603). Empathetic and supportive nurses who facilitated the women's early, awkward efforts at caring for their infants were highly valued.

Phase three is described as emerging awareness, and includes the time from discharge from the hospital until about 8 weeks postpartum. The demands of being home with and having to care for a new baby are

increased by the demands of recovery from major surgery. Women reported the strong need to be taken care of, to be nurtured and nourished. Along with this, women often experienced disappointment in their mothering skills, the development of which was hampered by the postoperative recovery period. A cesarean birth may also be blamed for difficulties that exist normally in the postpartum period. Aside from "normal" new mothering difficulties, however, awareness of the meaning of the cesarean to the individual begins to emerge. Perceptions of stigma, feelings of failure and self-image problems bother many women during this phase. Phase four is called intermediate resolution. This phase occurs from about 2 months postpartum through the end of the first postpartum year. It is characterized by an intermittent intrapsychic struggle to accept and understand the cesarean experience. Primary factors that are responsible for moving through this phase are:

> (1) Recovery from surgery and return of a subjective sense of strength and well-being; (2) increasing maturity of the infant, leading to a strengthening of the mother/infant relationship and increased confidence in mothering skills; (3) a combination of repression and denial of some negative aspects of the cesarean experience; and (4) the passive or active process of growing

> awareness of and coping with feelings and memories that re-emerge into consciousness. (Lipson & Tilden, 1980, p. 604)

Many cesarean mothers reported a common experience in that intense feelings or memories of the cesarean began to surface unexpectedly, often unbidden, with upsetting results. Participation in a support group at this time may serve as a catalyst for resolution. Attending just one meeting may trigger psychological processes that move a woman rapidly and intensely through this phase. Such processes include catharsis, reconstruction of the birth experience, "legitimation" (normalizing), and placing her personal experience in a broader context.

> Reconstruction of the birth experience, begun in earlier phases, becomes increasingly complete. In addition to filling memory gaps and missing details, the process entails awareness of and labeling the feelings that accompany various aspects of the experience. Reconstruction frequently occurs in the process of verbally relating one's experience to others, and identifying with them as they relate their experiences. (Lipson & Tilden, 1980, p. 605)

Phase five is resolution, the final resolution of the birth experience characterized by a woman's feelings of acceptance and a sense of placing the cesarean in the perspective of the rest of her life. Lipson and Tilden (1980) made the point, however, that:

> Complete and final resolution of a significant life event is rare. Rather, a degree of resolution is achieved with the passage of time, and residual affect connected to the event may be rekindled at an anniversary or a new but symbolically related event. (p. 606)

Resolution of the cesarean experience is likened to the resolution of grieving, in that a new and more realistic appraisal of a lost object becomes possible. One other aspect of this phase of resolution involves the woman becoming a more responsible and assertive health care consumer.

One finding of Lipson and Tilden's study dealt with prenatal preparation. Prenatal preparation had a significant impact on a woman's plans and expectations for childbirth. These authors found that women who were better prepared for cesarean birth had a better experience and fared better emotionally afterward. This was consistent with Affonso's (1981) findings and publications based on her study of 105 post-cesarean women. Affonso and her contributors discussed many various aspects of cesarean childbirth with regard to the past and present, women's perceptions and feelings, the fathers, the newborn; in regard to the health care system: obstetrics, nursing and anesthesia, as well

in regard to the impact of cesarean childbirth on society and the future.

Summary

The first part of the review of literature described the various theories of self-esteem, beginning with the work of William James. The discussion then moved on the works of Cooley, Fitts, Horney, Maslow, Mead, and Rogers. The major research studies regarding self-esteem have been conducted by Rosenberg and Coopersmith. Most authors, however diverse they may be on how one develops or gains self-esteem, agreed that self-esteem is an essential element in one's emotional well-being. Growth and development of the *self* is dependent on the development and maintenance of self-esteem.

The second part of the review of literature extensively described cesarean childbirth, beginning with the history and development of cesareans. Incidence of cesarean birth, which ranges from 15% to 30%, was discussed as well as the major contributory factors. Indications (both fetal and maternal) for cesarean deliveries were given. Discussion of the psychophysiological considerations made up the remainder of the chapter. The major finding in reviewing the literature

was the substantiation of James' simple equation mentioned previously. Women seemed to "judge their worthiness," in Coopersmith's words, by how well they thought they had done during the childbirth experience in accordance with what they had expected of the situation and of themselves. Rubin (1968) summarized as follows:

> The ability to function with control for time and place is held in personal, social and cultural esteem. The ability to use oneself in such a way, functionally, as to achieve precisely what he intended--no more, no less, and precisely at the right time and place--gives a person a high sense of accomplishment. (p. 21)

Many facets of the perception of the cesarean experience have been discussed. Resolution of the cesarean experience was compared with the grieving process, and was described by Lipson and Tilden as five phases of assimilation. Final resolution of the experience allows the woman to place the event in the perspective of the rest of her life.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

As related in both Polit and Hungler (1978) and in Kerlinger (1973), many research problems do not lend themselves to an experimental or quasi-experimental method. For this reason, the ex post facto approach was selected for this study. In this type of research, the independent variable is not manipulable, the research being conducted after the variations in the independent variable have occurred in the "natural course of events" (Polit & Hungler, 1978). Abdellah and Levine (1979) described this type of research as nonexperimental. These authors further stated that the manipulation of the independent variable is done by bringing subjects into the study who already possess that quality of the independent variable. Polit and Hungler (1978) and Kerlinger (1973) described this process as self-selection.

The specific design used in this study was a comparitive retrospective survey method (Adbellah & Levine, 1979; Polit & Hungler, 1978). The independent

variable in this study was the type of delivery, vaginal or cesarean, over which there was no investigator control. The dependent variable was the level of self-esteem measured by the Rosenberg Self-Esteem Scale (Rosenberg, 1965).

Setting

This study was conducted in the patient rooms on the postpartum units of two private hospitals located in a large metropolitan city in the Southwest part of the United States. Hospital A was a 213 bed institution with a 27-bed postpartum/gynecology unit. The average monthly delivery rate was 110-112 babies at the time of the study. The average cesarean delivery rate was 15% to 20%.

Hospital B was a 367 bed facility with a 34-bed postpartum unit. The average monthly delivery rate was 280-310 babies at the time of the study. The average cesarean rate was 25% to 30%. In both institutions, the patient population was primarily white.

Population and Sample

The population for this study consisted of women who were admitted to the selected hospitals for delivery

of their infants at term. The following criteria were used to select the sample:

1. All women were primigravidas.

2. All women had childbirth preparation classes. They did not have any special preparation in regard to cesarean birth other than that included in the routine prenatal class information.

3. All women were able to read, write, and speak English.

4. All women had prenatal care under the supervision of a physician.

5. All women had normal term infants; term is defined as being equal to or greater than 38 weeks gestational age.

6. All women were free of postpartum complications.

7. Women who were scheduled for a cesarean prior to hospital admission were excluded from the study.

By convenience sampling, the sample was comprised of two groups. The first group, women who had normal vaginal deliveries, consisted of 21 subjects who were admitted for labor and delivery at term. The second group, women who were admitted for labor and delivery

at term and subsequently underwent an unexpected cesarean delivery, consisted of 18 subjects.

Protection of Human Subjects

This study was exempt from approval by the Texas Woman's University Human Subject Research Review Committee as it falls under Category I of the Federal Guidelines for Research of Human Subjects, indicating no risk for the subjects (Appendix B). Permission to conduct the study was also obtained from the graduate school (Appendix C) as well as the participating agencies (Appendix D). The questionnaire was introduced to the subject by the investigator, using a standardized format (Appendix E), explaining the nature of the study, and discussing potential risks and benefits. Participant consent was designated by the return of the completed questionnaire. This was clearly indicated on the questionnaire. In order that anonymity be preserved, the participants were asked not to identify themselves on the questionnaire.

Instrument

The tool selected for this study was Rosenberg's Self-Esteem Scale (Appendix F). The scale is a simple,

10-item Guttman scale design, in Rosenberg's words, with the following considerations: "ease of administration, economy of time, unidimensionality, and face validity" (Rosenberg, 1965, pp. 16-17). The 10 statements revolve around liking/disliking and approving/disapproving of the self. The items are answered on a 4-point scale from "strongly agree" to "strongly disagree." The items are arranged so that positive and negative items alternate, avoiding what Rosenberg (1965) called a response set.

The 10 items are combined in a pattern for scoring which produces six total responses. For example, one out of two or two out of two positive responses are considered positive for a particular combined item. The six responses are then added, resulting in a single score ranging from -6 to +6, with -6 being the highest self-esteem score, and +6 being the lowest self-esteem score.

Reliability

According to Robinson and Shaver (1973), Silber and Tippett (1965) found that the instrument had a test-retest correlation over 2 weeks of .85 (n = 28). According

to Rosenberg (1965), the Guttman scale insures a unidimensional continuum by establishing a pattern which must be satisfied before the scale can be accepted. Rosenberg (1965) also stated:

> the adequacy of each item is not determined primarily by its relationship to the total score but its patterned relationship with all other items on the scale. (pp. 16-17)

Validity

Silber and Tippett (1965) found that the scale correlated from .56-.83 with several other similar measures and clinical assessment. Robinson and Shaver (1973) have found that the scale correlated .59 with Coopersmith's Self-Esteem Inventory, and scored as 10 items, .60. These authors also reported a .27 correlation with the California Psychological Inventory. Rosenberg (1965) believed that the scale has face validity. Rosenberg (1965) stated that face validity,

> while important, is not sufficient to establish the adequacy of the scale. Unfortunately, there are no "known groups" or "criterion groups" which can be used to validate the scale. (p. 18)

Rosenberg (1965) defended the adequacy of the scale on these grounds:

> if this scale actually did measure self-esteem, then we would expect the scores on this scale to be associated with other data in a theoretically meaningful way. (p. 18)
>
> If the scale actually measures low self-esteem, then we would expect those with low scores to appear depressed to others and to express feelings of discouragement and unhappiness; to manifest symptoms of "neuroticism" or anxiety; to hold a low sociometric status in the group, to be described as commanding less respect than others and to feel that others have little respect for them. The evidence supports these expectations. (Rosenberg, 1965, p. 30)

Some of these relationships with self-esteem include the following: depression, psychophysiological indicators, peer-group reputation, interpersonal attitudes, concern with broader social affairs, and occupational values and aspirations.

Demographic Data

In addition to the Self-Esteem Scale, demographic data (Appendix G) were obtained as part of the questionnaire completed by the participant. The demographic data included the following: age, education, nature of delivery (vaginal or cesarean), type of anesthesia, father presence in the delivery room, and amount of time prior to actual surgery/delivery that the cesarean mothers were informed of the impending surgical delivery.

Data Collection

Data collection was accomplished by alternating collecting periods between the two hospitals on a weekly basis. Data were collected until at least 15 subjects were obtained for each group. Specific days and times were arranged with the head nurse of each unit in order that data collection interfered as little as possible with normal unit routines. The investigator utilized the head nurse or charge nurse in the selection of the subjects. The investigator did not review patient records. Data were collected for the normal vaginal delivery group during the first through the third postpartum day. Data for the cesarean delivery group were collected on the second through the fifth postpartum day. No data were collected for either group on the day of delivery or the day of discharge.

After the individual was evaluated as having met the criteria for inclusion in the study, she was approached in her room by the investigator with regard to her willingness to participate in the study. The oral explanation and the questionnaire were presented. Anonymity was assured. Upon agreement to participate, the subject then completed the questionnaire in privacy,

choosing the response most closely expressing her feeling on the particular item. The subject was also asked to complete the page of demographic data. She was told that she would need about 10-15 minutes to complete the questionnaire, although there was no time limit. The subject sealed the completed questionnaire in an envelope provided by the investigator. Time was then provided for the woman to express any feelings or make any comments regarding the questionnaire, its content, or her experience.

Treatment of Data

The demographic data were presented and summarized. This data were analyzed with regard to age, education, nature of delivery and type of anesthesia, as well as presence of the father in delivery. Also included was the amount of time prior to the actual delivery that cesarean mothers were informed of the impending surgery.

The scores of the questionnaires were obtained as directed by Rosenberg (1965), to arrive at a score ranging from -6 to +6. The statistical analysis of the data was completed through the use of the *t*-test for independent samples, with a significance level of

$p < .05$. Polit and Hungler (1978) have stated that a comparison of two groups of subjects on the dependent variable is a common research situation. In this study, two independent variables were considered. The basic parametric procedure for testing the significance between two groups is the *t*-test for independent samples.

CHAPTER 4

ANALYSIS OF DATA

This ex post facto study was designed to determine if there was a difference in the level of self-esteem in primiparous women who were delivered by cesarean section and those who had normal vaginal deliveries. The study was conducted using 21 subjects who had vaginal deliveries and 18 subjects who had unexpected cesarean deliveries.

Description of the Sample

The sample for this study was drawn from the population of women admitted to the selected hospitals for delivery of their infants at term. Specific criteria used in selecting the women for the sample were previously described. The sample consisted of two groups, women who had normal vaginal deliveries and women who underwent unexpected cesarean deliveries.

In order to further describe the sample, demographic data were collected in regard to maternal age, education, type of anesthesia, father presence in the delivery room, and amount of time prior to actual

surgery that women were informed they would be having a cesarean. The normal vaginal delivery group (NVD) ranged in age from 19-33 years, with a mean age of 25.3 years. The cesarean delivery group (CD) ranged in age from 19-30 years, with a mean age of 25.5 years. No apparent difference in age was observed.

The educational levels of the subjects in the NVD group ranged from high school completion to graduate study without completion of a higher degree. Ten subjects (48%) had completed high school, 4 subjects (19%) had attended college, 6 subjects (28%) had completed a bachelor's degree. One subject (5%) had done post-graduate study. Among the CD group, the educational levels ranged from high school completion to master's degree completion. Six subjects (33.3%) finished high school, 6 subjects (33.3%) attended some college, 2 subjects (11.1%) completed bachelor's degrees, and 2 subjects (11.1%) had done post-graduate study. As with the ages, the two groups showed almost equal levels of education, with the CD group being slightly more educated. No apparent difference in educational levels was observed.

Data concerning the types of anesthesia the subjects had for delivery were analyzed. The NVD group experienced three types of anesthesia. Two subjects (9.5%) had general anesthesia, 9 subjects (43%) had epidural anesthesia, 4 subjects (19%) had regional anesthesia, with 6 subjects (28.5%) having no anesthesia. The CD group experienced only two types of anesthesia: general and epidural. Eleven subjects (61%) had general anesthesia for delivery and 7 subjects (39%) had epidural anesthesia.

Data concerning father presence in the delivery room were analyzed. In the NVD group, 14 fathers (67%) were present for the delivery, 7 fathers (33%) were not present. In the CD group, the percentages were reversed: 6 fathers (33%) were present for delivery and 12 (67%) were not.

Data were analyzed with regard to how far ahead of the actual surgery the cesarean group was informed of the need for the surgical delivery. The times ranged from 5 minutes to 3 hours prior to actual delivery. The mean time was 57 minutes. Fourteen subjects (78%) had 1 hour or less to prepare for the operative delivery.

The scores obtained by the subjects on the Rosenberg Self-Esteem Scale were analyzed. Keeping in mind that -6 represented the highest score of self-esteem, and +6 the lowest score on the Self-Esteem Scale, the NVD group scored as follows. Fifteen subjects (71%) had a score of -6, 4 subjects (19%) had a score of -5, and 2 subjects (10%) had a score of -4. There were no scores equal to or less than -3. The mean score for the NVD group was -5.62.

The CD group included 11 subjects (61%) with a score of -6, 4 subjects (22%) with a score of -5, and 3 subjects (17%) with a score of -4. Again, there were no scores equal to or less than -3. The mean score obtained for the CD group was -5.40. These data are presented in Table 1.

Findings

In order to test the hypothesis that primiparous women who have been delivered by unexpected cesarean section will have lower self-esteem than those who have had a normal vaginal delivery, the self-esteem scores obtained from the Rosenberg Self-Esteem Scale were compared. Simple numerical comparison of the mean self-esteem scores revealed a slight difference

Table 1

Comparison between Groups by Self-Esteem Scores

Self-esteem score	Normal vaginal Delivery		Cesarean Delivery	
	Number (n = 21)	Percentage	Number (n = 18)	Percentage
-6	15	71	11	61
-5	4	19	4	22
-4	2	10	3	17
-3	0	--	0	--

Total n = 39.

between the two groups, with the normal vaginal delivery group scoring .22 higher than the cesarean delivery group. The t-test for independent samples was performed.

Summary of Findings

The one-tailed probability test for significance revealed $t_{(37)} = -.75$, $p = .23$; there was no significant difference between the gwo groups at $p < .05$ level. On that basis, the hypothesis was rejected.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter presents a summary of the entire study and is followed by a discussion of the findings of the study. Conclusions and implications of the findings are presented as well as recommendations for further study.

Summary

The problem of this study was to determine if there was a difference in the level of self-esteem in primiparous women who had vaginal deliveries and those who had unexpected cesarean births. The review of literature was divided into two major sections. The first section reviewed the major self-esteem theorists and their works, as well as the major researchers. The second section focused on a number of aspects of cesarean childbirth, including its history, incidence of and indications for, and psychophysiological factors affecting the mother's perceptions of the experience.

An ex post facto, comparative retrospective survey approach was used to test the hypothesis that

primiparous women who have been delivered by unexpected cesarean section will have lower self-esteem than those who have had a normal vaginal delivery, as measured by their scores on the Rosenberg Self-Esteem Scale. The convenience sample was selected through the use of criteria as outlined previously. The sample was made up of two groups. The first group, women who had normal vaginal deliveries, consisted of 21 subjects who were admitted for labor and delivery at term. The second group, women who were admitted for labor and delivery at term and subsequently underwent an unexpected cesarean delivery, consisted of 18 subjects.

The instrument selected for this study was Rosenberg's Self-Esteem Scale (Rosenberg, 1965), a simple 10-item questionnaire. The items revolved around liking/disliking and approving/disapproving of the self. They were answered on a 4-point scale from "strongly agree" to "strongly disagree." The scoring of the scale resulted in a single score ranging from -6 to +6, with -6 being the highest self-esteem score, and +6 being the lowest self-esteem score. Demographic data were also obtained as part of the questionnaire. This data were analyzed with regard to age, education,

nature of delivery, and type of anesthesia, as well as presence of the father in delivery. Also included was the amount of time prior to the actual surgery that cesarean mothers were informed of the impending surgery.

The scores of the Self-Esteem Scale were obtained as directed by Rosenberg (1965), to arrive at a single score ranging from -6 to +6. The statistical analysis of the data was completed through the use of the *t*-test for independent samples with a significance level of $p < .05$. The results of the *t*-test gave a score of $t_{(37)} = -.75$, $p = .23$, showing that there was no significant difference between the two group's self-esteem. Primiparous women who underwent unexpected cesarean deliveries did not have lower levels of self-esteem than women who had normal vaginal deliveries.

Discussion of Findings

The finding that primiparous women undergoing unexpected cesarean delivery did not have lower self-esteem than women having normal vaginal deliveries was not consistent with the literature. This finding does not appear to support the conceptual framework, that self-esteem is a ratio of success to aspirations.

Affonso (1981) found that women who had unplanned cesarean births had lowered self-esteem, many expressing disappointment in the self. Using Rosenberg's Self-Esteem Scale, Cox and Smith (1982) found that women who had cesarean deliveries did experience a significantly lower level of self-esteem.

There is a number of possible explanations for findings of the present study. Consideration should first be given the instrument. The tool was designed by Rosenberg to measure self-esteem and has established reliability and validity. It is possible, however, that the instrument may not be appropriate for use with postpartum women. One subject made the remark upon completion of the questionnaire that "this is silly--what's it got to do with having a baby?" Perhaps a tool more specific to childbearing women could be developed.

The sample size of the present study must also be considered. The total sample size was 39. A larger sample might have been more useful. The method and timing of data collection may have influenced results. It is possible that the subjects could have been influenced by the presence of the investigator, members of the nursing staff, visitors, or roommates. It is

also possible that the administration of the questionnaires interfered with with routine care of the subjects. The timing of the data collection, 1 to 5 days postpartum, may have affected the results, as well, although Affonso's (1977, 1981) studies demonstrating lowered self-esteem were conducted within the same time period. Cox and Smith's (1982) study was carried out 4 weeks postpartum. It is also possible that pre-delivery self-esteem levels of the subjects may have been high to start with. Therefore, post-delivery self-esteem levels may not have been significantly changed.

It is also possible that an unidentified variable may have affected the results, such as supportive, understanding nursing care. The sample consisted of private patients in private hospitals. Private hospitals are generally able to provide more individualized care.

Conclusions and Implications

The conclusion that may be drawn from the present study is that having an unexpected cesarean delivery appeared to have no adverse effect on the self-esteem of the mother identifiable within 5 days of delivery. With the size of the sample used from the data

obtained, this study is not generalizable to any population. Due to the nature of the finding of this study, the only implication which can be drawn is that further study is necessary. While it is recognized that not all women suffer from lowered self-esteem following a cesarean delivery, this has been a considerable problem for some women, according to the literature. Thoughtful nursing intervention can help prevent, or at least minimize, this problem for the increasing number of women who experience cesarean deliveries.

Recommendations for Further Study

Based on the findings and conclusions of this study, the following recommendations are suggested for further research:

1. A similar study be conducted using a larger sample.

2. A study be conducted comparing self-esteem several days postpartum and 4 to 6 weeks postpartum.

3. A more specific tool be developed or modified that is valid and reliable in measuring self-esteem of pregnant and postpartum women.

4. A study be conducted comparing self-esteem of women who have been prepared prenatally for the possibility of cesarean childbirth and those who have not.

5. A study be conducted comparing pre- and post-delivery self-esteem levels of cesarean women.

APPENDIX A

Cesarean Childbirth Publications

Lay

Donovan, B. The cesarean birth experience. Boston: Beacon Hill, 1978. (paper or hardback)

Hausknecht, R., & Heilman, J. R. Having a cesarean baby. New York: E. P. Dutton, 1978. (paper)

Meyer, L. D. The cesarean (r)evolution. Edmonds, WA.: Chas. Franklin Press, 1979. (paper)

Vestal, L. Cesarean celebration. Madison, WI.: Cesarean Families of Childbirth and Parent Education Assoc., 1978. (paper)

Wilson, C. C., & Hovey, W. R. Cesarean childbirth: A handbook for parents. New York: Doubleday and Co., 1980. (paper)

Professional

Affonso, D. D. Impact of cesarean childbirth. Philadelphia: F. A. Davis co., 1981.

Kehoe, C. F. The cesarean experience: Theoretical and clinical perspectives for nurses. New York: Appleton-Century-crofts, 1981.

APPENDIX B

Prospectus for Thesis
Approval Form

This proposal for a thesis by Janet Hook Mansir, RN, BS and entitled Self-Esteem of Primigravidas Following Vaginal and Cesarean Births has been successfully defended and approved by the members of the Thesis Committee.

This research is xx is not _____ exempt from approval by the Human Subjects Review Committee. If the research is exempt, the reason for its exemption is: This study falls under Category I of the Federal Guidelines for Research of Human Subjects, indicating "no risk" for the subjects.

Thesis Committee: Janet Dawson, Chairperson
Estelle L. Kurtz, Member
Lois Watson, Member

Date: December 10, 1981

_____ Dean, College of Nursing

Date: _____

BVW/smu
10/14/81

APPENDIX C

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133
THE GRADUATE SCHOOL

April 27, 1982

Mrs. Janet Hook Mansir
2704 Laramie Street
Irving, TX 75062

Dear Mrs. Mansir:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Robert S. Pawlowski
Provost

ap

cc Ms. Jane Dawson
Dr. Anne Gudmundsen

APPENDIX D

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO JANET HOOK MANSIR, R.N., B.S.
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 purpose of the study will be to determine if there is a difference in the level of self-esteem in primigravidas who have had vaginal deliveries and those who have had unexpected cesarean births.

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: 3/5/82

Janet K. Mansir
Signature of Student

Signature of Agency Personnel

Jane Dawson
Signature of Faculty Advisor

*Fill out & sign three copies to be distributed as follows: Original - Student; First copy - Agency; Second copy - TWU College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO JANET HOOK MANSIR, R.N., B.S.
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4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

_____

_____

Date: 6th of February, 1982

_____
Signature of Agency Personnel

Janet H. Mansir
Signature of Student

Jane Dawson
Signature of Faculty Advisor

*Fill out & sign three copies to be distributed as follows: Original - Student; First copy - Agency; Second copy - TWU College of Nursing.

APPENDIX E

Oral Explanation to Subjects

My name is Janet Mansir. I am a Texas Woman's University graduate student working on a Master's degree in nursing. The study I am doing deals with how new mothers feel about themselves after the delivery of their babies. The purpose of the research is to identify these feelings, providing information for nurses to utilize in caring for new mothers.

Your participation in this study would be very helpful. You would be required to complete a short-two-part questionnaire. This will take only about 15 minutes, although there is no set time limit. You would complete the questionnaire in privacy, placing it in an envelope I will provide. You would seal the envelope and return it to me. Questions will be answered prior to completion of the questionnaire. You would have an opportunity afterwards to ask any questions or express feelings or make comments.

All questionnaires and related information will remain confidential. You will not be identified in any way in the final report. All responses will remain anonymous. If you wish, you will be provided with results of the study upon its completion.

Possible risks or discomforts you may experience by completing the questionnaire include having some uncomfortable feelings about how you perceive yourself and your childbirth experience. Whether or not you participate in the study will have no effect on your care.

Possible benefits that may result include: enjoying completion of the questionnaire, being able to understand and organize your thoughts and feelings about your birth experience, health care professionals will be better able to identify and understand the feelings of new mothers, and thereby, be able to give better care.

You may withdraw from the study at any time. If you agree to participate, you will receive the questionnaire, be given time to complete it, and have an opportunity to discuss it afterwards. Thank you very much for your time and cooperation.

APPENDIX F

COMPLETION AND RETURN OF THIS TOOL WILL BE CONSTRUED AS INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY

Questionnaire--Part I

These statements relate to the feelings a person has about herself. Please circle the response that most closely describes how you feel about yourself at this time. DO NOT WRITE YOUR NAME ON THIS FORM.

SA -- Strongly agree
A -- Agree
D -- Disagree
SD -- Strongly disagree

1.	I feel that I'm a person of worth, at least on an equal basis with others.	SA	A	D	SD
2.	I feel that I have a number of good qualities.	SA	A	D	SD
3.	All in all, I'm inclined to feel that I'm a failure.	SA	A	D	SD
4.	I am able to do things as well as most people.	SA	A	D	SD
5.	I feel that I do not have much to be proud of.	SA	A	D	SD
6.	I take a positive attitude toward myself.	SA	A	D	SD
7.	On the whole, I am satisfied with myself.	SA	A	D	SD
8.	I wish I could have more respect for myself.	SA	A	D	SD
9.	I certainly feel useless at times.	SA	A	D	SD

10. At times, I think I'm no good at all. SA A D SD

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22 February 1982

Ms. Janet H. Mansir
2704 Laramie Street
Irving, Texas 75062

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APPENDIX G

COMPLETION AND RETURN OF THIS INSTRUMENT WILL BE CONSTRUED AS INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY.

Questionnaire--Part II

Please place the answer to each item in the space provided. DO NOT WRITE YOUR NAME ON THIS FORM.

1. Age in years:_____

2. Education (high school, college, etc.)

_____

3. What type of birth did you have (vaginal or cesarean).

_____

4. Was the father present for the delivery?_____

5. What kind of anesthesia did you have (spinal, epidural, general, other)?

_____

6. If you had a cesarean, how far ahead did you know that it would be necessary?

_____

7. Please write any comments you may have:

_____

_____

_____

_____

Thank you for taking time to complete this questionnaire. Your participation and cooperation are greatly appreciated.

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