SELF-ESTEEM IN PRIMIPARAS: VAGINAL VERSUS CESAREAN BIRTHS

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We hereby recommend that the thesis prepared under our supervision by Betsy B. McCune entitled Self-Esteem in Primiparas: Vaginal Versus Cesarean Births be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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DEDICATION

To my husband, Lorne

who has lived before me Galatians 5:13

". . . through love serve one another."

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CHAPTER 1

INTRODUCTION

In the last 10 years considerable information on childbirth has been published for the general public. As consumers have begun to demand a more personalized approach to childbirth, the focus of many publications has become that of preparing the pregnant woman and her family for a positive and shared birth experience.

While most pregnancies culminate in the birth of a healthy infant by means of a "normal vaginal delivery," during the past decade there has been a steady rise in the number of cesarean births. This trend is often explained as arising from advanced technological procedures, fewer breech vaginal deliveries, and the older age at which women are having children. Whatever the cause, this increase in cesarean births has ramifications for woman, families, and anyone concerned with childbirth.

Not least among the ramifications of cesarean births are the effects upon maternal emotions, self-concept, and infant attachment. The manner in which an infant is ushered into the world has deep meaning and significance for the parents, especially if the birth does not

meet their expectations. Often the announcement that a cesarean section is necessary is greeted with reactions ranging from dismay, anger, or fear, to relief that labor will end. Moreover, after delivery the new mother may need to deal with negative feelings toward herself and her efforts during labor.

These considerations are important when one realizes that "family centered maternity care" is rapidly becoming expected rather than simply anticipated. Many professionals are attempting to update their skills and orientations toward maternity care in compliance with public demand. As this family emphasis continues, nurses and other professionals need to become sensitive to not just the physical needs, but also to the emotional needs of new parents.

Problem of Study

The problem for this study was: Is there a difference in self-esteem in primiparas who deliver vaginally and primiparas who deliver by unexpected cesarean section?

Justification of the Problem

Several factors must be considered when one thinks about cesarean birth and the influence the method of delivery has upon a woman's self-concept. Of great importance is the current trend toward minimal medical intervention and natural childbirth. Any plans a woman has in these areas become secondary to those of medical personnel when an unexpected cesarean birth becomes necessary.

From the moment that a cesarean birth is decided upon, the mother-to-be and her family face a chain of events that may be difficult to accept. Usually the family is asked to leave while the patient is readied for surgery and given preoperative medication. They may have a few moments of privacy before the mother is taken to surgery, but little time to adjust their thinking to the unexpected circumstances. If the surgery is a true emergency, the atmosphere of semi-panic may create a sense of helplessness and fear in the patient and her family.

Throughout labor, delivery, and the postpartum period nurses have an important role in the care of mothers and their families. Nurses are the primary care givers and are the individuals who have the most contact on

a day-to-day basis with mothers. During the days that a cesarean mother recuperates from her surgery, nurses could explore with this woman her thoughts and feelings about a surgical birth. Often, however, nurses busy themselves so much with the physical care of patients that the emotional needs are unmet.

Presently nurses are attempting to define their roles and the scope of their practice in a more concrete way than has heretofore been the case. This study can assist this effort by helping to pinpoint patient needs that a nurse can best meet.

Conceptual Framework

This research was conducted on the basis of Rosenburg's (1965) concept of self-esteem. Though Rosenburg's research centered on the adolescent self-image, his thinking is appropriate to adults also. Because Rosenburg believed that adolescence is a period of life involving numerous physical adjustments and important decisions, this researcher hypothesized that adolescents are very aware of their self-image. The same is also true of pregnancy which, like adolescence, includes both physical and emotional adjustments.

Rosenburg differentiated between two connotations connected with self-esteem. This author defined self-esteem as a positive or negative attitude toward oneself. However, one may think he is good without believing he is good enough. If a person has established certain performance standards for himself, he may feel inadequate in comparison to others, while at the same time, considering himself superior overall.

To Rosenburg (1965), high self-esteem implied that an individual

> respects himself, considers himself worthy. . . . He does not feel that he is the ultimate in perfection, but recognizes his limitations and expects to grow and improve. (p. 31)

The term "self-acceptance" may also be used to describe these people. Those people with high self-esteem exude confident anticipation of success even as they consider their deficiencies. On the other hand, low self-esteem

> implies self-rejection, self-dissatisfaction, self-contempt. The individual lacks respect for the self he observes. The self picture is disagreeable, and he wishes it were otherwise. (Rosenburg, 1965, p. 31)

Rosenburg arrived at his concept of self-esteem through various observations and a synthesis of interactions with others. Rosenburg's definition of self-esteem included at least four assumptions as follows:

1. An individual's self-esteem is influenced by what those around him think of him.

2. An individual's social interaction is significantly influenced by his own feelings about others and the manner in which he deals with them.

3. "People act on the basis of their assumptions of what they are like, and these actions, in turn, have characteristic consequences for their lives in society" (Rosenburg, 1965, p. 187).

4. Interaction with one's interpersonal environment more directly influences one's feelings of worth than society as a whole.

The aspect of Rosenburg's concept of self-esteem which was investigated in the present study was that of whether the way one performs in meeting a goal influences an individual's self-esteem. Specifically, the present study investigated whether the failure to meet the goal of a vaginal birth adversely influenced a woman's self-esteem.

Hypothesis

The hypothesis for this study was as follows:

There will be no significant difference in the self-esteem scores of primiparas who deliver vaginally

and primiparas who deliver by unexpected cesarean section.

Assumptions

The assumptions for this research were as follows:

1. It is possible to think of oneself positively overall without approving of the manner in which one performs in reaching a specific goal.

2. High self-esteem connotes awareness and acceptance of one's strengths and weaknesses with the goal of self-improvement.

3. A person with low self-esteem does not like himself.

4. Significant others have a profound influence upon one's feelings of worth.

5. People with high self-esteem act and interact with others in a different way from those with low self-esteem.

6. Failure to meet the performance standards a woman has set for herself in delivering a baby may negatively influence her self-esteem.

Definition of Terms

The following terms were identified for this study:

1. Self-esteem--the positive or negative feelings (attitudes) a person has toward himself as measured by the Rosenburg Self-Esteem Scale.

2. Primipara--a woman who has delivered her first child.

3. Vaginal delivery--the birth of a child through the vagina.

4. Unexpected cesarean section--the medical decision made during labor to deliver an infant through an abdominal and uterine incision rather than allowing the infant to deliver vaginally. The woman and her family did not plan or prepare for a surgical birth.

Limitations

The limitations for this study were as follows:

1. Subjects were able to read, understand, and speak English.

2. The self-esteem of participants prior to delivery could not be controlled.

Summary

This study, based upon Rosenburg's (1965) concept of self-esteem, investigated the problem: Is there a difference in the self-esteem of cesarean delivery primiparas and vaginal delivery primiparas? It was hypothesized that there would be no significant difference in the self-esteem scores of these two groups. An unexpected cesarean birth was defined as one which the doctor determined to be necessary when labor had begun and for which the woman and her family had not planned or prepared. From the present study, it was hoped that the role of the nurse in maternity care would be more clearly defined.

CHAPTER 2

REVIEW OF THE LITERATURE

For the purposes of this study, literature on two major subjects was reviewed. These subjects were factors during childbirth that influence a woman's self-concept and self-concept and cesarean birth. Research studies appropriate to these subjects were incorporated into the review.

Factors during Childbirth that Influence a Woman's Self-Concept

In 1967, Grimm documented that a woman's feelings and attitudes about the birth experience influences her concept of self as a woman and mother. Further investigation into the subject of childbirth and self-concept revealed four major factors that influence a woman's feelings about the birth experience. These factors were reviewed individually.

Control

Control seems to be one factor that many women view as essential to a positive childbirth experience. Universally, women regard labor as an anxiety provoking

situation (Jensen, Benson, & Bobak, 1978) over which they hope to exercise some degree of control. To be in a situation where the need for control is threatened allows the laboring woman to derive greater satisfaction in her own efforts should control be maintained (White, 1969).

Marut and Mercer (1979) compared the perceptions of childbirth in two groups of primiparas. Thirty primiparas had delivered vaginally and 20 primiparas had delivered by cesarean section. Interviews were conducted with each mother within 48 hours after delivery and each mother completed a 29-item questionnaire designed to measure maternal perceptions about the labor and delivery experience. Among their findings was that primiparas' satisfaction with childbirth was linked to feelings of "confidence, pleasant feeling states, and their perceived control during labor" (Marut & Mercer, 1979, p. 262). This finding coincides with that of Affonso (1976) who stated that the maintenance of control during labor influenced the woman's feelings of self-esteem as she reviewed the birth experience.

In reviewing the labor and delivery evaluation reports of 145 women who had attended childbirth preparation

classes and delivered vaginally, Willmuth (1975) concluded that maintaining control was the one factor that made women feel positive about their childbirth experience. Of utmost importance was the ability to be self-sufficient and to be an active participant.

Highley and Mercer (1978) verified Willmuth's (1975) observations. In writing about one woman's labor and delivery experience, these writers concluded that maintaining control, whether it be in a spatial, temporal, cognitive, or biophysiological sense, gives a woman the motivation to handle each hurdle as it arrives. Highley and Mercer noted a high correlation between maintaining control and high self-esteem.

Expectations and Loss

Rich (1973) stated that most women have certain expectations of themselves as they prepare for labor. Fulfilling or failing to fulfill these expectations is another factor that can influence a woman's self-concept.

Butani and Hodnett (1980) conducted interviews within 48 hours after delivery with 29 primiparas and 21 multiparas to discern their subjective reactions to labor. From these interviews, these researchers determined that 32 of the 50 women had negative perceptions of labor

because it did not meet their expectations. The most commonly given reasons for the discrepancies between expectations and reality were length of labor, difficulty of the labor, and the amount of pain experienced.

Grace (1978) related this discrepancy between a woman's expectations and reality with a sense of loss. Moreover, Grace postulated that an emotional response to loss, most commonly in the form of grief, is the norm. While many parents experience some negative feelings about their childbirth experiences, Grace believed that health professionals and those closest to the parents may assume that these feelings of loss are negated by the joy of having the baby. Rubin (1968), however, related feelings of loss to lowered self-esteem with feelings of shame and humiliation as possible outcomes.

Mercer (1981) stated that

> the mother expressing failure and shame seems to sense that if she doesn't live up to her expectations in one feminine function, she can't live up to them in the others. (p. 341)

Mercer (1981) believed that one of the first tasks a mother must complete postpartally is to review the events of childbirth, "reflect on how they differed from what she expected, and integrate the experience into her expectations" (p. 341).

Assumptions

A woman's feelings about herself may be influenced by her assumptions regarding birth, the postpartum period, and parenthood. In attempting to recover from childbirth, women may assume that they should be back to normal quickly. They forget the fact that physical adjustments are not the only changes underway and that time is needed to fully recuperate.

Becker (1980) pointed out the fallacy of expecting a healthy, smooth, and natural transition from pregnancy to the postpartum period and parenthood. Becker (1980) argued that if

> one's definition of health encompasses more than physiological function to include emotional and social function, . . . [then the new mother] cannot adapt in such a short time [6 weeks]. (p. 24)

Gruis (1977) divided the needs and tasks of the new mother into four broad areas: (a) physical restoration, (b) learning infant needs, (c) relating to the newborn, and (d) accommodating a new family member. Gruis' study of mothers' postpartum concerns identified that many new mothers have difficulty coping with all the adjustments that are expected of them and that there is a dirth of information provided to families before delivery to correct improper assumptions or after delivery to support them as needs arise.

Perhaps no one summarized the plight of the new family better than Rubin (1975). Writing about the postpartum period, Rubin (1975) stated that the "postpartum period is unbelievably cruel. It suffers from the methology of misstatement, understatement, and wholesale neglect" (p. 1684). Families are told and read about the beauty of childbirth and the "normal" recovery that follows. Few families automatically assume that they will have problems intrapartally or postpartally. These assumptions, when combined with a lack of information, may lead to difficulties after delivery that could influence a woman's self-concept.

Significant Others

Finally, the responses of significant others to a woman during labor and after delivery may influence a woman's self-concept. Most women have family members and/or friends who share the birth experience with them. Encouragement, care, and concern from significant others before, during, and after delivery is perceived as vital to a positive childbirth by many women (Butani & Hodnett, 1979; Rinquist, 1976).

Hott (1980) believed that a woman's perception of herself and childbirth "depends largely on her husband's

perception of the event" (p. 21). When fathers are able to actively participate during labor and delivery, they often have positive feelings about the mothers (Tanzer, 1968). Moreover, Hott (1980) found in a study of 70 first-time fathers that even the 18 fathers whose wives had cesarean deliveries described these mothers as close to ideal wives. Mothers are also more likely to describe participating fathers as strong, competent, active, supportive, and indispensable (Goodwin, 1970; Tanzar, 1968) and to seek the help of the father when concerns related to childbirth arise (Gruis, 1977).

Rosenburg (1965) pointed out that the comparison one makes between his own performance standards and the evaluation of his behavior by someone else may cause feelings of inadequacy. Mothers who say, "I let my husband [family] down," or who apologize for some perceived failure are responding to what they believe are others' evaluation of them (Affonso & Stichler, 1978).

Self-Concept and Cesarean Birth

The idea that a cesarean mother's self-concept may be influenced by a surgical birth is not new. Women who deliver vaginally may have the power to make decisions about medication during labor, the presence of support

persons during labor, and positions for birth. These same choices are not available for women who experience cesarean delivery. As Fawcett (1981) stated:

> The cesarean mother experiences physical and emotional stresses related to loss of control over the situation and of bodily function, anxiety and fear about her own welfare and the life of her child, guilt that she has done something wrong, and disappointment that the birth was not what she expected. (p. 372)

Fawcett's (1981) retrospective study of the needs of 24 sets of cesarean birth parents was conducted with an open-ended questionnaire and revealed that "the event of cesarean birth is problematic for many parents especially if it is an emergency procedure" (p. 374).

As Marut and Mercer (1979) interviewed and compared the perceptions of childbirth between 30 primiparas who had delivered vaginally and 20 primiparas who had delivered by cesarean section, they noted a distant difference. Mothers who had delivered vaginally had higher levels of self-esteem because they had a sense of reality during labor, positive feelings about an effective labor, and positive birth experiences.

These observations have implications for the woman who anticipates a "normal delivery" and has an unexpected cesarean birth. Cohen (1977) described a surprise

cesarean delivery as a potentially "shattering emotional experience" (p. 114), and Enkin (1977), as leaving the woman with not only a "scarred belly and uterus [but often with a] scarred mind" (p. 101). Conner (1977) stated that feelings of fear, disappointment, and frustration are common and that a woman's self-esteem "often suffers tremendously after a cesarean birth" (p. 112). Hausknecht and Heilman (1978) proposed that an unplanned cesarean birth is

> frequently experienced as an attack on one's femininity, one's normalcy, and one's body [and that it] may affect the way (mothers) feel about themselves and the way they feel about their bodies. (pp. 146-147)

Marut (1978) also found in interviews with cesarean mothers that these women were highly critical of their performances and needed reassurance about their efforts during labor.

Reactions to cesarean birth vary depending upon circumstances. Often a woman has only moments to assimilate the news that she needs a cesarean delivery (Affonso & Stichler, 1978), and if the cause is truly an emergency, she does not have the choice of a spinal or general anesthesia. While it is true that ultimately success is measured by having a healthy baby, a "normal birth" is

perceived by some women as a test of their womanhood (Enkin, 1977). Thus, a failure to deliver vaginally may generate feelings of inadequacy, guilt, and depression (Mitchell & Nason, 1981) or feelings of having been cheated (Rakowitz & Rubin, 1978). For example, in studying 17 women who had attended cesarean preparation classes with 21 women who had not, Hart (1980) found no significant difference in the scores of primiparas and multiparas who delivered by cesarean section on the Maternal Attitude to Pregnancy Instrument. However, Hart noted a higher score among women who had delivered one or more children vaginally before having a cesarean birth. Donovan (1977) summarized the feelings of cesarean mothers by noting that at times they referred to themselves as "failures and natural childbirth flunkies" (p. 4).

Postpartally, cesarean mothers may express a need for "time to pull themselves together . . . before moving on to the tasks of motherhood" (Marut & Mercer, 1979, p. 264). Reynolds (1977) reported that as mothers and fathers share their feelings they may sense loss of the "we did it together" and the "wonderful experience" that was promised them and that everyone seems to talk about. Affonso and Stichler (1978) noted in interviews with

105 women that grieving behaviors and powerlessness are common to women experiencing unexpected cesarean births and that some express feelings of inadequacy and jealousy toward women who deliver vaginally.

Meyer (1979) compared a woman's response to cesarean birth to the stages of grief identified by Drolar, Baskiewicz, Irvin, Kennell, and Klaus (1975): disbelief and shock, denial, sadness and anger, equilibrium and acceptance, and reorganization and reconstruction. Meyer (1979) believed that the grief process may take anywhere from a few hours to a few days to resolve, and that "in stages I, II, and III there is a loss of self-esteem which improves as the individual proceeds through stages IV and V" (p. 46).

Recently, Cox and Smith (1982) studied the self-esteem of women who had delivered vaginally and by cesarean section. One hundred cesarean mothers and 100 vaginal delivery mothers were mailed a copy of Rosenburg's (1965) Self-Esteem Scale and a demographic information sheet 1 month after delivery. Of the 200 questionnaires mailed, 76 cesarean mothers and 78 women who had delivered vaginally returned them. Using the Mann-Whitney U test, Cox and Smith (1982) determined that cesarean

mothers had a significantly lower level of self-esteem than mothers who had delivered vaginally.

Following cesarean delivery, there are also physical concerns which may influence a woman's response to her infant and her attitude toward herself. Rubin (1961) pointed out that during the first few days new mothers are generally passive in regard to their own and their baby's care and that a mother's concern focuses initially on herself as she recuperates from birth. When a cesarean delivery has been necessary, the mother may well focus even more of her attention upon herself because of the increased need for physical care (Schlosser, 1978). The early postoperative days may also expose such reactions as hostility (Marut & Mercer, 1979), apathy, or anxiety toward the infant (Affonso & Stichler, 1980). Attachment to the infant may also be delayed because of separation during the early hours and because of fatigue, pain, or soreness from the delivery.

Even as the woman begins to recover and assume self and infant care responsibilities, the cesarean mother may struggle with fluctuating emotions. Bampton and Mancini (1973) observed that cesarean mothers had lower self-esteem several days after delivery as they visited

other mothers caring for their infants and were limited in their own caretaking activities because of physical discomfort.

Affonso (1977) observed that "women who encounter an expected cesarean section are vulnerable to forgetting certain important areas of their childbirth experiences" (p. 163). Affonso suggested that nurses should be sensitive to the mother's need to share and clarify all of her memories about labor. This sharing may release some hidden reactions and allow the woman to better understand what happened as she moves toward acceptance of all events surrounding her delivery.

Summary

Two subjects have been reviewed in this chapter: factors during childbirth that influence a woman's self-concept and cesarean birth and self-concept. Four major factors were discussed relative to the first topic: control, expectations and loss, assumptions, and significant others. A discussion of the self-concept of cesarean mothers revealed that a surgical birth may negatively influence a woman's self-concept.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This investigation was classified as descriptive/exploratory research. Descriptive investigation is explained as that which "observes, describes, and perhaps, classifies" (Polit & Hungler, 1978, p. 24). Exploratory research is termed an "extension of descriptive research. . . . which is more directly oriented toward the discovery of relationships" (Polit & Hungler, 1978, p. 24). This investigation was conducted to determine whether the manner in which a primipara delivered influenced her self-esteem.

Setting

This research was conducted in a Southwestern city with a population of approximately 1,000,000 persons. In this city there are six major hospitals. A 500+ bed hospital with a monthly delivery average of 275 deliveries was used as the center for data collection. In 1981 and 1982, the cesarean section rate at this institution was approximately 20%. The specific setting for this

study was a 32-bed postpartum unit which includes 2 private rooms, 1 ward with 4 beds, and 13 semi-private rooms.

Population and Sample

The target population for this study was all primiparas who delivered vaginally or by unexpected cesarean section at the specified institution during the months of February and March of 1983. By including only those primiparas who delivered by unexpected cesarean section, time for emotionally preparing for the event was controlled.

The sample was of a nonprobability, convenience type and included 24 primiparas in each group. All participants voluntarily agreed to be included in the study. Though convenience sampling is more likely to be atypical of the population under consideration (Polit & Hungler, 1978), it nevertheless allowed the investigator to use those people most readily available at the time they were needed.

Criteria for inclusion in the study were:

1. Primiparas delivering vaginally were 2 to 3 days postpartum.

2. Primiparas delivering by cesarean section were 2 to 3 days postoperative.

3. Any primiparas developing complications (infection or hemorrhage) following delivery were excluded from the study.

Protection of Human Subjects

This study was in compliance with Category I of the Human Subjects Research Risk Categories of the Federal Regulations for the Protection of Human Subjects and did not necessitate full Human Subjects Committee Review (Appendix A). However, an application to conduct this study was made to the research committee of the institution and written permission was obtained (Appendix B). Because it was deemed necessary by the research committee of the institution, permission from individual physicians was obtained (Appendix C). Individual participants were informed of the purpose, potential risks, and possible benefits of the study. An assurance of anonymity was given and volunteers were informed that there were no penalties or extra benefits for declining or agreeing to participate (Appendix D). Completion and return of the Self-Esteem Scale was construed as informed consent to act as a subject in the study.

Instruments

Two instruments were used to collect data. One instrument was a background information sheet (Appendix E) which was used to elicit information regarding the participant's age, marital status, and whether or not she attended a class on cesarean birth. The second instrument, the Rosenburg Self-Esteem D-1 Scale (Appendix F) was used to measure self-esteem in the subjects. This Likert-type scale included 10 simple statements which require that one responds with one of four possible answers ranging from "strongly agree" to "strongly disagree." To prevent the possibility that participants will complete the scale with a "response set," Rosenburg (1965) alternated the positive and negative items.

The Rosenburg Self-Esteem Scale consists of 10 statements which are combined into six items for scoring purposes. Item 1 includes three statements; items 2 and 6, two statements; and items 3, 4, and 5, one statement. For scoring item 1, a positive answer on two of the three or three of the three statements renders a positive score. If one of the two or two of the two statements in items 2 and 6 are answered positively, the items receive a positive score. Statements 3, 4, and 5 are scored individually.

Each scale item has two possible negative and two possible positive answers. "Positive" responses indicate low self-esteem and "negative" responses indicate high self-esteem. Total scores range from -6 (high self-esteem) to +6 (low self-esteem) and are determined by adding positive and negative responses.

According to Rosenburg (1965), the major advantage of the scale is its construct validity which was computed by the comparison of the scale with the Leary (cited in Rosenburg, 1965) scale, a Guttman scale of "depressive affect," report of psychosomatic symptoms, and with sociometric studies among high school students. In addition, with adult subjects, the scale correlated .67 with a difference between the Self and Ideal Self test, .83 with a difference between Self and Social Self, and .56 with a self-esteem interview (Silber & Tippett, 1965).

Rosenburg (1965) reported reproducibility coefficient of .92 using the Guttman procedure. First developed in the 1940s, the Guttman procedure uses the concept of cumulative items. "In a cumulative scale, items are selected so that, ideally, the person who agrees with item four also agrees with items three, two, and one"

(Polit & Hungler, 1978, p. 365). To evaluate a Guttman scale the individual is given a score equal to the number of items with which he/she agrees or disagrees. Silber and Tippett (1965) also reported a test-retest correlation of .85 over a 2-week period with adult subjects.

Data Collection

After obtaining approval to conduct this research from the selected institution and from individual physicians, the investigator went to the postpartum unit of the hospital. A list of primiparas was obtained from the nursing kardex. Those primiparas delivering vaginally were approached on their second or third postpartal day. Those primiparas delivering by cesarean section were approached on their second or third postoperative day.

The researcher went to the rooms of the potential participants, introduced herself, and explained the purpose, risks, and benefits of the study. Requirements of the individuals were explained, an assurance of anonymity given, and an opportunity to ask questions was given. Once any questions were answered, the individual was asked to complete the questionnaire and

was given a copy of the scale, an envelope, and a pencil. Adequate lighting and privacy were provided. During completion of the scale the researcher left the subject's room. Approximately 3 to 5 minutes were provided for completion of the scale. After the scale had been completed, the participant placed the scale in the envelope, sealed it, and handed it to the investigator. Envelopes were coded with a number 1 for vaginal deliveries and a number 2 for cesarean deliveries. This procedure was continued until there were 25 individuals in each group. Background information was also given by the subject at this time.

Treatment of Data

To analyze the data, the scores of individuals were tabulated in accordance with the instructions given by Rosenburg (1965). A group score was then computed from the individual scores and the means of the group scores were determined. The mean scores were subjected to the *t*-test with a significance level of .05 for rejection of the hypothesis. For independent samples, Polit and Hungler (1978) stated that this statistical test was appropriate. Background information was summarized by the use of descriptive statistics. For computation

purposes and in order to assure accuracy, the services of a private statistician and computer were utilized.

CHAPTER 4

ANALYSIS OF DATA

The purpose of this study was to determine if there was a difference in the self-esteem levels of primiparas delivering vaginally and primiparas delivering by unexpected cesarean section. In addition, background information was collected which included age, marital status, and whether subjects had attended a class on cesarean birth. This chapter discusses the analysis of the collected data beginning with a description of the sample. Findings of the study follow, and the chapt concludes with a summary of the findings.

Description of Sample

The sample population included 50 primiparas with an equal division of 25 cesarean births and 25 vaginal births. Each subject delivered in the specified hospital during the months of February and March of 1983, and were 2 or 3 days postdelivery at the time of data collection. All participants had a normal postdelivery course without complications (hemorrhage, infection) and volunteered to participate in the study.

Subjects delivering vaginally ranged in age from 17 to 33 years, and cesarean mothers' ages ranged from 16 to 37 years. Mean ages were 24 years for primiparas delivering vaginally and 24.56 years for primiparas delivering by unexpected cesarean section.

Most of the subjects in both groups were married. In the vaginal delivery group, 21 (84%) were married and 4 (16%) were single. In the cesarean delivery group, 23 (92%) were married and 2 (8%) were single.

Attendance at a class on cesarean childbirth was divided almost evenly. Thirteen (52%) of the pimiparas delivering vaginally attended a class, and 14 (56%) of the cesarean mothers had attended a class.

Findings

The computation of the self-esteem scores for the two groups resulted in a mean score of -5.44 for vaginal birth mothers and -4.32 for cesarean birth mothers. The frequency distribution of individual scores is shown in Table 1.

As delineated in Table 1, 20 vaginal birth mothers and 13 cesarean birth mothers had very high self-esteem scores with a score of -6. Four vaginal birth mothers scored -4, and six cesarean birth mothers scored -4.

In addition, four cesarean birth mothers scored -2. Form the total of 50 participants, only three (one vaginal birth mother and two cesarean birth mothers) could be construed as having less than positive self-esteem.

Table 1

Frequency Distribution of Scores of Vaginal Birth Mothers and Cesarean Birth Mothers

Score	Vaginal Births (n = 25)	Cesarean Births (n = 25)
-6*	20	13
-4	4	6
-2	0	4
0	1	1
+2	0	1
+4	0	0
+6**	0	0

* = highest self-esteem.
** = lowest self-esteem.

Table 2 delineates the range, mean, and standard deviation of each score from the mean. The 25 vaginal birth mothers' scores ranged from -6 to 0 with a mean

of 5.44 and a standard deviation of 1.36. The 25 cesarean birth mothers' scores ranged from -6 to +2 with a mean of -4.32 and a standard deviation of 2.21.

Table 2

Range, Mean, and Standard Deviation of Individual Scores from the Mean for Vaginal Birth and Cesarean Birth Groups

	Vaginal Births (n = 25)	Cesarean Births (n = 25)
Range	-6 to 0	-6 to +2
Mean	-5.44	-4.32
Standard deviation	1.36	2.21

Using the t-test to compare the means of each group resulted in a score of -.61 which was not significant at the .05 level, t (48) = 2.0100, p = .05). Thus, the hypothesis that there would be no significant difference in the self-esteem levels of vaginal birth primiparas and cesarean birth primiparas was supported. Primiparas delivering vaginally and by cesarean section had similar levels of self-esteem.

Summary of Findings

The *t*-test was used to compare the mean scores of vaginal birth primiparas and cesarean birth primiparas on a self-esteem questionnaire which was completed 2 to 3 days after delivery. No significant difference was found in the self-esteem levels of the two groups at the .05 level.

CHAPTER 5

SUMMARY OF THE STUDY

When the need for an unexpected cesarean birth arises the potential for the mother to have difficulty adjusting emotionally postpartally may increase. The purpose of this study was to examine whether the self-esteem of cesarean birth primiparas was different from the self-esteem levels of vaginal birth primiparas. The hypothesis stated that there would be no significant difference in the self-esteem levels of primiparas delivering vaginally and primiparas delivering by unexpected cesarean section.

Summary

To test the hypothesis, based on Rosenburg's (1965) concept of self-esteem, a non-experimental, exploratory research study was conducted. The target population included all primiparas who delivered in a 500+ bed hospital in a large Southwestern city during the months of February and March of 1983. From this population two groups of 25 primiparas consented to participate. One group included 25 primiparas who had delivered

vaginally, and the other group included 25 primiparas who had delivered by unexpected cesarean section. All subjects were voluntary participants, were 2 to 3 days postdelivery, and had no postpartal complications (infection, hemorrhage). Subjects in both groups were asked to complete the Rosenburg (1965) Self-Esteem D-1 Scale and to provide minimal background information.

Data analysis included determination of the range, mean, and standard deviation of both sample populations, and computation of the t-test. Background information was summarized by the use of descriptive statistics.

Discussion of Findings

The findings of the present study were not supported by the literature. In particular, the research conducted by Bampton and Mancini (1973), Cox and Smith (1982), Hart (1980), and Marut and Mercer (1979) documented that the cesarean mother's self-esteem was adversely influenced by a surgical birth. According to Meyer (1979), a cesarean mother also actively grieves because she feels like a "failure." Additionally, Rosenburg's (1965) concept of self-esteem indicated that failure to meet one's performance standards may foster feelings of inadequacy.

The difference in the self-esteem levels of the vaginal delivery primiparas and the cesarean delivery primiparas was minimal and not significant at the .05 level. Of the participants in the present study, only one subject had negative self-esteem, and she was a cesarean mother. Overall, only three mothers (two cesarean mothers and one vaginal delivery mother) could be construed as having negative self-esteem.

Several possible explanations existed for the finding that cesarean mothers' self-esteem did not differ from the self-esteem of mothers who delivered vaginally. First, the present study sample size was small, and data collection was limited to one institution. These factors could have influenced the results because contamination of the sample could have occurred. Nursing personnel and physicians were aware that research on this topic was in progress and may have been generally positive toward cesarean primiparas during the data collection period.

Secondly, the researcher could not control the self-esteem levels of the participants prior to data collection and had no way of assessing how much emotional support the mothers had received from significant others since

delivery. If the subjects had been given much positive feedback, their feelings of well-being could possibly have influenced how they perceived themselves.

Most importantly, the sample was limited to primiparas who were still hospitalized. While using primiparas was designed to eliminate previous attitudes toward childbirth, the general attitude of all subjects was that they were thrilled about being mothers for the first time. Several cesarean mothers commented that they did not care about the cesarean, but only about the baby. This feeling seemed reasonable when the emergency nature of the cesarean birth was considered. The fact that the subjects were still hospitalized meant that they had not had much time to reflect upon their birth experiences or to become discouraged by all the changes required during the early weeks at home. Cox and Smith's (1982) data collection occurred 1 month after delivery. During this month numerous extraneous variables could have influenced the subjects' feelings toward themselves.

Conclusions and Implications

The conclusion from this study was that there was no difference in the self-esteem levels of vaginal birth and cesarean birth primiparas. From this conclusion

nurses should realize that a cesarean birth alone may not lower a woman's self-esteem immediately after delivery. Rather, it is important that nurses be sensitive to the needs of each mother and individualize their care accordingly. Included in postpartal care should be an opportunity for each mother to share her thoughts about childbirth to a non-threatening person in a neutral environment.

Recommendations for Further Study

Based upon this study, the following recommendations for further study were made:

1. This study should be replicated using a larger sample and more than one institution for data collection.

2. A longitudinal study should be conducted that would measure a group of cesarean mothers' self-esteem immediately postpartum and 1 month later.

3. A study that controls for predelivery self-esteem levels should be conducted. This study would require measuring self-esteem prior to delivery, eliminating those subjects who had negative self-esteem before delivery, and measuring the remaining subjects' self-esteem postpartally.

APPENDIX A

Prospectus for Thesis
Approval Form

This proposal for a thesis by Betsy McCune

and entitled Self-Esteem in Primiparas: Vaginal Versus Cesarean Births

has been successfully defended and approved by the members of the Thesis Committee.

This research is X is not _____ exempt from approval by the Human Subjects Review Committee. If the research is exempt, the reason for its exemption is: It is in compliance with Category I of the Human Subjects Research Risk Category.

Thesis Committee: Jane Watson, Chairperson
Judith Henley, Member
Member

Date: 5/8/82

_____ Dean, College of Nursing

Date: _____

BVW/smu
10/14/81

APPENDIX B

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Betsy McCune
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.

Self Esteem in Primiparas: Vaginal Versus 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: 10-21-82

Signature of Agency Personnel

Betsy McCune
Signature of Student

Jane Watson
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 C

Study: Self-Esteem in Primiparas: Vaginal Versus Cesarean Births

I give my permission for Betsy McCune to include my patients as subjects in her master's thesis entitled Self-Esteem in Primiparas: Vaginal Versus Cesarean Births. I understand that this study will in no way minimize the quality or quantity of nursing care my patients receive, nor will it interfere with my medical treatment.

_____

Physician's Signature

_____

Date

APPENDIX D

Verbal Explanation to Subjects

My name is Betsy McCune and I would like to take a few minutes of your time. I am currently working on my master's degree, and it is in this area that I would like to solicit your assistance.

Currently I am studying the self-esteem of new mothers. From this study I hope to find out what we as nurses can do to better assist new mothers' adjustment to parenthood. To help me I would like you to complete a 10-item questionnaire which should require only 3 to 5 minutes of your time. You will be asked to choose one of four answers to the questions. There are no right or wrong answers.

You have the right to refuse to take this questionnaire. Should you decide not to participate there will be no effect on the quality of your care while you are a patient in this institution. On the other hand, agreement to help in the study does not give you extra benefits or care at any time. You will merely be helping me and possibly future new mothers who would benefit from help of some kind following delivery.

To assure that your answers will remain anonymous, you are asked not to sign your name on the questionnaires.

The only personal information you are asked to give is your age and whether or not you attended a class on cesarean childbirth. During the time you complete the questionnaire I will leave the room and try to minimize interruptions. When you have completed the questionnaire, you are asked to place it in an envelope and return it to me. Are there any questions?

APPENDIX E

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

Background Information

Your age:_____

Your marital status:_____

Did you attend a class on cesarean delivery:_____

APPENDIX F

Rosenburg Self-Esteem D-1 Scale

This copyrighted instrument may be obtained from the following company:

Princeton University Press

Princeton, New Jersey 08540

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