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**MOTHERS' SUPPORT AND MATERNAL ROLE  
ATTAINMENT IN FIRST-TIME MOTHERS**

**FAIZAH LEESEN**

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จาก

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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Thesis  
entitled

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IN FIRST-TIME MOTHERS**

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Maternal role attainment can enhance first-time mothers and their infants to have physical, psychosocial, and emotional well-being throughout their infants lives be good people in the future. This study was a descriptive research aimed to study the mothers' support and maternal role attainment in first-time mothers and to determine if mothers' support, age, family income, type of delivery, and infant health status have influence on determining the predictive power of maternal role attainment in first-time mothers. The sample consisted of 150 first-time mothers who lived in Satun Province during 4 to 8 weeks postpartum period while attending the postpartum clinic and the well baby clinic at Satun Hospital, Langu Hospital, Satun Municipality of Public Health Service Center. Moreover, home visits were done at the community of Kuandon District and Langu District. The data was collected in a three part questionnaire which included demographic data, mothers' support and maternal role attainment in first-time mothers. Data was analyzed by percentage, mean, standard deviation, Pearson' product moment correlation coefficient and stepwise multiple regression analysis.

The findings of this study showed that mothers' support was at a fairly good level and a good level of maternal role attainment. Multiple regression analysis revealed that mothers' support accounted for 15.2 percent of the variance of maternal role attainment.

The results suggested that nurses should encourage the first-time mothers' mothers, relatives, or close people to support the first-time mothers to establish maternal role attainment in the postpartum period.

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ฟาอิชะ หลีเส็น: การสนับสนุนจากมารดาของตนเองและความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก (MOTHERS' SUPPORT AND MATERNAL ROLE ATTAINMENT IN FIRST-TIME MOTHERS). คณะกรรมการควบคุมวิทยานิพนธ์: เขียวลักษณ์ เสรีเสถียร, พย.ค., สุปราณี อัทธเสรี, ค.ม., ยุพิน จันทร์คคะ, ค.ม. 94 หน้า. ISBN 974-665-042-4

ความสำเร็จในบทบาทการเป็นมารดา จะส่งผลให้มารดาและบุตรมีสุขภาพทางด้านร่างกาย จิตใจ อารมณ์ และสังคมที่ดี ตลอดจนทำให้บุตรมีการเจริญเติบโตดี และเป็นคนดีของสังคม การศึกษาครั้งนี้เป็นการศึกษาเชิงบรรยาย เพื่อศึกษาการสนับสนุนจากมารดาของตนเองและความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก และศึกษาอำนาจการทำนายของการสนับสนุนจากมารดาของตนเอง อายุ รายได้ของครอบครัว ชนิดของการคลอด และภาวะสุขภาพของบุตร ที่มีต่อความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก กลุ่มตัวอย่างเป็นมารดาที่มีบุตรคนแรกที่อยู่ในระยะ 4-8 สัปดาห์หลังคลอดในเขตจังหวัดสตูล ที่มารับการตรวจหลังคลอดที่คลินิกตรวจหลังคลอด หรือที่พานูตรมารับวัคซีนที่คลินิกเด็กดีใน โรงพยาบาลสตูล โรงพยาบาลละงู ศูนย์บริการสาธารณสุข เมืองสตูล และออกเยี่ยมบ้านกลุ่มตัวอย่างที่อยู่ในเขตอำเภอควนโดน และอำเภอละงู จำนวน 150 ราย เก็บรวบรวมข้อมูลด้วยตนเองโดยใช้ แบบสอบถามการสนับสนุนจากมารดาของตนเอง และแบบสอบถามความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก วิเคราะห์ข้อมูลด้วยการคำนวณ ค่าร้อยละ ค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน ค่าสัมประสิทธิ์สหสัมพันธ์พหุคูณ และวิเคราะห์ถดถอย พหุแบบขั้นตอน

ผลการวิจัยพบว่ากลุ่มตัวอย่างมีการสนับสนุนจากมารดาของตนเองค่อนข้างดี และมีความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรกอยู่ในระดับดี และพบว่า การสนับสนุนจากมารดาของตนเองเป็นปัจจัยเดียวในจำนวนห้าปัจจัยที่สามารถทำนายความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก ได้ร้อยละ 15.2 ( $p < .001$ )

ผู้วิจัยจึงมีข้อเสนอแนะว่า พยาบาลควรส่งเสริมให้มารดาหรือญาติหรือบุคคลใกล้ชิดของมารดาที่มีบุตรคนแรกให้การสนับสนุนและช่วยเหลือมารดาที่มีบุตรคนแรก เพื่อให้มารดาที่มีบุตรคนแรกสามารถประสบความสำเร็จในบทบาทการเป็นมารดาได้ดีต่อไป

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# CHAPTER I

## INTRODUCTION

### **Background and Significance of the Study**

Transition to the maternal role involves many adjustments in a woman's life. Transition to the maternal role is a period of reorganization in a woman's life that involves the addition of the mothering role to an established set of roles that vary according to the particular stage of life (Burr, Leigh, Day, & Constantine, 1979 cited by Mercer, 1985: 198). Especially, the first-time mothers require major adaptation changes (Pridham, Lytton, Chang, & Rutledge, 1991: 21). Acquiring the maternal role is a complicated process especially for first-time motherhood. Mothers must learn and adjust continuously to fulfill their expected role by interaction with their infants in accordance with the social context (Hardy & Conway, 1988: 66, Rubin, 1976a: 237-245), and mothers must learn to relate to and care for their new infant while their sense of self and relationship undergoes change (Chick & Meleis, 1986; Goldberg, 1988 cited by Pridham, Lytton, Chang, & Rutledge, 1991: 21). Maternal behavior that is sensitive and responsive to the infant is especially important for healthy, emotional development in the infant's first year (Ainsworth, Blehar, Waters, & Wall, 1978 cited by Walker, Crain & Thompson, 1986a: 352). Many first-time mothers experience feelings of inadequacy associated with their lack of knowledge about infants behavior, and the mother's interpretation of the infants cues has consequences for the infant. Inability to read cues accurately, may result in insufficient, inappropriate, or excessive stimulation of the infant, which has been associated with atypical infant behavior and

development (Flagler, 1988: 274). Inappropriate nourishing, child abuse, and neglect of the child are usually found as its consequence (Traus & Kramer, 1986: 459). A mother will use a magnitude of her own potentials and abilities to alter her physical, psychological and social entities to attain the maternal role and integrate into the role set as maternal identity (Mercer, 1981: 74; Walker, Crain, Chang, & Rutledge, 1986b, 69; Pridham, Lytton, Chang, & Rutledge, 1991: 21; Koniak-Griffin, 1993: 258; Zabielski, 1994: 12)

Mercer (1985: 198) explicates maternal role attainment (MRA) by defining it as a process in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother. If the first-time mothers attain the maternal role, they are happy and proud in the role taking. On the other hand, the mothers do not take the role may think they can not care for the infant they are non-responsive, feel confused and guilty. They also have low self-esteem because they feel uncertain and grief that they failed in the role and therefore distant the infant while most women achieve the role successfully, approximately one to two million mothers experience difficulty with the role, as evidenced by the number of abused or neglected children (Mercer, 1981: 73).

Several levels of adaptation are required as the process of role acquisition proceeds: adaptation at the physical or biological level, at the psychological or emotional level, at the cognitive level, and at the social level (Koniak-Griffin, 1993: 258). Maternal role attainment was evaluated by the feeling, perception, and behavior of the mothers. It is essential to be measured by 3 components which includes maternal-infant attachment, maternal role competence/confidence and maternal roles

gratification/satisfaction (Mercer, 1985: 198-204; Koniak-Griffin, 1993: 258, Meighan, Bee, Legge, & Oetting, 1998: 410). The description is as follows:

Maternal-infant attachment was the acceptance of the infant, concern, and interactive process between partners resulting in a satisfying experience. Emotional bond motivation, and parental commitment to care for the infant begins during pregnancy and continues after birth (Klaus & Kennell, 1982: 3; Mercer & Ferketich, 1990: 268; Bee, Legge, & Oetting, 1994: 393; Meighan, Bee, Legge, & Oetting, 1998: 411).

Immediately after birth, infants are particularly alert and responsive to their environment. The time period encompassing the first hours following delivery has been labeled as the "maternal sensitive period" because of the lasting effects this time can have on the mother-infant relationship (Klaus & Kennell, 1982: 87, Mercer & Ferketich, 1990: 268). Klaus & Kennell stated that touch, eye-to-eye contact, mother's voice, odor, entertainment, biorhythmicity, and reciprocity and synchrony are important.

The development of a healthy parent-child relationship in the early postpartal days and weeks increase optimal child growth and development. Poor attainment and bonding can lead to such disorders such as vulnerable child syndrome, child abuse, failure to thrive, and a disturbed parent-child relationship (Klaus & Kennell, 1982: 1-79, Babak & Jensen, 1993: 674-676). Similarly, Cropley (1979: 13) described the birth of high-risk infant or of a child to parents with physical or emotional difficulties can threaten the development of maternal attachment, increase the potential for problems which can lead to future risk situations, such as child abuse or failure to thrive. In addition, Green & Solnit (1964: 58-66) have suggested that high-risk situation such as

failure to thrive child abuse and neglect, and the vulnerable child syndrome are often related directly to disorders of maternal-infant attachment. By contrast, when secure attachment occurs, children grow up to be secure and self-reliant, trusting, cooperative, and helpful toward others. The securely attached child can be described as having a representational model of himself, both as able to help himself and as worthy of being helped should difficulties arise (Bowlby, 1979 cited by Dizon, 1984: 28).

**Maternal competence/confidence** was the acts or tasks of a mother is expected to perform in relation to her child are referred to as the maternal role. Thus, early maternal behaviors related to maternal performance involves tasks related to feedings, elimination, comfort, skin care, activity and health (Simone & Gottlieb, 1987: 21). The mothers' feelings of confidence in their ability to care for their infants is necessary for a healthy adaptation to parenthood and a positive mother-infant relationship (Zahr, 1991: 279). The study of Walker, Crain, & Thompson (1986b: 68-71) found that multiparas had more self-confidence and positive evaluations of self-as-mother than did primiparas, although primiparas' self-confidence increased more across the first 4 to 6 weeks postpartum.

**Maternal role gratification/satisfaction** was the feeling of enjoyment, reward, or pleasure that a woman experiences in interacting with her infant and in fulfilling the usual tasks inherent in mothering (Bee, Legge, & Oetting, 1994: 405; Koniak-Griffin, 1993: 257-261; Meighan, Bee, Legge, & Oetting, 1998: 393). The study of Mercer (1985: 198 –204) found that in a primiparous sample, gratification in the maternal role increased from 1 to 4 months postpartum but decreased for younger mothers (ages 15-19, 20-29, 30-42).

Women come to the task of parenting a new baby from different life contexts and with varying personal reassurance that affects the role-taking process (Mercer, 1981: 73), especially in first-time mothers. Accordingly those who do not have experience in infant care, they must be adaptable to provide infant care as established by Steele & Pollock (1968 cited by Bobak & Jensen, 1993: 672). They also described parenting as one process with two components. The first being practical or mechanical in nature involves cognitive and motor skill. The second, is emotional in nature which involves cognitive and affective skill.

Maternal role attainment in first-time mothers depends on many factors which Mercer (1981: 73-77, 1985: 198-199, 1986: 9-13; Bee, Legge, & Oetting, 1994: 393-394) describes as the ease or difficulty with which a woman takes on the mothering role is influenced by both situational or environmental factors and individual factors that include mother and infant factors. For situational or environmental factors, those are events that occur such as family context, the partner relationship, social support, and social stress. The individual factors contain maternal and infant factors. Maternal factors are age, education level, family income, marital status, etc., and infant factors are health status, ability to give cues, responsiveness, etc. (Mercer, 1986: 12; Grace, 1993: 431-432; Mercer & Ferketich, 1995: 334).

As mentioned, the researcher was interested in studying the factors that influence the maternal role attainment in first-time mothers. This includes situational or environmental factors such as mothers' support. The maternal factors are age, family income and type of delivery and the infant factor is infant health status. It is described as follows:

House (1981 cited by Tilden, 1985: 201) referred to an important contribution to the definition of social support in two ways. First, he structured the definition issue as who gives what to whom regarding which problems. Second, he reviewed definitions of social support in the literature, noting the range of aspects, the common themes, and the point of divergence. He offered a four-part definition of social support that subsumed all subconcepts of other definitions: emotional support, appraisal support, informational support, and instrumental support. If the first-time mothers receive mothers' support as describes by House's conceptual framework, they will attain the maternal role.

**Mothers' support** is situational or environmental factors which includes support from their mothers who is in a closed bloodline, they were cared for and loved and they want to help to the fullest. Moreover, their mothers had experience, therefore they are appropriate helpers. **Emotional support:** when the first-time mothers become bored, their mothers encourage esteem, trust, concern and they are great listeners. **Appraisal support:** their mothers express admiration to correct behavior, provided consistent feedback about behavior and performance for the first-time mothers to evaluate themselves. They have confidence in themselves to nurture infant care and respond to the infant as well. In addition, first-time mothers compare their behaviors with other first-time mothers to evaluate themselves. **Informational support:** to give advice about the skill to care for the infant, such as bathing, feeding, etc. The first-time mothers receive advising about physical psychological, emotional, and social solving behaviors. **Instrumental support:** involves direct did for homework, and care for the infant sometimes, the giving of material supplies, services, time, and money (Flaherty, Facticeau & Garver, 1987: 61-73). If the first-time

mothers receive support from their mothers according to the conceptual framework of House as mentioned they will reduce their difficulty in the maternal role through their confidence in giving infant care. Thus, the first-time mothers are happy and satisfied with good maternal-infant attachment. Finally, the first-time mothers attain the maternal role. The study of Sriyasak (1996: 74) found that most of social support in adolescent mothers were their mothers. Similarly with the study of Parawech, (1989: 32) who found that mothers' support had positive significant relationship to adaptation in adolescent mothers.

Furthermore, the researcher selected the maternal and infant factors that may be influenced to the maternal role attainment in first-time mothers that includes maternal factors such as age, family income, and type of delivery and an infant factor, such as infant health status.

**Age** is measure of person maturity. It is the social acceptance of the maternal role as an adult role which can be inappropriate for the psychosocially immature teenager (Mercer, 1981: 74). In addition, young mothers are considered to be at a higher risk than adult women in parenting because they are often psychologically immature, lack of knowledge about child growth and development and have normal developmental need that may conflict with their infants (Koniak Griffin, 1993: 258). Semilary with the study of Mercer (1986 cited by Koniak-Griffin, 1993: 259) who found teenagers had fewer psychosocial assets for performing the role than older women.

**Family income** is an important indicator of economic and social conditions of the first-time mothers. The difference of family income may impact on the maternal

role attainment in first-time mothers. The study of Varachnonth (1998: 75) found that family income was statistically significant with adaptation in postpartum mothers.

**Type of delivery** is an important factor to maternal role attainment in first-time mothers. Women who have a cesarean describe greater disappointment in their loss of an optimal delivery experience, feelings of defeat, and greater body-image distortions than women who deliver vaginally (Birdsong, 1981; Mercer & Marut, 1981 cited by Mercer, Hackley & Bostrom, 1983: 203). For instance, mothers who had cesarean sections are not only patients, but they must be responsive to the infant, spouse and family members in which their bodies were not ready for the task (May & Mahlmeister, 1990: 118; Sherwen, 1993: 728). On the other hand, mothers who had vaginal delivery attach with their infant early after delivery. Therefore, they are immediately confident and more satisfied than mothers who had cesarean sections.

**Infant health status** is the last factor that may be influenced to maternal role attainment in first-time mothers. Accordingly the infant who has an illness causing a physical abnormality or a low birth weight that may cause maternal-infant separation may have a problem with the attachment process. As mentioned the mothers may have difficulty in maternal role attainment. Similarly, Rujiraprasert (1996: 60) found that infant health condition had a negative significant relationship with maternal role attainment in mothers of low birth weight infants.

In summary, the first-time mothers may have difficulty in maternal role attainment. Mercer said mothers who achieve competence in the role and integrates the mothering behaviors into her established role set, may be comfortable with her identity as a mother. However, it depends on situational or environmental, and individual factors. Thus, the researcher was interested in studying the power of

predictability of mothers' support and basic characteristic factors such as age, family income, type of delivery, and infant health status to maternal role attainment in first-time mothers. Expecting the results of this study, it will be crucially utilized as a guideline for further formulation of a nursing plan, as well as to bring about the effectiveness of competency development in terms of maternal role attainment.

### **Research Question**

Do mothers' support, age, family income, type of delivery, and infant health status have influence to determine the predictive power of maternal role attainment in first-time mothers?

### **Purpose of the Study**

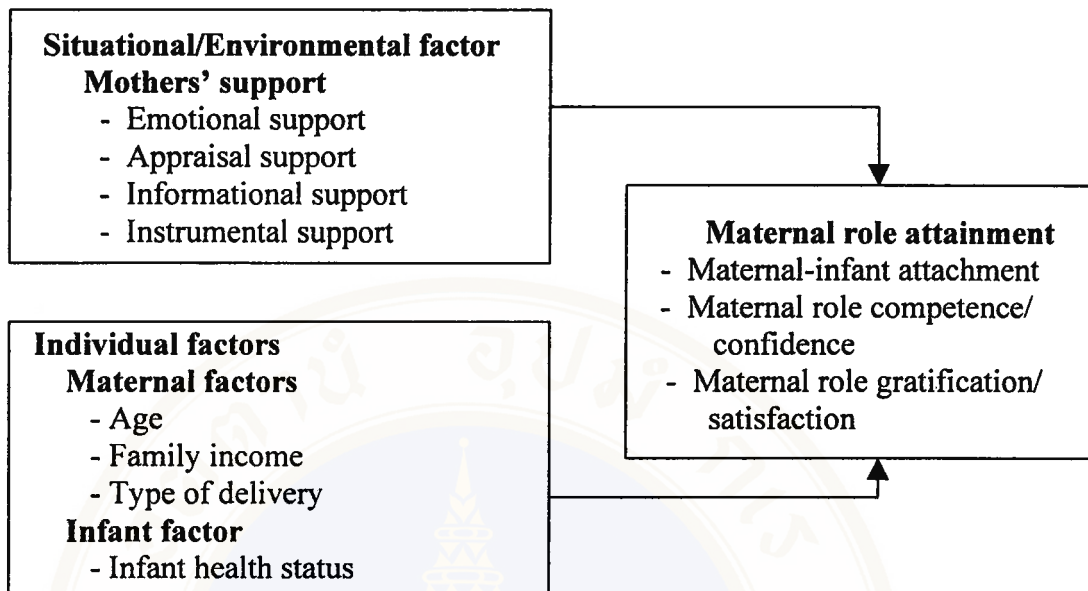
1. To study the mothers' support and maternal role attainment in first-time mothers.
2. To determine the predictive power of predictor variables; age, family income, type of delivery, infant health status, and mothers' support to maternal role attainment in first-time mothers.

### **Conceptual Framework**

Parenting is a complex process encompassing various tasks, attitudes, and responsibilities through which a mature adult tasks on the care of a dependent child (Cohen, Kenner, Hollingsworth, 1991: 1074). Especially, first-time mothers may have difficulty with the maternal role. Thus, the mothers must be adaptive to the situation and the new role and to attain appropriate effectiveness in the maternal role.

Mercer (1985: 198-204) said that the maternal role attainment is developmental task during pregnancy and continues postpartum, which use highly qualified adaptation at the physical or biological level, at the psychological or emotional level, at the cognitive level, and at the social level by including three components. 1) maternal-infant attachment by acceptance, attention and interaction 2) maternal role competence/confidence in which the skill of the role-takings related to feeding, elimination, comfort, skin care, activity and health through assessment of the infant care needs (Simone & Gottlieb, 1987: 21-25), and 3) maternal role gratification /satisfaction in which mothers have enjoyment, rewardment, or pleasure (Bee, Legge, & Oetting., 1994: 393; Koniak-Griffin, 1993: 257-261; Meighan, Bee, Legge, & Oetting, 1998: 408–411). Moreover, Mercer (1981: 73-77, 1985: 198–199) refers to influential factors of maternal role attainment by situation or environment factors that include mothers' support; maternal factors that include age, family income, and type of delivery; and an infant factor that include infant health status.

In this study, the researcher was interested in mothers' support and maternal role attainment in first-time mothers through age, family income, type of delivery, infant health status, and mothers' support to determine the predictive power of maternal role attainment in first-time mothers. The correlation among variables affecting Mercer's conceptual framework is shown in Figure 1.



**Figure 1.** Conceptual framework adapted from conceptual framework of Mercer (1985)

### Hypothesis

Mothers' support, age, family income, type of delivery, and infant health status are factors revealed to predict maternal role attainment in first-time mothers.

### Scope of the Study

This research was to study the factors influencing maternal role attainment in first-time mothers. The subjects for this study were first-time mothers 4 to 8 weeks during their postpartum period who had followed up at postpartum clinic or well baby clinic of Satun Hospital, Langu Hospital, and Satun Municipality of Public Health Service Center. The mothers lived in community of Kuandon District, and specially at

Langu District who did not come to follow up at Langu Hospital that were home visited by researcher.

### **Definition of Terms**

1. Maternal role attainment is defined as an intersectional and developmental process that occurs over a period of time during which the mothers become attached to their infants. This acquires competence in the care taking task involved in the role. The movement to the personal state in which the mothers experience a sense of harmony, confidence, and competence in how she performs the role is the end point of maternal role attainment-maternal identity. This was evaluated by the questionnaires of Sookkavanawat (1998) which modified from the researcher categorized these into 3 components as follows:

1.1 Maternal-infant attachment is viewed as a process in which an enduring affectional and emotional commitment to an individual is formed. Sookhavanawat adapted to base on the conceptual framework of Klaus & Kennell (1982), and developed by the Maternal Attachment Inventory (MAI) of Muller (1994).

1.2 Maternal role competence/confident is the first-time mothers' feeling and behavior to able in skill of infant care related to feeding, elimination, comfort, skin care, activity and health. Sookhavanawat adapted from Perceived Maternal Task Performance Scale (PMTPS) of Perry (1985) was developed by Simone & Gottlieb (1987).

1.3 Maternal role gratification /satisfaction is the sense of enjoyment reward, or pleasure that mothers experience in interacting with their infants and in



fulfilling the usual task inherent in mothering. Sookhavanawat adapted from Gratification Checklist of Russell (1974)

2. Mothers' support is the sense of the first-time mothers with receive helping from their mothers during the postpartum period which is based on the conceptual framework of House (1981) which consists of 4 parts as follows:

2.1 Emotional support is the perception of the first-time mothers about receiving of encouragement in which esteem, affect, trust, concern, and listening from their mothers.

2.2 Appraisal support is the perception of the first-time mothers about receiving of encouragement in which affirmation, feedback, and social comparison from their mothers.

2.3 Informational support is the perception of the first-time mothers about receiving of encouragement in which advice, suggestion, directives, and information from their mothers.

2.4 Instrumental support is the perception of the first-time mothers about receiving of encouragement in which did in kind, money, labor, time, and modifying environment from their mothers.

3. Age is defined as a full year of first-time mothers' age that start to count since the date of birth up to date of study.

4. Family income is defined as the average income per month of first-times mothers and spouses or only one person if one person has no employment as counted in baht per month.

5. Type of delivery is defined as the ways of delivery which consists of vaginal delivery and cesarean section.

5.1 Vaginal delivery is defined as normal labor, forceps extraction, and vacuum extraction.

5.2 Cesarean section is defined as the operative abdominal labor.

6. Infant health status is defined as the condition of the infant evaluated from birth at 4 to 8 weeks postpartum. It has 2 categories.

6.1 With health problems that is defined as an illness or physical abnormality of the infants causing maternal-infant separation that interferes with the attachment process.

6.2 Without health problems is defined as an infant well beings after birth.

### **Expected Outcomes and Benefits**

1. Nurses may use the results of this study as a basic information to promote maternal role attainment in first-time mothers.

2. The results of this study can be used as a guidelines for further studies in other topics for the development of maternal role attainment.

## CHAPTER II

### LITERATURE REVIEW

A study of mothers' support and maternal role attainment in first-time mothers, and power of prediction factors that include age, family income, type of delivery, infant health status, and mothers' support to maternal role attainment in first-time mothers. The components of review of the literature consists of the following topics:

- Maternal role attainment in first-time mothers
- Influential factors on maternal role attainment in first-time mothers

#### **Maternal role attainment in first-time mothers**

Becoming a mother is described as the major transition point in a woman's life (Rossi, 1968: 26-29) which refers to a crisis inherent in becoming a mother and claims these crises result in a intrapsychic reorganization (Bibring, 1959 cited by Zabielski, 1994: 5). Especially in first-time mothers, 1 to 2 months after birth is the consolidation period. Maternal role behavior was developed with maternal role attachment so that it is translated to the maternal role with difficulty in the role performance. (Rubin, 1977: 67-75). The transition to the maternal role is a period of reorganization in a woman's life that involves the addition of the mothering role to an established set of roles that vary according to their particular stage of life (Mercer, 1985: 198). Because of the maternal role attainment is a complex cognitive-affective process (Walker, Crain, & Thompson, 1986a: 352). Thus, first-time mothers who have no experience in infant care must learn new behaviors and coping skills. They

may feel inadequate maternal role taking process (Grace, 1993: 431-439). First-time mothers should receive help to for reduce the difficulty in these problems, especially in infant care. Maternal-infant attachment, and a sensitive awareness of their infants' needs and patterns of expressing those needs, and establishment an emotional linkage to their infants (Walker, Crain, & Thompson, 1986a: 352) as maternal self-confidence in caregiving especially important for a healthy emotional development in the infants' first year (Ainsworth, Blehar, Waters, & Wall, 1978 cited by Walker, Crain, & Thompson, 1986a: 352).

### **Concept of maternal role attainment**

First-time mothers can do the tasks and responsibilities to complete the maternal role, far from being an intuitive feminine function. This is a complex social and cognitive process by experience from infant, emotional maturity and attitude, agreement, social value and closer (Rubin, 1967a: 237; Steels & Pollock, 1968 cited by Jensen & Bobak, 1985: 672). Thus, becoming a mother is described as the major transition point in a woman's life (Rossi, 1968: 26-29) which a new role of person depends on role process. This consist of role expectations and role perception (Sabin, 1954 cited by Zabielski, 1994: 4). However, maternal role which occurred and developed by role expectations which are seted by social norms and status in each social or culture in which explanation to maternal role was not clear for practice. So, while most of women achieve the role successfully, approximately one to two million mothers experience difficulty with the role, as evidence by the number of abused or neglected children (Mercer, 1981: 73).

Rubin (1967a: 237-245, 1967b: 342-346) is the earliest description of the process of maternal role attainment. It is a process of maternal behavior during pregnancy and continues through infancy until the identity of the child and the reciprocal maternal identity are fully constructed. Formulation of a maternal identity marks the culmination of the process of MRA (maternal role attainment). Several behaviors are used by mothers to learn the maternal role which consist of five stages include mimicry, role play, fantasy, introjection–projection–rejection, and grief work.

Later, Mercer (1981: 73–74, 1985: 198–204) studied and developed framework of the maternal role attainment of Rubin, (1976a) and social role acquisition of Thronton & Nardi (1975). The MRA develops over four stages- anticipatory, formal, informal, and personal. The anticipatory stage is the period prior to incumbency when an individual begins social and psychological adjustment to the role by learning the expectations of the role. The formal stage begins with actual incumbency during which role behaviors are largely guided by formal, consensual expectations of others in the individual's social system. The informal stage begins as the individual develops unique ways of dealing with the role that are not conveyed by the social system. During the final, or personal, stage of role performance and others largely accept the enactment; maternal role is achieved (Mercer, 1981: 74, 1985: 198; Grace, 1993: 436; Bee, Legge, & Oetting, 1994: 396; Mercer & Ferketich, 1995: 333–334; Meighan, Bee, Legge, & Oetting, 1998: 412).

Thus, the first-time mothers develop the role until they are able to feel a congruence of self and as others accept their role performance which is the endpoint of maternal role attainment–maternal role identity refer to Mercer (1985: 198) defined maternal role attainment as process in which the mother achieves competence in the

role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother. Moreover, maternal attainment is a complex cognitive–affective process (Walker, Crain, & Thompson, 1986a: 352). Its origin is in a woman’s own experience of being mothered (Benedek, 1956: 272–278) and gradually proceeds throughout pregnancy, culminating with the attainment of a maternal identity sometime during the first year after delivery (Rubin, 1976b: 342–346). Furthermore, Mercer (1985: 198–204) conducted a longitudinal study of first-time mothers in the process of maternal role attainment during the first year of motherhood and found maternal role attainment occurs continually. The first three months to balances the physio-biological aspect of the infant in which feeding, sleeping and elimination is achieved through stimulation until ten months of infant–maternal identity occurs. Similarly with study of Pridham and Chang (1989 cited by Grace, 1993: 432) reported increased maternal self–evaluation scores between 1 week and 3 months postpartum and decreasing scores for centrality of the baby. However, this time of period is different for each person. In postpartum, it is comparable to point of the mothers role–taking to infant. By 2 to 3 days after birth, a woman’s estimation of her parenting abilities is an early indicator of maternal role attainment. Women who verbalize satisfaction with early parenting efforts are more likely to achieve the maternal role in a smooth, predictable manner (May & Mahlmeister, 1990: 1089; Reeder, Martin, & Koniak, 1992: 606). Four to eight weeks postpartum is important to develop maternal attachment. If first–time mothers achieve the maternal role in a smooth and appropriate manner, they are confident and proud in their maternal role. This is important to the developmental, physical, psychosocial, and well–being. They can appropriately show emotion and behavior. Maternal role attainment is evaluated

by a sense and behavior using the conceptual framework maternal role attainment of Mercer. It has 3 components--maternal-infant attachment, maternal role competence/confidence, and maternal role gratification/satisfaction (Koniak-Griffin, 1993: 258; Sherwen, Scoloveno, & Weingarten, 1995: 646; Bee, Legge, & Oetting, 1994: 395) are described as follows:

**1. Maternal-infant attachment:** A mother's affectionate to her infant as recognized as a major contributor to the child's health, growth and development (Koniak-Griffin, 1993: 257). The mothers have a sense of the behavior of the infant in which acceptant, fulfillment, nurturing, and bonding occur. Klaus & Kennell (1982: 72-82) suggested that maternal-infant attachment in the first days of an infant's life, especially at the first hour after birth, is an important and sensitive period in which maternal-infant attachment occurs. The first-time mothers can perform touch and eye-to-eye contact. Also, the mother's voice, odor, entrainment, biorhythmicity, reciprocity and synchrony first occurs (Klaus & Kennell, 1982: 87). This in turn evokes a response from the infant. In addition, Muller (1994: 130) defined maternal attachment as the unique, affectionate relationship that develops between a woman and her infant that persists over time.

Thus, if first-time mothers have a positive relationship between the infant, they provide effective care to the infant. The infant receives lovingly and appropriately care to promote growth and well-being. By contrast, poor attachment and bonding can lead to such disorders as vulnerable child syndrome, child abuse, failure to thrive and disturbed parent-child relationship. These children trend to be anxious or insecure individuals, usually described as overdependent or immature (Cropley, 1979: 15, Klaus & Kennell, 1982 cited by Dizon, 1984: 28)

**2. Maternal role competence/confidence:** Mother's skill and interactions in the care of the infant promotes the infant's development. It may be measured either by an observer who rates maternal behaviors or by the woman's perceived competence in the role (Mercer, 1985: 198, 1986: 9–10). It includes the skills and tasks involved in fostering the physical, social and psychological development of the child related to feeding, elimination, comfort, skin care, activity and health (Simone & Gottlieb, 1987: 21). Also, the cognitive skills in which the behavior of the infant is perceived by the mother's ability to read her infant's behavioral cues is known as maternal role confidence (Walker, Crain, & Thompson, 1986b: 69; Flagler, 1988: 274; Zahr, 1991: 280). Nurturing the infant is as follows:

**2.1 Feeding:** The food of choice for an infant under 6 months of age is milk, either human milk or prepared formula, both of which provide all known nutritional requirements, with the possible exception of Vitamin D and fluoride for breast milk. Human milk and formula also provides an optimal balance of carbohydrate, protein, and fat in a readily digested form (Mott, James, & Sperhac, 1990: 152). However, breast milk is a best food for infants because it enhances maternal role attainment.

**2.2 Elimination:** The infant can have frequency of elimination. The infants should be washed with clean water and dried well with each diaper change to prevent the infant's skin from causing a diaper rash. Diaper rash has numerous causes, including contact with ammonia or acid from urine and feces (Mott, James, & Sperhac, 1990: 150; Pillitteri, 1992: 675). In addition, the mothers should observe for abnormality of elimination.

### 2.3 Comfort consists of the following:

2.3.1 Sleep: The arrangement of the infant's room is determined by the furniture and the space available. The room should be well ventilated and well lighted. The bed room is quiet during the day and is probably one of the calmer rooms in the house (Cohen & Goirand, 1982: 90–91). Besides, the windows should be draft-free and screened to keep out insects and rats. The infant should be positioned on alternate sides following feeding, to keep respiratory secretions or mucus from collecting or pooling and to prevent flattening of one side of the infant's head (Pillitteri, 1981: 49–501).

2.3.2 Clothing: The amount of clothing the infant wears is determined by the temperature. Thus, mothers should use only enough clothing to keep her infant comfortably warm. The less clothing the baby wears, the easier it is to dress him and the infant will have greater freedom to move and exercise. Infants need only to wear a T-shirt, diaper (diaper cover or plastic pants if using cloth diaper), and a sleeper. On a fairly cool day, the infant should also be wrapped in a light blanket while being fed (Pillitteri, 1981: 50 ; Ladewig , London, & Olds, 1994: 625).

2.3.3 Crying: For the infants, crying is only means of expressing their needs vocally. The mothers learn to distinguish different tones and qualities of the infant's cry, such as the amount and sound of the cry which can be highly individual. Some will cry as little as 15 to 30 minutes in 24 hours, or as long as 2 hours every 24 hours. When crying continues even after comfort, sometimes the infant cries because he wants the mother's attention (Cohen & Goirand, 1982: 173–176; Ladewig, London, & Olds, 1994: 629). However, first-time mothers must learn the infant's needs and have a positive response to their infants.

2.4 Skin care: The bath is an important moment in the infant's day. Bathing is the best way to avoid skin problems so that the infant should be bathed twice a day and should be cleaned with a soft, clean washcloth, warm water, and mild soap. Do not bath the infant immediately after feeding time because the extra activity may cause digestive problems and might result in burping up the last feeding. Consequently, the bath depends on the condition of the infant's skin and temperature of the environment (Cohen & Goirand, 1982: 172–179; Pillitteri, 1981: 502; Phillips, 1996: 336–337).

2.5 Activity: Play is the dominant waking activity of the infant. Play during infancy is an important way of practicing motor skill and becoming acquainted with the environment. Thus, first-time mothers need to learn to interact with their infant during alert times. The infant does not need expensive toys and equipment for stimulation. They also respond to black geometric figures on a white background. Skin to skin contact is especially appreciated by the infant. Moreover, first-time mothers should hold the infant as usual. First-time mothers should provide appropriately-age play toys to the infant for growth and development (Scipien, Chard, Howe, & Barnard, 1990: 71; DiDona & Marks, 1996: 329; Vichitsukon, 1989: 89–105).

2.6 Health: The first-time mothers need to be aware that newborns “scoot” (the crawl reflex). Thus, they are prone to falling from an elevated surface (e.g., bed) if precautions are not taking. Neonates also require protection against other environmental hazards, such as exposure to cold or excessive heat (e.g., a too warm bath, sun exposure), and pillows or other objects which can cause suffocation

(Scipien, Chard, Howe, & Barnard, 1990: 70-72). In addition, the first-time mothers take the babies to see the doctor for vaccinations on appointment or abnormal acts.

The study of Mercer (1985: 198–204) found maternal competency behaviors increased from 1 to 4 months, but 4-month mean scores were higher than 8- and 12-month mean scores. These findings, coupled with qualitative data, indicated that the decline was due to new competencies required to care for the older infant.

**3. Maternal role gratification/satisfaction:** A sense of first-time mothers to accept the role, enjoyment, reward, or pleasure that the mothers experience in interacting with their infants. In fulfilling the usual tasks inherent to mothering (Bee, Legge, & Oetting, 1994: 393; Meighan, Bee, Legge, & Oetting, 1998: 410). The study of Adams (1963: 72-77) found the mothers who observed their infants behavior had a trend of being a better mother. This was concluded because they understood their infants need and provided what was needs. Grace (1993: 431–439) studied the development of the maternal role for primiparas (n = 29) at 1, 3, 4 ½, and 6 months postpartum. She found that mothers who were satisfied with their role performance and had increased gratification of mothering over time was consistent with movement toward the personal stage of maternal role development. Here performance pleases self as well as others.

As mentioned, first-time mothers must receive the knowledge and motor skills for nurturing the infant. They will become confident and competent in maternal role attainment. Thus, first-time mothers must have these factors to enhance, support, or cope with problems and to appropriately and effectively achieve the maternal role.

### **Influential factors on maternal role attainment in first-time mothers**

Mercer (1986: 9) said that the ease or difficulty which a woman take on the mothering role is influenced by both situational or environmental and individual factors which are described as follows:

1. Situational or environmental factors are events that occur and effect the maternal role attainment, including mother–father relationship, social support, family functioning, and stress (Koniak–Griffin, 1993: 258–260; Mercer, 1991 cited by Meighan, Bee, Legge, & Oetting, 1998: 413).

2. Individual factors are personal characteristics that include maternal and infant factors,

2.1 Maternal factors, such as attitudes, pregnancy or birth experience, health, depression or anxiety, age, family income, socioeconomic status (SES), marital status, type of delivery, infant care experience, etc. (Mercer, 1981: 74–76, 1985: 198, 1986: 12; Mercer & Ferketich, 1995: 334).

2.2 Infant factors, such as temperament, appearance, characteristics, responsiveness, infant health status, etc.

In this study, the researcher selects some factors that are expected influence maternal role attainment in first-time mothers. This includes situational or environmental factors, such as their mothers' support from which they have a close social network with. Maternal factors, such as age, family income, and type of delivery and the infant factor of infant health status were studied.

### **Mothers' support and maternal role attainment in first-time mothers**

Maternal influence is more apparent when the daughters becomes mothers. Flaherty (1988: 191) said the relationship between mother and daughter is highly significant and affects women throughout their lives. A mother is the first mediator of the environment for a daughter. Through very subtle cues from her mother, a daughter first learns what is expected of her by her culture. Accordingly, their mothers' experience is to give support in other aspects. In addition, Sherwen, Scoloveno, & Weingarten (1995: 655) described helpful grandparenting behaviors that included supporting the new mother and father in parenting activities, helping run the household while the mother recuperates from childbirth, providing additional attention to older children, avoiding putting parents in conflicting situations concerning childcare advice, and passing on appropriate family rituals, such as baptism or bris (ritual male circum cision). Moreover, Burr, et at. (1979 cited by Mercer, 1986: 21) said the positive feedback from significant others in the environment regarding role performance enhances the quality of role enactment. Similarly, Cobb (1976: 300) 's definition of social support as leads to the belief that one is cared for, loved, esteemed, valued, and part of a network of communication and mutual obligation. In contrast, Kahn and Antonucci (1980 cited by House, 1981: 16) defined social support as interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid.

Nevertheless, House (1981: 22) offered a four-part definition of social support that includes emotional support, appraisal support, informational support, and instrumental support. For first-time mothers, their mother is the one who will strongly

and effectively enhance adaptation to the role of the maternal role, Mothers' support according to the concept of House' social support is described as follows:

**1. Emotional support:** The mothers who give love, concern, and attention will encourage esteem for first-time mothers. Listening to problems helps first-time mothers to achieve conduct to maternal role attainment. House (1981: 24) agrees with Gottlieb (1978 cited by House, 1981: 24) that emotional support is the most important aspect in buffering stress and facilitating health, Mercer (1986: 9–12) studied the power of prediction in maternal role attainment in first-time mothers at 1,4,8, and 12 months and found which maternal age differences were important. That the teenager group who provided only emotional support correlated significantly with maternal behavior, and the emotional support to the teenagers' maternal attitudes was much stronger (control of child's aggressive response).

**2. Appraisal support:** Mothers help to understand the events that occur to first-time mothers. Besides, mothers help with informational behavior, in agreeing with first-time mothers to evaluate themselves by comparison with other first-time mothers. It can make first-time mothers confident, and feel they are a part of the social system to achieve the maternal role.

**3. Informational support:** After birth, first-time mothers might have problems in how to take care of themselves accordingly. They lack knowledge and experience and need a person who can give to advice on how to care for themselves and their infants, Thus, first-time mothers receive information from their mothers because they know how to nurture the infants and reduced stress. Mothers are closely attached in the maternal role because they are confident in their competence, and become satisfied in the maternal role.

**4. Instrumental support:** The direct help first-time mothers need, including helping with tasks and infant care because they need their rest. In some families, first-time mothers quit working, which can cause socioeconomic problems. If first-time mothers receive help from their mothers in the form of money, they progress to achieve the maternal role. In addition, spending time with first-time mothers, such as being their friend or going to the hospital with for their follow up at postpartum clinic, is important. As mentions, instrumental support from their mothers will help first-time mothers to achieve the maternal role. Similarly with the study of Cronenwett (1985: 98) who found that access to instrumental support had a positive association with postpartum outcomes.

In summary, the postpartum mothers who lack their mothers' support and resources, may produce a crisis for the new parents, especially for first-time mothers during the first year after childbirth. Lack of support is linked with impaired physiologic and emotional recovery and potential impairment in maternal role attainment (Weiss, 1974: 23–24 cited by Dimond & Jones, 1983: 146; Driscoll, 1990: 1-10) also Curry (1983: 115-121) found that mothers who lacked social support had difficulty in adjusting to parenthood. If first-time mothers receive support from their mothers according to the conceptual framework of House, they achieve the maternal role. The study of Parawech (1989: 62) found mothers' had support was positive significant relationship with adaptation in adolescent mothers. Similarly, Sriyasak (1996: 106) found that families' support, especially mothers' support had a positive significant relationship with adaptation in adolescent mothers Thus, mothers' support should be an influential factor in maternal role attainment in first-time mothers.

Furthermore, the researcher selected the individual influential factors that are expected to achieve maternal role attainment. Maternal factors include age, family income, and type of delivery. Infant factor includes infant health status. They are described as follows:

**Age.** The social acceptance of the maternal role as an adult role may be inappropriate for the psychosocially immature teenager (Mercer, 1981: 74). Accordingly young mothers lack knowledge about child growth and development and have normal developmental needs that may conflict with their infants (Koniak-Griffin, 1993: 258). Thus, older mothers are more ready than younger mothers. Mercer (1986: 9–32) studied 294 first-time mothers aged 15 to 42 found that mothers 20–29 years of age were significant gratification the mothering role. As reasons, maternal age may be predicted maternal competence during the first year. Besides, Jones, et al. (1980: 579–584) suggested a lack of readiness for the role in the younger mother. They observed that mothers under 19 year of age less than older mothers and were less sensitive in responding to their infants. Kamolsunthom (1993: 82) found that maternal age had a positive significant relationship with adaptation in primigravida.

**Family income.** People who have a high family income have the opportunity to seek good facilities and had greater resources available and knowledge better than a people who have a low income (Pender, 1987: 161–162). Cohen, Kenner, Hollingsworth (1991: 1081) said that the family with limited finances may be unable to obtain necessities for the child, which can makes them more vulnerable to stress and sets the stage for problems in the couple's relationship and the parent-child relationship. The study of Varachnonth (1998: 63) found that family income had a positive significant relationship with adaptation of postpartum mothers. Similarly,

Walker, Crain, & Thompson (1986a: 354) found that socioeconomic status was significantly related to both behavioral ratings and subjective component.

**Type of delivery.** A woman's feeling about her childbearing experience may influence her feelings about the maternal role. Fawcett, Pollio, & Tully (1992: 439) referred that most researchers found that cesarean delivered women felt less positive about childbirth (Marut & Mercer, 1979: 260-266; Mercer, Hackley, & Bostrom, 1983: 202-207), were less satisfied with their experiences (Bradley, Ross, & Warnyca, 1983: 79-83; Kearney, Cronenwett, & Reinhardt, 1990: 97-103), and enjoyed childbirth less than vaginally delivered women (Norr, Block, Charles, Meyering, & Meyers, 1977: 260-275). Other investigators reported that revealed that women who had cesarean deliveries may feel like failures because they could not give birth vaginally and may even blame their infants for the operative delivery and subsequent postpartum pain and emotional distress (Affonso & Stichler, 1978: 88-94, Marut & Mercer, 1979: 260-266). Moreover, the mothers who had cesarean sections felt negatively towards themselves and had a low self esteem (Dickason, Schult, & Silverman, 1990: 224). Mothers who had cesarean sections were also a patient after an operation. However, they had responsively nurtured the infant (Pillitteri, 1992: 557). Thus, first-time mothers who had cesarean sections delayed the maternal role attainment more than vaginal delivery. Abused children are reported to have a cesarean birth rate much higher than the general population (Helfer, 1975 cited by Mercer, 1981: 75). In conclusion the type of delivery may be a influential factor on the maternal role attainment.

**Infant health status.** It is the condition of the infant after delivery. Low birth weight, physical abnormalities, and illnesses may interfere with the attachment process (Bee, Legge, & Oetting, 1994: 393). When first-time mothers are separated

from their infants due to infant illness or physical abnormality, there is an increased risk for problems in achieving the maternal role (Koniak-Griffin, 1993: 259). Moreover, if the infant's illness requires hospitalization, it may also lead to a brief or long period of maternal-infant separation. If early infant illness is severe, the mother may withhold affection or avoid contact in fear that the infant might die. A higher rate of infant illness was reported as a variable in child abuse (Mercer, 1981: 76). Similarly with the study of Rujiraprasert (1996: 60) found that the infants' condition had a negative significant relationship with maternal role attainment in infants of low birth weight. In contrast, the study of Sriyasak (1996: 86) found that sick infants and healthy infants were not significantly different with adaptation in adolescent mothers. Thus, infant health status is an influential factor on maternal role attainment in first-time mothers.

In summary, first-time mothers that achieve competence in their role and integrate the mothering behaviors into their established role set, are comfortable with their identity as a mother. On the other hand, if first-time mothers can not achieve the maternal role they feel stress, tired, boredom, and failure with the maternal role. It impacts physically and psychosocially of the infant in the future. Enhancement that first-time mothers achieve the maternal role must know the influential factors to be correctly enhanced. Thus, in this study, the researcher selected the factors that expected to have influence on the maternal role attainment. Age, family income, type of delivery, infant health status, and mothers' support can achieve the maternal role in first-time mothers and once achieved the mothers are happy with their new role.

## CHAPTER III

### METHODOLOGY

#### Research Design

This study was a descriptive research. The purpose of this study described maternal role attainment in first-time mothers, and determined the predictive power of age, family income, type of delivery, infant health status, and mothers' support to maternal role attainment in first-time mothers.

#### Population and Sampling

**Population:** The population of this study were first-time mothers in the postpartum period during 4-8 weeks in the area of Satun Province including Satun Hospital, Satun Municipality of Public Health Service Center, Langu Hospital, the community of Kuandon District and Langu District.

**Sampling:** The purposive sampling method was used in this study. The inclusion criteria was follows:

1. full term and no maternal complications during the postpartum period
2. infants lived with their mothers.
3. the mothers of the subjects were alive
4. first-time mothers could communicate in Thai.

The sample size was calculated by a formula of sampling for multiple regression analysis (Kerlinger & Pedhazer, 1973 cited by Vorapongsathorn, 1989: 60) as follows:

$$n / k \geq 30$$

where  $n$  = sample size

$k$  = number of independent variables such as age, family income, type of delivery, infant health status, and mothers' support. In this study, there are five independent variables, then

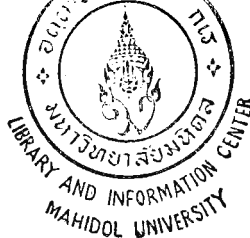
$$n \geq 30(5) = 150 \text{ cases}$$

The total samples should be 150 cases.

### Setting

Satun Province is located in the southern part of Thailand. It consists of five districts. The study setting was Satun Hospital, Satun Municipality of Public Health Service Center, Langu Hospital, the community of Kuandon District and Langu District. Each setting provided services for first-time mothers as follows:

1. The postpartum clinic of out patient department in Satun Hospital opened on Monday from 8.30 to 12.00 pm. The first-time mothers received follow up care 6-8 weeks during their postpartum period.
2. The health promotion department in Langu Hospital opened on Wednesday from 8.30 to 4.30 pm. This setting conducted check up in the postpartum period and family planning.
3. The well baby clinic opened on Monday from 1.00 to 3.00 pm. at Langu Hospital. Satun Municipality of Public Health Service Center opened on Tuesday from 8.30 to 12.00 pm. and Satun Hospital opened from 1.00 to 4.30 pm.



4. A home visit at the community of Langu District was done on Saturdays and in the community of Kuandon District was visited on Thursdays and Fridays from 8.00-4.00 pm.

### **Instrumentation**

The instruments composed of a three parts questionnaire:

**Part I.** Demographic data such as age, religion, education level, marital status, family characteristics, occupation, family income, type of delivery, experience of infant care in 1-3 months, knowledge about infant care, infant health status, their mothers' age, living with their mothers, relationship with their mothers, communication with their mothers, occupation of their mothers, spouse' s age, and spouse' s occupation.

**Part II.** Mothers' support was developed from social support framework of House (1981). The questionnaires consists of four aspects, 20 items in total:

- 2.1 Emotional support 5 items (1-5)
- 2.2 Appraisal support 5 items (6-10)
- 2.3 Informational support 5 items (11-15)
- 2.4 Instrumental support 5 items (16-20).

The answer of the questionnaires consisted with the meanings of:

- “extremely true” means that first-time mothers were in very strong agreement with the questions
- “mostly true” means that first-time mothers were in strong agreement with the questions

“moderately true” means that first-time mothers were in moderate agreement with the questions

“slightly true” means that first-time mothers were in a little agreement with the questions

“not true at all” means that first-time mothers did not agree with the questions.

The subjects were free to answer the questionnaires according to their feelings and behaviors. The questionnaires were weighted by assigning a 5 rating scale as follows:

“extremely true”	is equivalent to 5 points
“mostly true”	is equivalent to 4 points
“moderately true”	is equivalent to 3 points
“slightly true”	is equivalent to 2 points
“not true at all”	is equivalent to 1 point.

The minimum mean score was one and the maximum mean score was five.

The interpretation of maternal role attainment in the first-time mother was based on following criteria:

Mean score 4.00-5.00 means that first-time mothers was at a good level of support from their mothers

Mean score 3.00-3.99 means that first-time mothers was at a fairly good level of support from their mothers

Mean score 2.00-2.99 means that first-time mothers was at a fairly poor level of support from their mothers

Mean score 1.00-1.99 means that first-time mothers was a poor level of support from their mothers.

**Part III.** Maternal role attainment questionnaires in first-time mothers were modified from Sookkavanawat, (1998) who developed these from Mercer' framework (Mercer, 1985). The original questionnaires had 32 items in three aspects; maternal-infant attachment, competence and confident in role and gratification and satisfaction. The questionnaire used in this study composed of 36 items as follows:

3.1 Maternal-infant attachment 12 items (1-12)

3.2 Maternal role competence/confidence 15 items (13-27)

3.3 Maternal role gratification/satisfaction 9 items (28-36).

The response of the questionnaires consisted of positive and negative meanings:

“extremely true” means that first-time mothers were in very strong agreement with the item

“mostly true” means that first-time mothers were in strong agreement with the item

“moderately true” means that first-time mothers were in moderate agreement with the item

“slightly true” means that first-time mothers were in a little agreement with the item

“not true at all” means that first-time mothers did not agree with the item.

The score was assigned to each response as follows:

	The Positive	Negative	
“extremely true”	5	1	points
“mostly true”	4	2	points
“moderately true”	3	3	points
“slightly true”	2	4	points
“not true at all”	1	5	point.

The interpretation of maternal role attainment in first-time mother was based on the following criteria:

Mean score 4.00-5.00 means that first-time mothers was at a good level of maternal role attainment

Mean score 3.00-3.99 means that first-time mothers was at a fairly good level of maternal role attainment

Mean score 2.00-2.99 means that first-time mothers was at a fairly poor level of maternal role attainment

Mean score 1.00-1.99 means that first-time mothers was at a poor of maternal role attainment.

### **Validity**

These instruments were tested for content validity by six experts as follows:

One expert doctor in the field of obstetrics and gynecology

One expert in the field of public health

One expert in the field of social science.

Three experts in the education field of obstetrics and gynecologic nursing.

After recommendation by the experts, the questionnaires were corrected according to their ideas and suggestions, to improve the clarity of the questions, to provide more appropriate order of questions and to ensure appropriate language.

### **Reliability**

The instruments were tried out with 30 mothers of the same characteristics in the selected population. Thereafter, the instruments were calculated for their reliability by using Cronbach's Alpha Coefficient formula (Loecha, et al., 1997: 122-129).

Result of the reliability of the questionnaires were:

1. Mothers' support in first-time mothers = .90
2. Maternal role attainment in first-time mothers = .90

### **Data Collection**

The researcher performed data collection using the following steps:

1. The researcher requested an introduction letter from the Dean of Faculty of Graduate Studies Mahidol University to the Director of Satun Hospital, the Mayor of Satun Municipality and the Director of Langu Hospital, Satun Province. The data was collected from May 1, 2000 to June 30, 2000. The description of data collection was as follows:

### Postpartum Clinic

Place	Day	Time
Satun Hospital	Monday	8.30-12.00 pm.
Langu Hospital	Wednesday	8.30-4.30 pm.

### Well Baby Clinic

Place	Day	Time
Langu Hospital	Monday	1.00-4.30 pm.
Satun Municipality of Public Health Service Center	Tuesday	8.30-12.00 pm.
Satun Hospital	Tuesday	1.00-4.30 pm.

### Home visit

Place	Day	Time
the community of Kuandon District	Thursday, Friday	8.00-4.00 pm.
the community of Langu District	Saturday	8.00-4.00 pm.

2. After permission, the researcher introduced herself to the Head of the postpartum clinic and the Head of the well baby clinic and described the objectives of the study, the procedures and asked for their cooperation in data collection.

3. The researcher selected the sample group following the criteria.

4. The researcher introduced herself and established a relationship with the sample. The researcher described the purpose of the study to them and asked for their permission by completing a consent form. The subjects could refuse or stop giving

information at any time during responding the questionnaires and this would not impact the treatment by the doctor.

5. The researcher described the questionnaires which had three parts including Part I is about demographic data, Part II is about mothers' support, and Part III is about maternal role attainment in first-time mothers. The researcher explained the method in answering the questionnaires to the subjects and let them answer the questionnaires by themselves. The subjects answered the questionnaires with out any time limitation, and they were allowed to ask additional questions when they had problems in answering the questionnaires.

6. The questionnaires were checked. If there were still some items unanswered, the researcher requested to them to complete the questionnaires.

7. The researcher thanked the subjects for their cooperation in gathering the data for this research.

8. In those cases who did not come to follow-up the researcher mad a home visit and asked them to complete the questionnaires.

### **Protection of Human Subjects**

Before collecting the data, the research provided the consent form (see APPENDIX B) to the subjects for protection of human subjects. The researcher gave information about the purpose of this study to the subjects. Their names were not attached to their data, a code number was used on the questionnaires instead. There was no cost to them, nor was there any payment. The subjects could terminate their cooperation at any time whenever they desired.

## Data Analysis

Data from 150 subjects were analyzed using program SPSS 7.5 for Window (Statistical Package for Social Science) as follows:

1. Compute the frequency distribution and percentage of demographic data.
2. Compute percentage, mean and standard deviation of mothers' support scores and maternal role attainment scores for an overall score, each aspects and each item.

3. Computation of multiple correlation coefficients between all variables was done. Demographic data was collected from factors such as maternal age, family income, type of delivery, and infant health status and mothers' support with maternal role attainment in first-time mothers. Calculation of the prediction of maternal role attainment in first-time mothers from these variables was done by utilizing stepwise multiple regression analysis. There were two variables of demographic data included type of delivery and infant health status used the nominal scale. They were changed to be a dummy variable using the following code:

type of delivery;	cesarean delivery	is 0
	vaginal delivery	is 1
infant health status;	with health problems	is 0
	without health problems	is 1.

## **CHAPTER IV**

### **RESULTS**

The research was a study of maternal role attainment in first-time mothers and to determine whether maternal role attainment could be predicted by selected factors including mothers' support, age, family income, type of delivery, and infant health status. A convenience sample of 150 women was recruited from first-time mothers during 4 to 8 weeks postpartum period in the postpartum clinics and the well baby clinics at Satun Hospital, Satun Municipality of Public Health Service Center, Langu Hospital, and the community of Kaundon District and Langu District.

The results will be illustrated in the table as follows:

- Part I. Descriptive statistics of demographic data of the first-time mothers in Tables 1-3
- Part II. Descriptive statistics for mothers' support in Tables 4-5
- Part III. Descriptive statistics on maternal role attainment in Tables 6-7
- Part IV. Power of prediction of the study variables to determine the maternal role attainment in Tables 8-10.

**Part I. Descriptive statistics of demographic data of the first-time mothers****Table 1.** Number and percentage of the subjects categorized by demographic data (n = 150)

<b>Demographic data</b>	<b>Number</b>	<b>Percentage</b>
<b>Age (years)</b>		
≤ 20	43	28.7
21-30	96	64.0
31-40	11	7.3
Mean = 23.68, SD = 4.57, range = 15-35		
<b>Religion</b>		
Islamism	111	74.0
Buddhism	39	26.0
<b>Educational level</b>		
Primary school	61	40.7
Junior high school	34	22.7
Senior high school / Primary vocation certification	24	16.0
High vocation certification / Diploma	13	8.7
Bachelor' degree	18	12.0
<b>Marital status</b>		
Married	149	99.3
Divorced	1	0.7
<b>Characteristics of family</b>		
Nuclear family	41	27.3
Extended family	109	72.7
Lived with their spouses, babies, and relatives	65	59.6
Lived with their spouses, babies, and spouses' relatives	43	39.4
Lived with her baby and relatives	1	0.9
<b>Occupation</b>		
Housewife	94	62.7
Employee	29	19.3
Government service / State enterprise	12	8.0
Commerce / Business person	9	6.0
Agriculture	6	4.0
<b>Family income (baht/month)</b>		
≤ 5,000	104	69.3
5,001-10,000	27	18.0
10,001-15,00	10	6.7
15,001-20,000	6	4.0
≥ 20,001	3	2.0
Mean = 6,284.67, SD = 5,854.94, range = 2,000-37,000		
<b>Enough of income</b>		
Just enough	140	93.3
Not enough	10	6.7

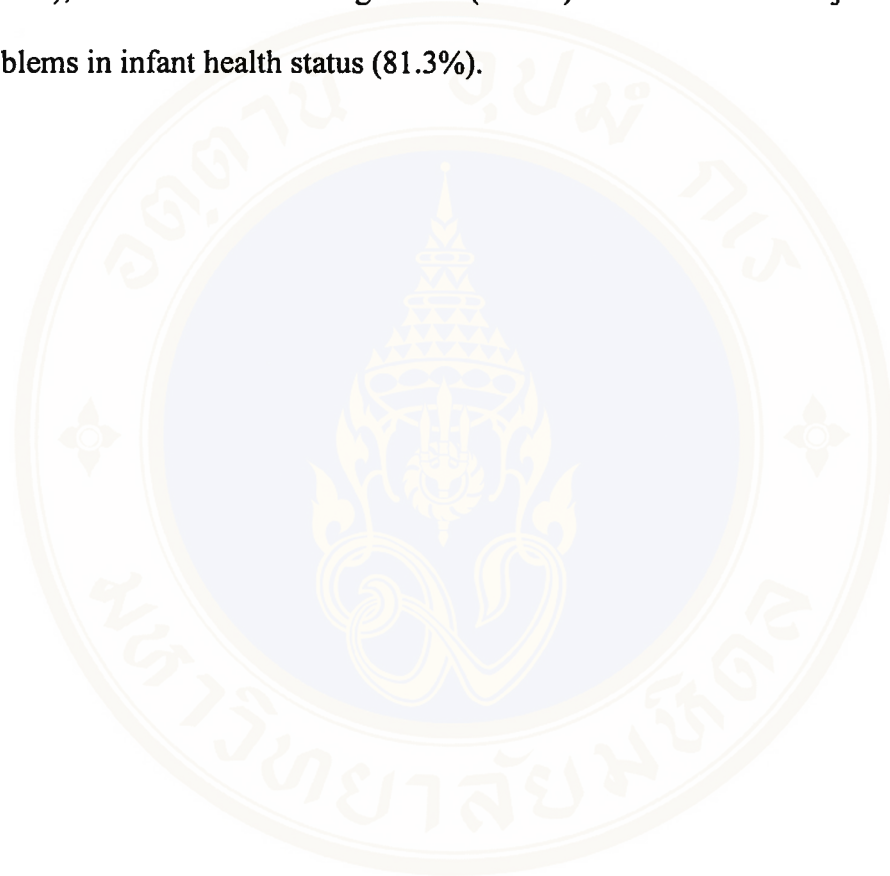
As shown in Table 1, 64% of the subjects ranged in ages from 21 to 30 years old, while 28.7% had an age of equal or less than 20 years old. The youngest was 15 years old and oldest was 35 years old. An average age was 23.68 years. The majority of the subjects were Islamic (74%). The most common educational level of the subjects was primary school, with junior high school (40.7% and 22.7%, respectively). The lowest level of education was four years of primary school, and a bachelor degree was the highest. Most of the subjects were married (99.3). The largest group of the subjects was the extended families (72.7%). Most of them lived with their spouses, babies, and relatives (59.6%) and 62.7% were housewife. Their families had monthly income of equal or less than 5,000 bahts (69.3%). The lowest family income was 2,000 bahts, highest family income was 37,000 bahts and average family income was 6284.67 bahts. The majority of the subjects had just enough income (93.3%).

**Table 2.** Number and percentage of the subjects categorized by demographic data (n = 150)

Demographic data	Number	Percentage
<b>Type of delivery</b>		
Cesarean delivery	38	25.3
Vaginal delivery	112	74.7
Normal delivery	103	92.0
Vacuum extraction	7	6.3
Forceps extraction	2	1.8
<b>Infant care experience</b>		
No	127	84.7
Yes	23	15.3
<b>Infant care knowledge</b>		
No	33	22.0
Yes	117	78.0
Sources of infant care knowledge (more than 1 )	(n = 117)	
Their mothers	61	52.1
Doctor / Nurse	47	40.2
Book / Magazine	46	39.3
Their mothers-in-law	21	17.9
Television	19	16.2
Relatives	16	13.7
Radio	4	3.4
<b>Infant health status</b>		
Without health problems	122	81.3
With health problems	28	18.7
Cause of health problem (more than 1)	(n = 28)	
Low birth weight (< 2500 gm.)	15	53.6
Jaundice (on phototherapy and without)	9	32.1
Hyperpnea*	4	14.3
Pneumonia*	1	3.6
Pyomyositis*	1	3.6
Always flatulence	1	3.6
Chickenpox	1	3.6

\* Hospitalization

As shown in Table 2, the majority of the subjects had vaginal deliveries (74.7%), whereas just 25.3% had cesarean deliveries. Of all subjects, 84.7% had no experience in infant care, 78% had knowledge in infant care. Knowledge in infant care came from various sources such as their mothers (52.1%), doctors and nurses (40.2%), and books and magazines (39.3%). Most of the subjects had without problems in infant health status (81.3%).



**Table 3.** Number and percentage of the subjects categorized by demographic data (n = 150)

<b>Demographic data</b>	<b>Number</b>	<b>Percentage</b>
<b>Mothers' age (years)</b>		
30-39	16	10.7
40-49	55	36.7
50-59	53	35.3
60-69	25	16.7
70-79	1	0.7
Mean = 50.54, SD = 8.72, range = 32-76		
<b>Mothers' occupation</b>		
Housewife	82	54.7
Commerce / Business person	29	19.3
Agriculture	21	14.0
Employee	14	9.3
Government service / State enterprise	4	2.7
<b>Living with their mothers (4-8 weeks postpartum )</b>		
Lived with their mothers	117	78.0
Did not live with their mothers	33	22.0
<b>Frequency of communication with their mothers</b>		
Regularly	129	86.0
Once in a while	21	14.0
<b>Spouses' age (years)</b>		
≤ 20	9	6.0
21-30	113	75.3
31-40	25	16.7
≥ 41	3	2.0
Mean = 27.17, SD = 4.93, range = 17-43		
<b>Spouses' occupation</b>		
Employee	92	61.3
Agriculture	23	15.3
Commerce / Business person	19	12.7
Government service / State enterprise	16	10.7

As shown in Table 3, 36.7% of the subjects' mothers were between 40 to 49 years old and 35.3% were between 50-59 years old. The youngest was 32 years old and the oldest was 76 years old. An average age was 50.54 years. About 54.7% of the subjects' mothers were housewives. Seventy-eight percent of the subjects lived with their mothers during 4 to 8 weeks postpartum. Eighty-six percent of them communicated regularly with their mothers. Most of the subjects' spouses were between 21 to 30 years old (75.3%). The youngest was 17 years old and the oldest was 43 years old. An average age was 27.17 years. The majority of them were employees (61.3%).

## Part II. Mothers' support

**Table 4.** Percentage, mean, standard deviation, and levels of mothers' support categorized by overall and each aspect (n = 150)

Mother' support	Good	Fairly good	Fairly poor	Poor	X	SD	Levels of mothers' support
	(%)						
<b>Overall mothers' support</b>	<b>70.0</b>	<b>20.0</b>	<b>10.0</b>	<b>0.0</b>	<b>3.94</b>	<b>0.64</b>	<b>Fairly good</b>
- Emotional support	100.0	0.0	0.0	0.0	4.19	0.76	Good
- Instrumental support	80.0	20.0	0.0	0.0	4.07	0.84	Good
- Appraisal support	40.0	60.0	0.0	0.0	3.93	0.67	Fairly good
- Informational support	60.0	0.0	40.0	0.0	3.56	0.75	Fairly good

As shown in Table 4, a mean of overall mothers' support score was at a fairly good level. For each aspect, a mean of overall emotional support and instrumental support score was at a good level, 100% and 80% respectively. Also, appraisal support was of them at a good level 40% and at a fairly good level 60%. Moreover, informational support was at a good level 60% and at a fairly poor 40%.

**Table 5.** Percentage, mean, standard deviation, and levels of mothers' support categorized by each aspect and each item (n = 150)

Mothers' support	5 4 3 2 1					X	SD	Levels of mothers' support
	(%)							
<b>Overall emotional support</b>						<b>4.19</b>	<b>0.76</b>	<b>Good</b>
- Concerning and giving attention	63.3	22.0	8.0	4.7	2.0	4.40	0.96	Good
- Speaking and giving willpower	45.3	36.7	13.3	2.7	2.0	4.21	0.91	Good
- Listening to problems	54.7	21.3	13.3	8.0	2.7	4.17	1.10	Good
- Comforting and encouragement	44.7	34.7	11.3	8.0	1.3	4.13	0.99	Good
- Sympathy	42.7	33.3	15.3	4.7	4.0	4.06	1.06	Good
<b>Overall instrumental support</b>						<b>4.07</b>	<b>0.87</b>	<b>Good</b>
- Giving time	66.0	15.3	8.7	4.0	6.0	4.13	1.17	Good
- Providing food	54.7	28.0	7.3	4.7	5.3	4.22	1.12	Good
- Helping and providing in the household	56.0	27.3	4.7	6.0	6.0	4.21	1.16	Good
- Giving of material supplies	46.7	25.3	17.3	6.7	4.0	4.04	1.13	Good
- Financial help	35.3	20.7	18.7	15.3	10.0	3.56	1.37	Fairly good
<b>Overall appraisal support</b>						<b>3.93</b>	<b>0.67</b>	<b>Fairly good</b>
- Suggestions to inappropriate activities	83.3	8.7	2.7	4.7	0.7	4.69	0.79	Good
- Commentings to inappropriate activities	68.7	22.7	4.7	2.0	2.0	4.45	0.84	Good
- Ideal acknowledgement ideal of my baby care	28.7	33.3	24.0	10.0	4.0	3.73	1.10	Fairly good
- Appreciate appropriateness with my baby care	22.0	33.3	24.7	16.0	4.0	3.53	1.12	Fairly good
- Comparing with other first-time mothers	16.7	23.3	31.3	17.3	11.3	3.17	1.23	Fairly good
<b>Overall informational support</b>						<b>3.56</b>	<b>0.75</b>	<b>Fairly good</b>
- Recommendations to self-care	69.3	21.3	4.0	3.3	2.0	4.53	0.88	Good
- Teaching the method about helping with abnormal baby acts	60.7	29.3	4.0	3.3	2.7	4.42	0.92	Good
- Advising and counseling	50.0	34.0	9.3	4.0	2.7	4.25	0.97	Good
- Searching books, magazines or receiving advice for self-care from TV programs	8.7	11.3	19.3	29.3	31.3	2.37	1.27	Fairly poor
- Searching books, magazines or receiving advice for baby care from TV programs	5.3	8.0	25.3	27.3	34.0	2.23	1.16	Fairly poor

5 = extremely true, 4 = mostly true, 3 = moderately true, 2 = slightly true, 1 = not true at all

As shown in Table 5, a mean of both overall and each item of emotional support score was at a good level. For each item, greater than 80% of the subjects responded extremely true and mostly true including “concerning and giving attention when I’m weak from caring for my baby” and “speaking and giving willpower about a good mother”. However, some subjects responded slightly true and not true at all in item: “listening to problems”, “comforting and encouragement”, and “sympathy when my baby was hardly cry” 10.7%, 9.3%, and 8.7%, respectively.

A mean of overall instrumental support score was at a good level. For each item, most of instrumental support was at a good level except to “financial help” was at a fairly good. Greater than 80% of the subjects responded extremely true and mostly true including “giving time”, “providing food”, and “helping and providing in the house hold”. However, some subjects responded slightly true and not true at all in item: “financial help” 25.3%.

A mean of overall appraisal support score was at a fairly good. For each item, most of appraisal support was at a fairly good level. But, two items were at a good level which included “suggestions to inappropriate activities such as lifting heavy things” and “commentings and suggestions about inappropriate activities such as resting, eating, etc.” by more than 90% of the subjects responded extremely true and mostly true. However, three items were at a fairly good level, which was “ideal acknowledgement with my baby care although it is different from my mothers”, “appreciate appropriateness with my baby care”, and “comparing with other first-time mothers”, the subjects responded slightly true and not true at all 14%, 20%, and 28.6%, respectively.

A mean of overall informational support score was at a fairly good level. For each item, there are three items of informational support was at a good level. Greater than 80% of the subjects responded extremely true and mostly true which included “recommendations to self-care in the postpartum period”, “teaching the method about helping with abnormal baby acts”, and “advising and counseling”. However, two items were at a fairly poor level such as “searching books, magazines, or receiving advice for self-care in the postpartum period from TV programs” and “searching books, magazines, or receiving advice for baby care from TV programs”. These two items, the subjects responded slightly true and not true at all 60.6%, and 61.3%, respectively.

**Part III. Maternal role attainment in first-time mothers****Table 6.** Percentage, mean, standard deviation, and levels of maternal role attainment categorized by overall and each aspect (n = 150)

Maternal role attainment	Good	Fairly good	Fairly poor	Poor	X	SD	levels of maternal role attainment
	(% )						
<b>Overall maternal role attainment</b>	<b>92.7</b>	<b>7.3</b>	<b>0.0</b>	<b>0.0</b>	<b>4.53</b>	<b>0.33</b>	<b>Good</b>
Maternal role gratification / satisfaction	96.0	4.0	0.0	0.0	4.66	0.33	Good
Maternal-infant attachment	95.3	4.7	0.0	0.0	4.63	0.34	Good
Maternal role competence / confidence	82.0	17.3	0.7	0.0	4.36	0.44	Good

As shown in Table 6, a mean of overall and each aspect score of maternal role attainment was at a good level. For each aspect, maternal role gratification /satisfaction, maternal-infant attachment and maternal role competence/confidence was at a good level 96%, 95.3%, and 82%, respectively.

**Table 7.** Percentage, mean, standard deviation, and levels of maternal role attainment categorized by each aspect and each item (n = 150)

Maternal role attainment	5 4 3 2 1					X	SD	Levels of maternal role attainment
	(%)							
<b>Overall gratification/satisfaction</b>						<b>4.66</b>	<b>0.33</b>	<b>Good</b>
- I'm happy	86.7	11.3	1.3	0.7	0.0	4.84	0.45	Good
- I'm proud	84.0	14.0	1.3	0.7	0.0	4.81	0.47	Good
- I'm hopeful	84.0	13.3	2.0	0.7	0.0	4.81	0.49	Good
- I'm satisfied	86.0	10.7	2.0	1.3	0.0	4.81	0.52	Good
- Meaning of life	79.3	18.7	1.3	0.7	0.0	4.76	0.54	Good
- My baby enjoys when I touch	77.3	19.3	3.3	0.0	0.0	4.74	0.51	Good
- I'm bored with the baby care*	0.0	1.3	4.7	14.7	79.3	4.72	0.61	Good
- Increase contact with neighbors	52.0	34.7	10.0	2.0	1.3	4.34	0.84	Good
- I'm not tried	40.7	34.7	17.3	5.3	2.0	4.07	0.99	Good
<b>Overall maternal-infant attachment</b>						<b>4.63</b>	<b>0.34</b>	<b>Good</b>
- Happy when my baby smile	91.3	7.3	0.7	0.7	0.7	4.89	0.39	Good
- Looking at my baby with love	85.3	13.3	0.7	0.7	0.0	4.83	0.44	Good
- Thinking of my baby when I'm far away	85.3	12.7	1.3	0.7	0.0	4.83	0.46	Good
- Giving time for my baby	78.7	19.3	2.0	0.0	0.0	4.77	0.47	Good
- My baby is ugly*	0.0	0.0	5.3	12.0	82.7	4.77	0.53	Good
- Holding and cuddling	81.3	12.0	4.7	2.0	0.0	4.73	0.64	Good
- Interest and attention	68.7	25.3	5.3	5.3	0.7	4.62	0.62	Good
- Playing with my baby	70.0	21.3	4.7	2.7	0.7	4.59	0.76	Good
- Checking my baby	68.0	24.7	4.7	2.7	0.0	4.58	0.71	Good
- Holding my baby close	65.3	28.0	4.0	1.3	1.3	4.55	0.75	Good
- Speaking sweetly	62.0	30.0	8.0	0.0	0.0	4.54	0.64	Good
- I know what my baby needs	35.3	31.3	24.7	6.7	2.0	3.91	1.02	Fairly good
<b>Overall maternal role competence / confidence</b>						<b>4.36</b>	<b>0.44</b>	<b>Good</b>
- Seeing the doctor for injections /	83.3	14.7	1.3	0.7	0.0	4.81	0.47	Good
-Complete cleaning for my baby' s things	72.7	25.3	2.0	0.0	0.0	4.71	0.50	Good
- Feeding every time	74.0	21.3	4.7	0.0	0.0	4.69	0.56	Good
- Always preparing to clean my baby' s items	70.7	25.3	2.7	1.3	0.0	4.65	0.60	Good
- Reliance to my baby care	62.7	28.7	8.0	0.7	0.0	4.53	0.67	Good
- Air flowed in living room	54.7	36.7	8.0	0.7	0.0	4.45	0.67	Good
- Choosing the clothes for air condition	55.3	34.0	8.7	2.0	0.0	4.33	0.74	Good
- Protection of the baby from danger	46.7	38.0	12.0	3.3	0.0	4.28	0.80	Good
- Comfort when the baby cries quietly	45.3	35.3	15.3	4.0	0.0	4.22	0.85	Good
- Complete bathe and shampoo	46.7	30.7	19.3	3.3	0.0	4.21	0.87	Good
- Observation of abnormal acts	46.7	32.7	12.7	7.3	0.7	4.17	0.96	Good
- After feeding, bringing up air	40.7	40.7	12.7	6.0	0.0	4.16	0.87	Good
- Telling about abnormal elimination	44.0	32.0	14.0	7.3	2.7	4.07	1.06	Good
- Helping my baby when spitting up or has vomiting	40.7	35.3	14.0	8.7	1.3	4.05	1.01	Good
- Taking the baby a long time to fall asleep	33.3	40.7	18.7	5.3	2.0	3.98	0.96	Fairly good

\*negative meaning, 5 = extremely true, 4 = mostly true, 3 = moderately true, 2 = slightly true, 1 = not true at all

As shown in Table 7, a mean of overall and each item score of maternal role gratification/satisfaction was at a good level. For each item, more than 95% of the subjects responded extremely true and mostly true in the first six items “I’m happy when I care for my baby by myself.”, “I’m proud with mothering.”, “I’m hopeful when I had my baby.”, “I’m satisfied when I found that my baby had normal developmental growth.”, “When I function in the maternal role, it adds meaning to my life.”, and “My baby enjoys being with when I touch or hold her/him.”. However, 7.3% of the subjects responded slightly true and not true at all was “ I’m not tried in caring for my baby ”

A mean of overall and each item score of maternal-infant attachment was at a good level except only one item was at a fairly good level: “I know what my baby needs when he/she cries.” For each item, more than 95% of the subjects responded extremely true and mostly true in the first four item: “I’m happy when my baby smiles.”, “I look at my baby with love”, “I think of my baby when I’m far away” , and “I give time for my baby.” However, 8.7% of the subjects responded slightly true and not true at all was “I know what my baby needs when my baby cries.”

A mean of overall and each item score of maternal role competence /confidence was at a good level except only one item was at a fairly good level: “I take my baby a long time to fall asleep.”. For each item, more than 95% of the subjects responded extremely true and mostly true in the first four items: “I see the doctor for injection/vaccination or when my baby acts abnormally.”, “I completely clean for my baby’ s things.”, “I feed my baby every time when he/she needs to be feed.”, and “I always prepare to clean my baby’ s items.”. However, in four items:

“I observe abnormal my baby acts.”, “I observe and tell about abnormal elimination of my baby.”, I can help my baby when she/he sprits up or has vomiting.”, and “I take my baby a long time to fall asleep.”. The subjects responded slightly true and not true at all 8%, 10%, 10%, and 7.3%, respectively.

**Part IV. Power of prediction of the study variables to determine the maternal role attainment in first-time mothers**

**Table 8.** Correlation coefficients among predictors and between predictors and criteria were presented by correlation matrix

Variables	1	2	3	4	5	6
1. Age	1					
2. Family income	.256**	1				
3. Type of delivery	-.206*	-.198*	1			
4. Infant health status	.049	-.039	.122	1		
5. Mothers' support	-.045	-.072	.159	.080	1	
6. Maternal role attainment	.113	.067	-.081	.025	.390**	1

\*  $p < .05$ , \*\*  $p < .01$

As shown in Table 8, maternal role attainment was positive correlated with mothers' support ( $r = .390$ ) at a statistically significant level of .01, but it had no relationship with age, family income, type of delivery and infant health status.

There were relationships among the predictor variables. For example, type of delivery was negatively correlated with age ( $r = -.206$ ) and family income ( $r = -.198$ ) at a statistically level of .05. Family income was positively associated with age ( $r = .256$ ) at a statistically level of .01.

**Table 9.** Multiple correlation coefficients between predictors and maternal role attainment by enter multiple regression analysis

predictors	b	SE	Beta	t
1. Age	.0067	.006	.092	1.068 <sup>NS</sup>
2. Family income	.0000	.000	.030	.350 <sup>NS</sup>
3. Type of delivery	-.0931	.060	-.122	-1.553 <sup>NS</sup>
4. Infant health status	.0024	.065	.003	.036 <sup>NS</sup>
5. Mothers' support	.217	.040	.412	5.443 <sup>***</sup>
Constant (a) = 3.571				
Multiple R = .430, R <sup>2</sup> = .185, adjusted R <sup>2</sup> = .156, SEE = .3047, Overall F = 6.527 <sup>***</sup>				

\*\*\* p < .001, NS = non significant

As shown in Table 9, five predictor variables included age, family income, type of delivery, infant health status, and mothers' support. These variables were entered into a multiple regression equation concurrently. The result of multiple regression analysis showed that all five predictor variables accounted for 18.5% (R<sup>2</sup> = .185) of the variables of maternal role attainment in first-time mothers. However, mothers' support was only one variable significantly correlated to maternal role attainment (p < .001).

**Table 10.** Multiple correlation coefficients between predictors and maternal role attainment by stepwise multiple regression analysis.

Step	predictor	Multiple R	R <sup>2</sup>	Adjusted R <sup>2</sup>	F	b	Beta	t
1.	Mothers' support	.390	.152	.147	26.621	.204	.390	5.16***
Constant (a) = 3.723					Overall F = 26.621			

\*\*\* p < .001

As shown in Table 10, only one predictor variable that mothers' support was accounted for 15.2 percent of the variance of maternal role attainment. at a significantly level of .001.

## CHAPTER V

### DISCUSSION

The purpose of this study was to describe mothers' support and maternal role attainment in first-time mothers. The subjects were 150 first-time mothers who lived in Satun Province during 4 to 8 weeks postpartum period while attending the postpartum clinic and the well baby clinic at Satun Hospital, Langu Hospital, and Satun Municipality of Public Health Service Center. Home visits were done at the community of Kuandon District and Langu District for those who did not follow up on their appointment at Langu Hospital. The findings are discussed according to the following purpose and hypothesis of the research.

**Purpose I: To study mothers' support and maternal role attainment in first-time mothers.**

#### **Mothers' support**

This study found the mean of the overall mothers' support score was at a fairly good level (Table 4). Each aspect, a mean of emotional support and instrumental support score was at a good level while appraisal support and informational support score was at a fairly good level (Table 4).

The findings also revealed that the subjects perceived about receiving encouragement with love, attention, suggestions, aid in kind, and affirmation from mothers was at a rather high level. The explanation for this is that all of subjects lived

in Satun Province which is one of the four border provinces in the Southern part of Thailand (Satun, Yala, Pattani, and Narathiwat Provinces). The religion of them mostly was Islamism (74%), (Table 1). In the Muslim family, when the daughter has given birth, her mother always will be a close helper. Seventy-eight percent of the subjects lived with their mothers during the 4 to 8 weeks postpartum period (Table 3). From the interviews, it was found that more than 80% of them considered Yoo-Fai (Thai tradition of rehabilitation of the mother after giving birth or a period of confinement and “mothers-roasting”---the warming of the mother using firewood or charcoal fires below or next to the bed). The subjects had Yoo-Fai during 10 to 60 days postpartum which was a different time for each mother. They were limited and avoided activities and foods such as hard work, going outside, etc. because they also believed that the cold air will enter their bodies and was caused sickness. Therefore, the subjects always stay in the house and in bed. The subjects’ mothers are the important and close people because they had birth experience. Their mothers advised and suggested about performing Yoo-Fai, by providing foods, helping in the household and helping in infant care. Although, some subjects who did not live with their mothers during the postpartum period, their house were near, which they always met and receive support from them. In addition, 78% of the subjects communicated regularly and 54.7% of subjects’ mothers were housewives (Table 3). The subjects’ mothers had time for their daughters in solving problems or caring in the postpartum. From this study, most of the subjects responded extremely true and mostly true about “concerning and giving attention”, “commenting to inappropriate activities”, “recommendation to self care”, and “helping and providing in the household”, 85.3%, 92%, 90.6%, and 83.3% respectively (Table 5). From these reasons, the subjects

perceived about receiving support from their mothers was at a fairly good level. Similarly with the study of Prakobsup (1998: 61) who found that a mean of overall mothers' support score of pregnant adolescents was at a fairly good level. Regarding mothers' support, this study is described in four aspects as follows:

**Emotional support.** It was found that the mean of the emotional support score was at a good level, which had a highest mean score (Table 4). Namely, most of the subjects perceived about receiving encouragement in which esteem, affect, trust, concern and listening to problems from their mothers was at a high level. The explanations is that emotional support involves providing empathy, caring, love, and trust, which seems to be most important and that agreement in emotional support was the most important type in buffering stress and facilitating health (House: 1981:24, cited by Tilden, 1985: 201). Similarly, Gottlieb (1978 cited by House, 1981: 24) suggested that emotional support category subsumes the largest number of specific acts of support. Furthermore, the results found that the majority of the subjects lived with their mothers during 4 to 8 postpartum period (78%), also 86% communicated regularly with their mothers (Table 5). This support from their mothers was at a good level. Similar to Sriyasak (1996: 74) who found that a mean of emotional support from family support score of adolescent mothers was at the highest score.

However, some subjects responded slightly true and not true at all in the items: "listening to problems", "comforting and encouragement", "sympathy when my baby hard cries", 10.7%, 9.3%, and 8.7% respectively. According to the twenty-two percent of the subjects did not live with their mothers, 14% had nuclear families. From the interviews, some subjects were far from their mothers' house such as living

in other provinces. Therefore, some subjects perceived about receiving this support from their mothers at a fair level.

**Instrumental support.** It was found that the mean of the instrumental support score was at a good level (Table 4). Namely, most of the subjects perceived about receiving encouragement in which aid in kind, money, labor, time, and modifying environment from their mothers was at a high level. For each item, greater than 80% of the subjects responded extremely true and mostly true about “giving time”, “providing foods”, and “helping and providing in the household” (Table 5). From the interviews, more than 80% of the subjects had Yoo-Fai during postpartum period, which limited activities and foods. Their mothers gave help including modifying the environment in the houses, infant care, etc. Therefore, this support from their mothers was at a good level.

However, the results indicated that some subjects responded slightly true and not true at all in the item: “financial help”, 25.3% (Table 5). Because of most of the subjects had just enough income (93.3%), (Table 1). They did not need to request financial help from their mothers. Moreover, 54.7% of the subjects’ mothers were housewives. They do not support financially for their daughters. It may be the results of most of the subjects who perceived about receiving encouragement with financial help from their mothers was at a fairly good level.

**Appraisal support.** It was found that the mean of the appraisal support score was at a fairly good level (Table 4). Namely, most of the subjects perceived about receiving encouragement in which affirmation, feedback, and social comparison from their mothers was at a rather high level. For each item, more than 90% of the subjects responded extremely true and mostly true in the items: “suggestion to inappropriate

activities such as lifting heavy things', and "commenting to inappropriate activities such as resting, eating, etc." (Table 5). It may be concluded that the subjects' mothers had birth experience. They know about how to practice appropriate behaviors in the postpartum as well. In addition, 86% of the subjects communicated regularly with their mothers. Their mothers had a chance to suggest about practices in postpartum period. Seventy-eight percent of the subjects lived with their mothers during postpartum period. Their mothers also observed behaviors of the subjects with comments and suggestions about inappropriate practices. As a result, these subjects perceived about receiving appraisal support from their mothers was at a fairly good level.

However, some subjects responded slightly true and not true at all including "ideal acknowledgement with baby care although it is different from my mother", " appreciate appropriateness with my baby care", and "comparing with another first-time mothers", 14%, 20%, and 28.6% respectively (Table 5). The results also indicated that 20.7% of the educational level of the subjects were diplomas and bachelor' degrees. They had a chance to seek knowledge for infant care by themselves. Moreover, the subjects received knowledge from doctors and nurses 40.2% which may be different from the traditional infant care of their mothers. In addition, in Thai culture is not common to protest or compare behavior with another when the person has inappropriate practices. As above mentioned, this support from their mothers was at a fair level.

**Informational support.** It was found that the mean of the informational support score was at a fairly good level (Table 4). Namely, most of the subjects perceived about receiving encouragement in which advice, suggestions, directives,



and information for postpartum practices and infant care was at a rather high level. Similar to Flaherty (1988: 191) who stated that a mother was the first mediator of the environment for a daughter through very subtle cues from her mother. A daughter first learned what was expected of her by her culture. Considering in each item, more than 80% of the subjects responded extremely true and mostly true which included “recommendations to self-care in the postpartum period”, “teaching the methods about helping with abnormal baby acts”, and “advising and giving counseling” (Table 5). According to the subjects who were first-time mothers, had no experience in postpartum practices and infant care. They needed to receive suggestions from a close person particularly their mothers. Then, 78% of the subjects lived with their mothers in the postpartum period. Prakobsup (1998: 61) also supported that a mean of emotional support from pregnant adolescents’ mothers was at a fairly good level.

However, in this study, it found that some subjects responded slightly true and not true at all in the items: “searching books, magazines or receiving advice for self care in the postpartum period from TV programs” and “searching books, magazines or receiving advice for baby care from TV programs”, 60.6% and 61.3% respectively (Table 5). From the interviews, most of the subjects’ mothers lived in the rural areas and they had a lower educational level than their daughters. Moreover, the subjects’ mothers watched TV programs about entertainment more than knowledge. Therefore, the subjects perceived about receiving this support from their mothers were at a fairly good level.

### **Maternal role attainment in first-time mothers**

This study showed that the mean of the overall maternal role attainment was at a good level (Table 6). Namely, the subjects expressed their feelings and behaviors about maternal-infant attachment, competence/confidence and gratification /satisfaction was at a good level. This result may be the consequences of several factors. First, 71.3% of the subjects were from 21 years of age (Table 1). They have completed maturity and have a lot of responsibilities. Moreover, they are prepared to make changes in their lives. Lazalus & Folkman (1984: 172) stated that the older women would have more experiences, higher maturity, more careful considerations and better decision making than younger mothers. Second, most subjects were housewives (62.7%). They always have time to be close with their babies. Third, most of the subjects were married (99.3%), 72.7% lived with their extended families, and 78% lived with their mothers during the postpartum period. The subjects probably had less stress in mothering because they received help in infant care from their mothers, spouses and relatives. Finally, the subjects have various sources of knowledge such as their mothers, doctors, nurses, magazines, etc. (Table 2). They had the opportunity to prepare physically and psychologically for the maternal role. The subjects also had a good relationship with their infants. They had confidence and satisfaction in the maternal role. Moreover, the results of this study found that mothers' support was at a fairly good level (Table 4). It was encouraged to achieve in the maternal role. Cohen, Kenner, & Hollingsworth (1991: 1081) suggested that a woman with many established relationships and extensive social support usually had an easier time adjusting to the role of new mother than one who was isolated. As a result, these subjects achieved the maternal role at a good level. Similarly with the study of

Sookkavanawat (1998: 85) who found that the mean of the overall maternal role performance score of adolescent mothers during postpartum period was at a good level.

Considering each aspect, all the aspects of the maternal role attainment were at a good level. Maternal role gratification/satisfaction was performed the most, followed by maternal-infant attachment, and maternal role competence/confidence respectively. This can be explained as follows:

**Maternal role gratification/satisfaction**, the mean of maternal role attainment in this aspect was at a good level (Table 6). It showed that most of the subjects felt happiness, enjoyment, pride, and satisfaction with the maternal role. Considering each item, all items had a mean at a good level (Table 7). Greater than 95% of the subjects responded extremely true and mostly true in first six items as “I’m happy when I care for my baby by myself.”, “I’m proud with mothering”, “I’m hopeful when I have my baby.”, “I’m satisfied when my baby has normal developmental growth.”, “When I function in the maternal role, it adds meaning to my life.”, and “My baby enjoys being with me when I touch or him/her.”. It can be explained that these subjects were first-time mothers who expected their infants from pregnancy until birth. After birth, it found that 81.3% of the subjects’ infants had no health problems (Table 2). Their infants were healthy with normal growth and development, which shows the good relationship with maternal-infant interaction. From this result, the subjects were happy and satisfied in the maternal role. Similarly with the study of Sookhavanawat (1998: 71) who referred to adolescent mothers who were satisfied in the maternal role performance was at a good level.

However, the results indicated some subjects responded slightly true and not true at all in which “I’m not tired in caring for my baby care.”, 7.3% (Table 7).

Accordingly, 84.7% of the subjects had no experience in infant care, 22.7% of them were nuclear families, 22% did not live with their mothers during 4 to 8 weeks postpartum. As mentioned above, the subjects have a burden for their infant care by only themselves when their spouses went to work. They must care for their infants nearly 24 hours, therefore they could become tired.

**Maternal infant attachment**, the mean of maternal role attainment in this aspect was at a good level (Table 6). It showed that most of the subjects had more love and bonding with their infants. For each item, the mean of the maternal-infant attachment was at a good level except in only one item: "I know what my baby needs when my baby cries." was at a fairly good level (Table 7).

For each item, means of the first four items were at a good level. More than 95% of the subjects responded extremely true and mostly true in these items: "I'm happy when my baby smiles", "I look at my baby with love", "I think of my baby when I'm far away", and "I give time for my baby." (Table 7). About 74.7% of the subjects had vaginal deliveries. The body has a shorter recovery time which immediately formed relationship with their infants. In addition, most infants had no health problems, 81.3% (Table 2). The subjects were close with their infants during delivery until 4 to 8 weeks postpartum. Similarly to the work of Klaus and Kennell (1982: 73,82) who stated maternal-infant attachment occurred in the first moments of life of the infant which was a sensitive period for interaction between them. Moreover, about 62.7% of the subjects were housewives (Table 1). They cared for their infants full time. The development of love and bonding occurs to continue. Therefore, maternal-infant attachment was at a good level.

However, about 8.7% of the subjects responded slightly true and not true at all in which “I know what my baby needs when my baby cries.”. According to 84% of the subjects who had no infant care experience (Table 2). Therefore, it is difficult to interpret the infants’ behaviors.

**Maternal role competence/confidence**, the mean of maternal role attainment in this aspect was at a good level (Table 6). It showed that most of the subjects had more competence and confidence in infant care. Considering each item, all items were at a good level except in only one item: “I take my baby a long time to fall asleep.” was at fairly good level (Table 7).

The subjects had competence and confidence in the maternal role at a good level in first four items which 95% of them responded extremely true and mostly true. For example, “I see the doctor for injection/vaccination or when my baby acts abnormally.”, “I completely clean of my baby’ s things.”, “I feed my baby every time when he/she needs to be feed.”, and “I always prepare to clean my baby items.” (Table 7). These results can be explained that nearly all the subjects were born at the hospitals. About 40.2% of them had ever received knowledge about infant care from doctors and nurses, 39.3% received information from books and magazines. Therefore, the subjects have knowledge about infant care as well as the infants were healthy. Moreover, 78% of the subjects lived with their mothers during the postpartum period (Table 3). With this results, it found that the subjects received instrumental support from their mothers at a good level (Table 4). Thus, they received suggestions about infant care, and develop skills and competence in the role until they had confidence in the maternal role. Similarly with the study of Zahr (1999: 279) who stated the mothers’ feelings of confidence in their abilities to care for their infants was

necessary for health adaptation to parenthood and a positive mother–infant relationship.

However, some subjects did not have confident performances in four items: “After feeding, my baby is brought up air.”, “I observe and tell about abnormal elimination of my infant.”, “I help my baby when he/she spits up or vomiting.”, and “I take my baby a long time to fall asleep.”. The subjects were able only 8%, 10%, 10%, and 7.3% respectively. Accordingly, 22% of the subjects did not live with their mothers during 4 to 8 weeks postpartum period. They may lack the skills in seeking information about abnormal signs and symptoms of their infants. From the interviews, the environment of the subjects had a lot of flies, mosquitoes, insect, etc. and some places had air pollution. This may add to the cause of the infant do not to sleep well.

**Purpose II:** To determine the predictive power of predictor variables such as age, family income, type of delivery, infant health status, and mothers’ support to maternal role attainment in first-time mothers.

**Hypothesis:** Mothers’ support, age, family income, type of delivery, and infant health status are factors revealed to predict maternal role attainment in first-time mothers.

The results of this study showed that the factor which could predict 15.2% of maternal role attainment in first-time mothers was mothers’ support ( $p < .001$ ), (Table 10).

**Mothers’ support.** The result illustrated that mothers’ support was significantly and positively related to maternal role attainment in first-time mothers ( $r = .390$ ,  $p < .01$ ), (Table 8) and it accounted for 15.2% of the variance in maternal

role attainment. This means that first-time mothers who had great support from their mothers would have better maternal role attainment. On the contrary, those with less support from their mothers would have poorer maternal role attainment.

Moreover, mothers' support was the only factor that could predict maternal role attainment. It could be explained that the subjects perceived about receiving support from their mothers was at a fairly good level. Namely, they received emotional support, instrumental support, appraisal support and informational support at a rather high level. The subjects who receive emotional support and instrumental support from their mothers such as psychological support, labor, material, money, and time, achieved in the maternal role. Similar to social support is emotional or instrumental assistance which helps cushion the individual against the harmful effects of stressful event and which facilitates physical and psychological well-being and effective performance (Caplan, 1974; Chan, 1978; Cobb, 1976 cited by Collecta, 1981: 191). Moreover, the results of this study are congruent with Burr, et al. (1979 cited by Mercer, 1986: 21) which said that positive feedback from significant others in the environment regarding role performance enhanced the quality of role enactment. As mentioned above, mothers' support was the secure utilization to respond to the basic needs of first-time mothers including physically, psychologically and emotionally support. This was important to reinforce that first-time mothers could achieve in the maternal role. Similarly with the study of Cutrona and Throutman (1986: 1507-1518) who found that mothers who perceived themselves as having adequate social support had more confidence in parenting their full-term infants than mothers who did not have adequate social support. Also, Curry (1983: 115-121) found that mothers who lacked social support had difficulty adjusting to parenthood. This is

congruent with the study of Parawech (1989: 56) which found that mothers' support had a positive significant relationship with maternal role adaptation in adolescent mothers. Sriyasak (1996: 106) who found that families' support was significantly and positively related to maternal role adaptation in adolescent mothers. This corresponds with the study of Mercer (1986: 21) which found that within the teenage group only emotional support correlated significantly with maternal behavior.

However, this study found that mothers' support accounted for only 15.2% of the variance in the maternal role attainment of first-time mothers (Table 10). It may be concluded that most of the subjects had an extended family (72%) which included their spouses, babies and relatives. Thus, the subjects may have received more encouragement or support from their spouses and relatives who are close to them. Besides, 13.7% of the subjects received knowledge for infant care from other relatives (Table 2). Therefore, mothers' support of the subjects accounted for only 15.2% of the variance in maternal role of first-time mothers.

The other factors found such as age, family income, type of delivery, and infant health status, not to chosen into the regression equation due to the following:

**Age.** The result showed that there was no relationship between age and maternal role attainment. This referred to the difference in age that did not cause a difference in maternal role attainment. Most of the subjects were adults (71.3%), (Table 1), over 20 years of age. They were assumed to be mature and able to develop in to the maternal role. They were able to assess the situation, decide and choose the way to perform their maternal role and to take responsibility to achieve in the maternal role. Also, most of the subjects' mothers always have a time to support their daughters during 4 to 8 weeks postpartum period. Therefore, the subjects had good

maternal role attainment. This result was not consistent with concept of Mercer (1981:74) who stated that social acceptance of the maternal role as an adult role was in appropriate for the psychosocially immature than teenager. In addition, Jones, Green, & Krauss (1980 cited by Mercer, 1981: 74) who suggested that a lack of readiness for the role in younger mothers. They observed that mothers under 19 years of age held their infants less than older mothers and were less sensitive in responding to them. Moreover, age had a positive relationship with family income and negative relationship with the type of delivery at a significantly level .01 and .05 respectively. Therefore, the variability of the maternal role attainment score due to age may be accounted for by other factors that significantly related to age. Similarly, Rujiraprasert (1996: 76) who found that there was no significant relationship between age and maternal role attainment among infants of low birth weight. Also, the study of Varachnonth (1998: 76) who found that age had a no significant relationship with maternal role adaptation of postpartum mothers.

**Family income.** This study revealed that there was no relationship between family income and maternal role attainment. This referred to the difference in family income that did not cause a difference in maternal role attainment. This can be explained in that the maternal role was assumed about feeling and performing in mothering for nurturing the infant. The researcher did not assess how family income could influence maternal role attainment. Also, income is an important factor regarding the basic necessities of life and also for maternal role potential of first-time mothers. Moreover, 93.3% of the subjects had just enough income (Table 1). They had no socioeconomic disturbances. The subjects have different incomes so that they attain the same. This result is consistent with that one of Rujiraprasert (1996: 69).

Similarly with the study of Sookkavanawat (1998: 93) who found that family income did not correlate with maternal role performance in adolescent mothers during the postpartum period, in that it was unable to predict maternal role attainment. Nevertheless, Varachanonth (1998: 63) found that family income had a positive significant relationship with maternal role adaptation of postpartum mothers. Sriyasak (1996: 102) found that adolescent mothers who had a high family income had better maternal role adaptation than mothers with a low family income.

**Type of delivery.** This result showed that there was no relationship between type of delivery and maternal role attainment. This referred to the difference in the type of delivery that did not cause a difference in maternal role attainment. This can be because 74.7% of the subjects had vaginal deliveries which had no influential rehabilitation on their bodies. Moreover, the researcher only collected data during 4 to 8 weeks postpartum. The subjects already passed the crisis period for pain and suffering from delivery and they already returned to their normal health status. They had a rapid attachment with their infant, competence/confidence and satisfaction with the maternal role. The subjects who had vaginal deliveries had no difference in the maternal role attainment than those who had cesarean deliveries. This is congruent with the study of Sriyasak (1996: 86) who found that normal delivery and cesarean delivery had no correlation with maternal role adaptation in adolescent mothers, also the same results with the study of Varachnonth (1998: 63). However, Charuwatcharapaniskul (1985) who found that maternal-infant attachment in normal delivery versus cesarean section in first-time mothers had a significant difference on the maternal role attainment.

**Infant health status.** This study revealed that there was no relationship between infant health status and maternal role attainment. This referred to the difference in infant health status that did not cause a difference in maternal role attainment. This can be explained in that 81.3% of the subjects' infants did not have any health problems. If the infants had health problems, they were not severe health problems such as birth weight less than 2500 grams or jaundice (on phototherapy and without phototherapy), 53.6% and 32.1% respectively (Table 2). From these reasons, the subjects can have early attachment with their infants after delivery, which was the sensitive period. It was established that the subjects had competence/confidence and satisfaction in the maternal role. As a result, the maternal role attainment did not depend on infant health status. This result is consistent with the study of Sriyasaak (1996: 86) who studied the comparison between the infants who had illnesses and healthy infants. She found no difference in significant adaptation in adolescent mothers during the postpartum period.

In summary, mothers' support accounted for 15.2% of the variance in the maternal role attainment of the first-mothers. The remaining 84.8 % of variances of the maternal role attainment cannot be explained in this study. As the influential factor to the maternal role attainment is referred in the conceptual framework of Mercer. Mercer indicated that individual factors and situational or environmental factors were factors influencing maternal role attainment. In this study, mothers' support was a situational or environment factor cited by Mercer's conceptual framework.

## CHAPTER VI

### CONCLUSION

#### Summary of the Study

This study was a descriptive research that aims to study the mothers' support and maternal role attainment in first-time mothers. In addition, it was designed to determine the predictive power of predictor variables; age, family income, type of delivery, infant health status, and mothers' support to maternal role attainment in first-time mothers. The subjects were 150 first-time mothers who lived in Satun Province during 4 to 8 weeks postpartum period while attending the postpartum clinic and the well baby clinic at Satun Hospital, Langu Hospital, and Satun Municipality of Public Health Service Center. Home visits were done at the community of Kuandon District and Langu District for those who did not follow up on their appointment at Langu Hospital. The instruments used in this study were composed of three parts including demographic data questionnaire, mothers' support questionnaire and maternal role attainment in the first-time mothers questionnaire. The data was analyzed by SPSS 7.5 for Windows, and presented by percentage, mean, standard deviation. Pearson's moment correlation coefficient and stepwise multiple regression were used to explain the association between predictor variables and maternal role attainment. The results are as follows:

1. The majority age of the subjects were between 21 to 30 years old (64%), 74% were Islamics, Most subjects had educational levels of primary school and junior high school (40.7% and 22.7% respectively). Most of the subjects were married

(99.3%), 72.7% living with their extended families and 62.7% were housewives. Their family incomes had monthly income of equal or less than 5,000 baht (69.3%). Most of the subjects had vaginal deliveries (74.7%). The infants of them mostly had no health problems (81.3%). Most of the subjects had no experience in infant care (84.7%), with 78% received knowledge about infant care. More than half of the sources of knowledge came from their mothers (52.1%). Most the subjects' mothers were between 40 to 49 years old and 50 to 59 years old (36.7% and 35.3% respectively). More than half of them were housewives (54.7%). Finally, most of the subjects lived with their mothers during the 4 to 8 weeks postpartum period (78%), and 86% communicated regularly with their mothers (Tables 1-3).

2. The overall mean score of mothers' support was at a fairly good level. Considering each aspect, it was found that the mean scores of two aspects were at a good level including emotional support and instrumental support, while two aspects were at a fairly good level including appraisal support and informational support (Tables 4-5).

3. The overall mean score of maternal role attainment was at a good level. For each aspect, it was found that the mean scores of all three aspects were also at a good level including maternal role gratification/satisfaction, maternal-infant attachment and maternal role competence/confidence (Tables 6-7).

4. The mothers' support was the only factor that accounted for 15.2% of the variance of maternal role attainment ( $p < .001$ ), (Table 10).

## **Implications and Recommendations**

From this study, mothers' support accounted for 15.2% of the variance of maternal role attainment in first-time mothers. The results of this study showed that maternal role attainment was at a good level, with a part of attainment came from their mothers' support. Therefore, the researcher recommendations to promote maternal role attainment in first-time mothers as follows:

### **Implications and Applications of Research Findings**

For nursing practice

1. Nurses in the Antenatal Care (ANC) unit should assess the support of the primigravidas from their mothers, relatives, or the close people. Nurses can develop a special class for their mothers, relatives, or the close people to realize their self-worth to support the primigravidas such as giving knowledge, suggestions, listening to problems, comfort, sympathy and encouragement thorough financial help. Nurses should be the moderators in this class.

2. Nurses in the postpartum clinic unit should promote maternal role attainment in first-time mothers as follows:

- 2.1 Nurses should assess the support of the first-time mothers from their mothers, relatives, or the close people. Before the first-time mothers are discharged, nurses should give knowledge and suggestions for their mothers, relatives, or the close people about helping with infant care such as bathing, giving love, showing concern, helping in the household and financial help. In addition, their mothers, relatives, or the close people should accept that the infant care might differ from their way. Moreover, they should appreciate appropriately in infant care of first-time mothers.

2.2 Although, the results found that the overall mean score of maternal role attainment was at a good level. However, for each item, it found that performance of first-time mothers were at a fairly poor and poor level such as observation abnormal acts of infant including fever, abdominal pain, constipation, diarrhea and rashes, observation and telling about abnormal elimination of my baby, helping infant when he/she spits up or has vomiting and taking infant a long time to fall asleep. Therefore, before the first-time mothers are discharged, nurses should be aware about giving knowledge, suggestions, by using brochures and pamphlets about the proper performances of first-time mothers during the postpartum period.

2.3 Nurses should arrange self-care groups between first-time mothers and multiparous to contribute knowledge, experiences and information, which the first-time mothers can benefit to learn from perform during the postpartum period.

2.4 Community nurses should be aware of the mothers, relatives, or the close people who encourage and support the first-time mothers. Therefore, community nurses should stimulate these people give to support to the first-time mothers for attainment in the maternal role.

### **Implications for Further Studies**

1. Comparisons of maternal role attainment between spouses' support and mothers in first-time mothers.
2. Comparisons of maternal role attainment between normal deliveries and cesarean deliveries in first-time mothers.
3. A qualitative research for infant care behaviors of Thai Muslim mothers in maternal role attainment.

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## **APPENDIX A**

### **List of Experts**

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## APPENDIX B

### Consent Form

#### คำชี้แจงและการพิทักษ์สิทธิของกลุ่มตัวอย่างในการเข้าร่วมวิจัย

สวัสดิ์ศึคะ ดิฉันเป็นพยาบาลชื่อฟาอิซ๊ะ หลีเส็น กำลังทำวิจัยเกี่ยวกับการสนับสนุนจากมารดาของตนเอง และความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก โดยมีจุดประสงค์เพื่อเป็นแนวทางในการประเมินและวางแผนให้การพยาบาล ส่งเสริมให้มารดาที่มีบุตรคนแรกสามารถประสบความสำเร็จในบทบาทการเป็นมารดาได้เหมาะสมและมีประสิทธิภาพ

เนื่องจากท่านเป็นมารดาที่มีบุตรคนแรก จึงใคร่ขอความร่วมมือจากท่านในการตอบแบบสอบถาม ซึ่งเป็นการถามเกี่ยวกับการสนับสนุนจากมารดาของท่านเอง และความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก โดยจะถามท่านในระหว่างที่ท่านรอรับการตรวจหลังคลอดหรือได้รับการตรวจแล้ว หรือระหว่างรอรับการตรวจสุขภาพเด็กหรือได้รับการตรวจแล้วในกรณีที่ท่านพบบุตรมารับวัคซีน โดยไม่จำกัดเวลาในการตอบแบบสอบถาม โดยข้อมูลทุกอย่างจะเป็นความลับ ไม่มีการเปิดเผยชื่อให้ผู้อื่นทราบ แต่ข้อมูลทั้งหมดจะนำไปวิเคราะห์ในภาพรวม เพื่อเป็นประโยชน์ในการพัฒนาและปรับปรุงการปฏิบัติการพยาบาลให้มีคุณภาพยิ่งขึ้น ซึ่งการเข้าร่วมวิจัยเป็นไปตามความสมัครใจและยินยอมของท่าน ไม่ว่าจะท่านจะเข้าร่วมวิจัยหรือไม่ก็ตาม จะไม่มีผลกระทบต่อการรักษาพยาบาลที่ท่านได้รับแต่อย่างใด และหากท่านยินดีเข้าร่วมวิจัยแล้ว ท่านก็มีสิทธิที่จะยกเลิกการเข้าร่วมการวิจัยได้ตลอดเวลา โดยไม่มีข้อแม้ใด ๆ และถ้ามีข้อสงสัยใด ๆ ดิฉันยินดีตอบข้อสงสัยของท่านตลอดเวลา

ที่สำคัญที่สุด งานวิจัยครั้งนี้จะสำเร็จได้ตามวัตถุประสงค์ก็ด้วยความอนุเคราะห์และความร่วมมือจากท่านที่กรุณาสละเวลาตอบแบบสอบถามครั้งนี้ จึงขอขอบคุณเป็นอย่างสูง

ฟาอิซ๊ะ หลีเส็น

ผู้วิจัย

สำหรับผู้เข้าร่วมวิจัย

ข้าพเจ้าได้อ่านหรือได้รับคำอธิบายตามรายละเอียดข้างบนอย่างครบถ้วน และมีความเข้าใจเป็นอย่างดี ยินดีเข้าร่วมวิจัยครั้งนี้

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ผู้เข้าร่วมวิจัย



### แบบสอบถามการสนับสนุนจากมารดาของตนเอง

คำชี้แจง แบบสอบถามชุดนี้ประกอบด้วยข้อคำถาม ซึ่งถามเกี่ยวกับการได้รับความช่วยเหลือและสนับสนุนจากมารดาของท่านเองในระยะหลังคลอด ขอให้ท่านอ่านข้อความต่อไปนี้แต่ละข้ออย่างรอบคอบแล้วกรุณา ทำเครื่องหมาย ✓ ลงในช่องที่ตรงกับความรู้สึกหรือความจริงที่เกิดขึ้นมากที่สุด ในแต่ละข้อของแบบสอบถาม ขอให้ท่านตอบเพียงคำตอบเดียวและกรุณาตอบทุกข้อ การเลือกตอบจะถือเกณฑ์ดังนี้

- ไม่เป็นความจริงเลย หมายถึง ข้อความในประโยคนั้นไม่ตรงกับความรู้สึกหรือความเป็นความจริงที่ท่านได้รับเลย
- เป็นความจริงบ้างเล็กน้อย หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเล็กน้อย
- เป็นความจริงปานกลาง หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเพียงครั้งหนึ่ง
- เป็นความจริงส่วนมาก หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับค่อนข้างมากแต่ไม่ทั้งหมด
- เป็นความจริงมากที่สุด หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเกือบทั้งหมดหรือทั้งหมด

#### ตัวอย่าง

ข้อความ	เป็นความจริงมากที่สุด	เป็นความจริงส่วนมาก	เป็นความจริงปานกลาง	เป็นความจริงบ้างเล็กน้อย	ไม่เป็นความจริงเลย
0. ฉันคิดว่าแม่ของฉันรักฉัน	✓				



## แบบสอบถามความสำเร็จในบทบาทการเป็นมารดาที่มีบุตรคนแรก

คำชี้แจง แบบสอบถามนี้ต้องการทราบว่าการทำหน้าที่เป็นมารดาใน 4 – 8 สัปดาห์ที่ผ่านมาท่านมีความรู้สึกหรือมีการปฏิบัติที่มีต่อตัวบุตรและการทำหน้าที่มารดาอย่างไร โปรดอ่านข้อความแต่ละข้อแล้วพิจารณาว่าข้อความนั้นตรงกับความรู้สึกและการกระทำของท่านมากน้อยเพียงใด และกรุณาทำเครื่องหมาย ✓ ลงในช่องที่ตรงกับความรู้สึกและการกระทำของท่านมากที่สุด ขอให้ท่านตอบเพียงคำตอบเดียว คำตอบที่ได้จะไม่มีข้อคิดหรือถูก โดยพิจารณาคำตอบดังนี้

ไม่เป็นความจริงเลย หมายถึง ข้อความในประโยคนั้นไม่ตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเลย

เป็นความจริงบ้างเล็กน้อย หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเล็กน้อย

เป็นความจริงปานกลาง หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเพียงครั้งหนึ่ง

เป็นความจริงส่วนมาก หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับค่อนข้างมากแต่ไม่ทั้งหมด

เป็นความจริงมากที่สุด หมายถึง ข้อความในประโยคนั้นตรงกับความรู้สึกหรือความเป็นจริงที่ท่านได้รับเกือบทั้งหมดหรือทั้งหมด

### ตัวอย่าง

ข้อความ	เป็นความจริงมากที่สุด	เป็นความจริงส่วนมาก	เป็นความจริงปานกลาง	เป็นความจริงบ้างเล็กน้อย	ไม่เป็นความจริงเลย
0. ฉันคิดว่าลูกฉันแข็งแรง	✓				



**BIOGRAPHY**

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