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A study of the immediate needs of the primagravida after discharge from the hospital.

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A STUDY OF THE IMMEDIATE NEEDS OF THE PRIMAGRAVIDA AFTER DISCHARGE FROM THE HOSPITAL

Submitted to
The Faculty of the Boston University School of Nursing

by
Barbara E. Abbott

In partial fulfillment of requirements for the degree of Master of Science in Nursing Education
1954

First Reader
Second Reader
Third Reader
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>LIST OF TABLES</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter I. INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>2</td>
</tr>
<tr>
<td>Scope of the Study</td>
<td>3</td>
</tr>
<tr>
<td>Treatment of the Data</td>
<td>4</td>
</tr>
<tr>
<td>II. THE PHILOSOPHY UNDERLYING THE STUDY</td>
<td>5</td>
</tr>
<tr>
<td>III. PRESENTATION OF THE DATA</td>
<td>16</td>
</tr>
<tr>
<td>Procedure of the Study</td>
<td>16</td>
</tr>
<tr>
<td>Evidence of the Primagravida Mothers Needs Revealed by Voluntary Questions</td>
<td>20</td>
</tr>
<tr>
<td>Evidence of the Primagravida Mothers Needs Revealed by Directed Interviews</td>
<td>25</td>
</tr>
<tr>
<td>IV. SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS</td>
<td>46</td>
</tr>
<tr>
<td>Summary</td>
<td>46</td>
</tr>
<tr>
<td>Conclusions</td>
<td>48</td>
</tr>
<tr>
<td>Recommendations</td>
<td>50</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>53</td>
</tr>
<tr>
<td>APPENDIXES</td>
<td></td>
</tr>
<tr>
<td>A. VOLUNTARY QUESTIONS</td>
<td>57</td>
</tr>
<tr>
<td>B. QUESTIONS USED FOR DIRECTED INTERVIEW</td>
<td>60</td>
</tr>
<tr>
<td>Table</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>1. Areas of Information Requested by Primagravidas in Terms of the Number and Percentage in Each Category</td>
<td>21</td>
</tr>
<tr>
<td>2. Information Relative to the Infant's Care Requested by Primagravidas in Terms of the Number and Percentage</td>
<td>22</td>
</tr>
<tr>
<td>3. Information Relative to Feeding as Requested by Ten Primagravidas in Terms of the Number and Percentage</td>
<td>24</td>
</tr>
<tr>
<td>4. Information Relative to Behavior Patterns, Clothing, and Sleep Requested by Ten Primagravidas in Terms of the Number and Percentage</td>
<td>26</td>
</tr>
<tr>
<td>5. Information Relative to Elimination, Equipment and Other Problems Requested by Ten Primagravidas in Terms of the Number and Percentage</td>
<td>27</td>
</tr>
<tr>
<td>6. Major Areas Relative to Types of Responses Expressed by Ten Primagravida Mothers in Terms of the Number and Percentage in Each Category</td>
<td>29</td>
</tr>
<tr>
<td>7. Responses Relative to the Hospital Experience Expressed by Ten Primagravida Mothers in Terms of Number and Percentage in Each Category</td>
<td>30</td>
</tr>
<tr>
<td>8. Reasons in Favor of Rooming-in as Stated by Ten Primagravida Mothers in Terms of the Number and Percentage</td>
<td>36</td>
</tr>
<tr>
<td>9. Reasons Against Rooming-in as Stated by Ten Primagravida Mothers in Terms of the Number and Percentage</td>
<td>37</td>
</tr>
<tr>
<td>10. The Number and Percentage of Primagravidas For and Against an Organized Teaching Program within the Hospital Situation</td>
<td>39</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

An increasing number of maternity patients are being hospitalized but the period of hospitalization is shorter now than formerly. A substantial number of these women are under the care of private physicians. Because the mothers are in the hospital only a short time it is hardly to be expected that they can take full responsibility for their babies and their households in the early days at home. There is increasing attention to providing preparation for motherhood to clinic patients through mothers' and sometimes parents' classes during the prenatal period and through demonstrations postnally. Private patients frequently have only cursory instruction from the physician. Is this satisfactory? Does it place additional teaching responsibility on the nurses taking care of the patient in the hospital? What the mother has learned within the hospital will be valuable only in so far as she can use it in her home situation. Is referral of primagravidas to Visiting Nurse Service necessary for continued care and supplemental teaching?

Statement of the Problem

This study is concerned with the following problem:
What are the immediate needs of the primagravida mother after she is discharged from a maternity unit?

1. What knowledge, understanding, and simple skills does a primagravida need?

2. Does the primagravida mother feel that the hospital experience provided her with adequate information and help to meet the changes which are necessarily involved when she takes home a newborn baby?

**Purpose of the Study**

There is a need to study more precisely some of the needs of the primagravida mother after she is discharged from the hospital in order to make known the kinds of problems she must face in the home situation. A knowledge of these problems might aid in providing the mother and maternity nurse with a more dynamic hospital teaching program.

In order to carry out this purpose the following sub-questions will have to be answered:

1. What are the concerns or problems of the primagravida mother after she is discharged from the hospital?

2. In what areas do her needs fall?

3. What are some of the factors which contribute to her problems?

4. What does the primagravida think of her period of hospitalization?
5. What is being done to meet her needs?

Scope of the Study

As a graduate student in maternity nursing the investigator had interviewed ten clinic patients during their postpartum stay in the hospital. These interviews revealed a lack of insight on the part of the primigravida in relation to her future adjustment to the home situation. Many of these patients were without home experience with a small baby. Most of the anxieties expressed dealt with her limited ability to give care to her infant. If clinic patients who had had benefit of mothers' classes were anxious about their ability to care for a small baby, might not private patients who had not had such preparation have equal anxieties? Working as a staff nurse in the nursery, the investigator had an opportunity to observe some of the problems the private patient found in relation to adjustment to the infant. Upon graduation the student is expected to be able to meet satisfactorily the needs of every patient.

Through an appraisal of ten primigravidas by means of the directed interview technique, two days after discharge, ways of providing more support and offering more satisfactory guidance should be found. The sampling was selected on the basis of the following limitations as one source which would have usefulness in indicating gaps and opportunities which can be given particular attention in setting up meaningful learning experience for the nursing
student and the mother within the area of maternity nurs-
ing.

1. It includes only the normal, uncomplicated post-
partum mother.
2. It includes only those mothers who are living
with their husbands.
3. It includes only those mothers who have a nor-
mal newborn infant.
4. It is limited to only the mothers whose obstet-
rician is on the staff at Hospital X.
5. It includes only those mothers who have not
shown any marked emotional problems.
6. It does not include the investigator's
responses to questions or problems.

Treatment of the Data

The philosophy underlying this study will be pre-
sented as a criteria to be used in the interpretation of
the data and in the formulation of the proposals. In
Chapter II, the philosophy underlying the study will be
discussed. In Chapter IV, a summary will be made, the
conclusions will be drawn, and proposals will be offered.
CHAPTER II

PHILOSOPHY

In the preface of an obstetric nursing text the following tribute to the obstetric nurse appears:

I am well aware of the arduous nature and multiplicity of duties of the obstetric nurse, and I know the difficulties she overcomes in carrying out the principles of obstetrics. I take this opportunity to applaud her success. The ability to do the same thing day by day and many times each day, year in and year out and do it well each time - this is the soul of the true artist.¹

For the last fifteen to twenty years emphasis has been placed on encouraging mothers to go to the hospital for delivery. This shift in the place for delivering babies has transpired under the impetus of protection for mothers and infants and for the convenience of physicians.² It has been accompanied by a significant reduction in maternal and infant mortality. The contributions of obstetricians have been monumental, but they have been almost entirely on the physical side.³


³Eastman, Nicholson J. "Obstetrician Looks at
The transfer of the locale for childbirth has broken into the family relationship. Society has recognized since ancient days that childbearing and childrearing are the responsibility of two people. The process begins in the emotional realm. The duality is maintained all through the life of the child. Law and social customs recognize it. Only once is this duality broken - at birth in a hospital. The mother and baby are routinely separated. This has resulted in an unnatural fragmentation of the family at a momentous time for building unity. These defects may be placed at the door of the central nursery, which became an essential part of hospital maternity care in the early part of this century. The nurses' role has been, in essence, custodial. The nurse has helped to save lives by following a prescribed series of procedures largely connected with aseptic measures. The techniques prescribed by the physician and implemented by the nurse in delivery room, ward, and nursery have been all engrossing. "The basic nursing instruction and experience in most maternity units in relation to the mother and infant has been rather a


This trend toward compartmentalization has seriously affected educational training and experience of nursing students. The hospital program came more and more to depend on institutional rules, formulae, and routines which has resulted in separate departmental supervision of mothers and babies, with no medical person or coordinated group having a responsible interest in the mother-infant relationship, in the father as an integral part of the family unit, or in the home background. The nursing students have had minimal and impersonal contact with their patients and lacked opportunity to study the effect of hospital routines when applied to home situations. In the centralized nursery situation the student passes out and collects babies. There is little time for a mother's questions or for admiration or cuddling of the baby. What is in this for the student beyond an alien and meaningless routine? The students' educational training and experience has not permitted continuity in maternity nursing care and provided opportunities which she could utilize in helping the mother and family meet the maternity experience in a constructive, happy fashion.

The maternity experience, as an integral part of

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nursing, cannot be conceived of today apart from the society in which it functions. Both the practitioners of nursing and its recipients, the public, are feeling the need for change. The change which is coming about has tended to separate the professional workers into two groups, which is understandable and is all a part of progress. The group which has treated childbearing as a physical experience has perfected techniques and methods for physical safety. "The traditionalists with deep regard for the reduction of maternal and infant mortality rates, however, have applied the mechanized economies of the mass production assembly line to human beings and dispensed care under a discipline which is autocratic." According to Corbin, the traditionalists have oversold themselves on institutional mechanized care. In order to make more efficient the care provided in hospitals, they have lost the essence, the heart and soul of that care.

The problem is not so much one of knowledge, but of attitudes. In the shift from home to hospital delivery the obstetrical personnel have been so engrossed in the perfection of their technical tasks that human dignity and desires

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8 Ibid., p. 433.
and relationships have sometimes been overlooked.

The other group has stressed childbearing as a combined psychic and somatic experience and have developed techniques and methods for the reduction of inner tensions and the achievement of emotional satisfactions. This group is known as the proponents of natural childbirth and rooming-in, but theirs is an attempt to direct consideration to some of the good aspects of the rapidly abandoned older ways associated with home deliveries, a recouping of some oldfashioned benefits of maternal and child care. Their meaning reaches beyond physical facilities and signifies an attitude in maternal and infant care and a general plan of supportive parental education which are based on the recognition and understanding of the needs of each mother, infant, and family. It is a plan to maintain natural mother-infant relationships, to reinforce the potentialities of each mother and infant, and to encourage the family unit. In other words, it is a program which is an integrated, interdepartmental program of professional assistance which is aimed to help parents achieve happy

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family unity and warm parent-child relationships.

This newer trend, which considers the psychic and somatic aspects of childbearing has received a tremendous amount of publicity as a method of maternity care in hospitals. It may or not be accepted as common methods of practice. Nevertheless, discussion of it has given professional groups, hospital authorities and even parents themselves an awareness of the need to know more about the fundamentals of human relations and the scientific facts of good maternal and child care. There may be a growing demand for nurses who are prepared to take part in programs of instruction and in service that require much more than superficial knowledge of these subjects.

Because two schools of thought exist in our society today in relation to the maternity cycle one must be cognizant of the features of both groups, the traditionalists and the moderns, when developing a student clinical experience. According to the Curriculum Guide for Schools of Nursing, the kind of training that puts its emphasis on unquestioning obedience to orders and drill in fixed habits of behavior and standardized procedures will not prepare the nurse to meet new and constantly changing situations where intelligence, initiative, and self direction are

needed. The fact that many nurses at some time will assume additional responsibilities as wives and mothers has been given minor consideration in formulating the learning experiences involved in maternity nursing. "In the basic maternity clinical experience attention has been given almost exclusively to developing techniques of nursing care leaving the function of teaching individuals and groups, largely to grow like Topsy." The traditional maternity unit has for too long provided the new mother with a system whereby a nurse has given last minute scientific instructions which emotion and lack of knowledge prevent her from understanding.

Maternity is a way of life. We are concerned with maternity nursing as a unit within the total curriculum that will prove to be a positive developmental influence in the growth of the student toward individual maturity and competence as a practitioner.

A program should provide the nursing student with organized situations which will promote and foster the mental, emotional and social development of the student and vitalizing enough that it sustains the interests of the student and directs her toward the maternity patient and her family.

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12 Ibid., p. 30.


Maternity care should be built upon knowledge and upon human service designed to enrich the lives of those who give and those who receive the service. The student must early be helped to understand that her province is to relate her sociological, scientific, and technical knowledge to the experiences that parents have encountered in dealing with their family problems. "It takes the combination of life experiences of parents and the technical knowledge and skill of the medical team to analyze situations, identify problems, and arrive at a possible course of action within the family structure." 15 This is in contrast to the regimentation which has existed for the nursing student, where she has done things as she was instructed to do them, and was left no plastic adaptation to individual situations and feelings of mothers. Eastman 16 suggests a wholesale reconstruction of our entire program, by new emphasis on the mother as an individual and by the introduction of some of the amenities of human relationships into every case.

The nurse cannot think ahead and predict what instruction or guidance a mother will need simply by knowing

15 Ibid., p. 93.

she has had a baby, or the routines of a particular hospital. Individualized teaching means studying the problem that the mother has, listening to her and observing her in order to determine how she feels about various aspects of her condition. This includes studying her personality and behavior traits. The nurse must adjust her nursing care and teaching to meet the needs of the individual mother. Interviewing allows for individuation when the nurse follows the leads the mother gives, asks neutral questions, uses minimal activity, draws upon the knowledge that the mother has, and encourages her to participate actively in the thinking. Thus individualization of nursing care according to the mother's comprehension implies that intellectually the mother understands, socially the teaching is suited to her, and psychologically her needs are met.

Maternity nursing, like other areas of nursing specialization, demands from the nurse an understanding of interpersonal and family relationships. She should see the mother and baby as a part of the family unit rather than as an isolated individual, that is, the mother not only as a patient, but also as a woman, a wife, and a mother living with her family that is an important unit in the community. The mother's role should be active rather than passive, the nurse being in the supportive cast.

17 Ibid., p. 642.
"doing with" the mother instead of "doing to." This is to say that the nurse must be so motivated during her theoretical and field experience that she readily acquires an attitude in maternal and infant care and a general plan of supportive parental education which are based on the recognition and understanding of the needs of each mother, infant, and family.

In summary it can be said that maternity care today should aim to: 1) promote the natural, biological relationships between the mother and her newly born infant for mutual comfort of both; 2) to provide facilities in the hospital for meeting promptly the infant's and mother's obvious needs, so that the mother's positive response to her infant is promoted by the genuine and timely help accorded her; 3) to offer natural stimulus and appropriate help to mothers who wish to breast feed their babies; 4) to provide opportunity for the mother, before she goes home from the hospital, to observe and learn her baby's reactions, to learn how to take care of him, and to have instruction in changes to be expected in the forthcoming weeks; 5) to develop a maternal response by offering the mother appropriate occupation during the lying-in period by providing opportunities for developing trust in her own observation, feelings, and judgment; 6) to provide opportunity for the father to share acquaintanceship of their newborn child with his wife and to learn the essentials in
taking care of the baby; and 7) to restore in some degree continuity of medical supervision for the mother throughout pregnancy, labor, puerperium, and postnatally at home.

Continuity in maternal and infant care may be achieved through close interdepartmental association and consultation of the professional staffs responsible for maternal care, both in and out of the hospital. The ideals of a program that embraces maternal, infant, and family welfare convey a sense of continuity when they are consistently represented by all attending nurses, obstetrician, and pediatricians and when collaboration between these groups and individuals is genuine and apparent. The aim of a collaboration continuum of maternity services is to offer parents a beneficent and consistent consultative service and to avoid their exposure to the bewilderment of contradictory, authoritarian advice.
CHAPTER III

PRESENTATION OF THE DATA

Procedure of the Study

To understand the sample and the problem there is presented a brief description of the hospital situation and teaching plan for the home care of the baby.

The mothers who participated in this study were those admitted to and discharged from the maternity service at Hospital X. Hospital X is a tax supported general hospital located in a New England city. It has a total capacity of 300 beds. Fifty of these beds are allocated to the maternity unit in conjunction with forty-two cribs and seven incubators. The majority of the mothers are registered with either a general practitioner or an obstetrician.

For purposes of this study the selected primagravidas represent the private patients of the three established obstetricians on the staff at Hospital X. The objectives of the proposed study was described to each of them. Their interest and cooperation was elicited without any difficulty.

The average length of hospitalization for the primagravida is six days. She is allowed to ambulate between the second and fourth postpartum day depending upon her obstetrician. The nursing mother sees her infant five times daily as against the two times allocated the mother.
who selects formula feeding for her infant. In either case the newborn is with the mother for approximately thirty to forty-five minutes at a time. Formal instruction consists of a bath demonstration which is given by a graduate nurse working in the nursery. A teaching room is provided for this purpose on the ward. Equipment similar to that which might be used by the mother at home is provided. The bath demonstration is scheduled for 11:00 A.M. and it terminates with a question and answer period. There is no follow-up, however, to ascertain what she has learned.

The data were collected over a period of one month. Because of this time element the mothers were chosen according to their availability and in accordance with the criteria for the study group described on page 4. Because the investigator worked part-time as a staff nurse in the newborn nursery of Hospital X, a substantial relationship could be established between the prospective interviewee and the interviewer. Each mother involved in this study was visited a day or two prior to discharge. The interview and its purposes were explained and anonymity was assured. It is worthy of note that each primagravida approached for permission to visit her home accepted the request without any hesitancy.

The mothers were visited two days after discharge from the hospital. This time was selected because the investigator felt that the mother might have a greater
awareness of the type of help she needed from the nurse. The home visit was made between the hours of 9:00 A.M. to 11:00 A.M. as this seemed to be the established hours for many mothers to bathe and feed their infants. Also this time seemed to involve less interruptions in relation to calls and visits from relatives, friends and neighbors. Other internal or external influences could not be controlled in this particular situation. During the first hour the mother was allowed to express her needs and present questions or problems. The investigator attempted to give the necessary support and help which seemed advisable in the particular situation. This was an attempt to reaffirm the relationship between the investigator and the mother in the home, that during the second hour the mother might respond freely to the guided interview.

The data collecting device used in this study was a guided interview. Patient opinion can result in suggestions which should serve as helpful guides in planning the amount and kind of care we need to provide.

The value of obtaining patient opinion is further justified by Randall, who states that we should be

1 See Appendix A.


concerned with patient opinion and use this information to locate sources of misunderstanding and dissatisfactions. Furthermore, Bernays\(^4\) suggests that patient opinions are important because nurses are dependent upon them for help in solving their problems.

The guided interview,\(^5\) was devised to include the following:

1) what mothers thought they needed to know which would be learned through direct statements, expressed fears, or vagueness of replies to the investigator's questions.

2) what mothers felt they learned in the hospital which had been of definite help to them.

3) what specific facts, not taught, would they now consider, in retrospect, to have been desirable.

An attempt was made by the investigator to establish a permissive atmosphere so that when presenting the questions for the most part, they appeared to be independent rather than to be structured in a definitely designed organization. It was feared that the latter might lead the mother to give

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\(^5\) See Appendix B.
answers expected rather than to present her real feelings.

The trial run for the directed interview was conducted with a selected group of five friends and neighbors who had had a postpartum experience within the year. This group studied and answered them, and offered constructive suggestions for re-wording some of the questions for clarification of their meaning. An attempt was made to word the questions in such a way that misinterpretation would be minimized and it seemed during the trial run that the questions did conform. According to Payne, it may be "almost certain that on nearly every question, some fraction of the respondents give answers which they do not really mean to give."

Evidence of the Primagravida Mothers Needs Revealed by Voluntary Questions

A total of forty-four types of questions were presented to the investigator during ten hours of non-directive interviewing. The ten primagravida mothers who volunteered the questions ranged in ages from seventeen to thirty-seven years. Of these ten mothers one attended prenatal classes, nine did not, three were not interested in such classes, five stated that they would like to have attended and one was advised by her physician not to attend. It is

interesting to note that the one mother who did attend a prenatal series of classes did so without the knowledge of her doctor. The investigator failed to elicit her reason for not notifying her physician.

These forty-four questions have been grouped under the following headings listed in descending rank order of frequency: requests for information relative to infant care, feeding, behavior patterns, clothing and questions regarding sleep, elimination, equipment, and miscellaneous items.

TABLE 1
AREAS OF INFORMATION REQUESTED BY PRIMAGRAVIDAS IN TERMS OF THE NUMBER AND PERCENTAGE IN EACH CATEGORY

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number</th>
<th>Questions Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Care</td>
<td>13</td>
<td>29.4</td>
</tr>
<tr>
<td>Feeding</td>
<td>12</td>
<td>27.6</td>
</tr>
<tr>
<td>Behavior Patterns</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>Clothing</td>
<td>4</td>
<td>9.3</td>
</tr>
<tr>
<td>Sleep</td>
<td>3</td>
<td>6.9</td>
</tr>
<tr>
<td>Elimination</td>
<td>2</td>
<td>4.4</td>
</tr>
<tr>
<td>Equipment</td>
<td>2</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>44</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Computed from forty-four types of voluntary questions.
The types of information relative to the infant's care requested by the mothers are shown in Table 2.

In analyzing the primagravida mothers' questions relative to infant care, it was noted that 54.3 per cent of their inquiries were concerned with dexterity and confidence in handling the infant and with the rudiments of infant hygiene. The requests seemed indicative of the mothers' need for support and understanding.

**TABLE 2**

**INFORMATION RELATIVE TO THE INFANT'S CARE REQUESTED BY PRIMAGRAVIDAS IN TERMS OF THE NUMBER AND PERCENTAGE**

<table>
<thead>
<tr>
<th>Information</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of cord</td>
<td>10</td>
<td>13.7</td>
</tr>
<tr>
<td>When to give tub bath</td>
<td>10</td>
<td>13.7</td>
</tr>
<tr>
<td>Technique of handling</td>
<td>10</td>
<td>13.7</td>
</tr>
<tr>
<td>Care of body areas</td>
<td>10</td>
<td>13.7</td>
</tr>
<tr>
<td>How to give sponge bath</td>
<td>8</td>
<td>11.0</td>
</tr>
<tr>
<td>Use of oil and powder</td>
<td>7</td>
<td>9.6</td>
</tr>
<tr>
<td>Cause and prevention cradle cap</td>
<td>7</td>
<td>9.6</td>
</tr>
<tr>
<td>Care of circumcision</td>
<td>6</td>
<td>8.2</td>
</tr>
<tr>
<td>Temperature of bath and sleeping room</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>73</strong></td>
<td><strong>100.0</strong></td>
</tr>
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</table>

Source: Computed from forty-four types of voluntary questions.
The following is illustrative of this: the mothers approached the investigator with the query, "Will you please show me how to bathe the baby?" The mother was offered one of two choices, either to observe the investigator giving the bath or having the investigator watch the mother perform the procedure. The latter choice was encouraged and eight mothers requested supervision. During the bath procedure the mothers evinced such statements as:

"This isn't half bad, I was afraid to do it."
"This is easier than I thought."
"I feel like giving my baby ten baths a day."
"I'm glad you let me do this, otherwise my mother would still have to do it."

This has significant implications for the maternity nurse as demonstrations without actual follow-up experience in supervision of the new mother carrying out the bath procedure is not enough. The return demonstration by the mother can and should be included during her hospital stay, considering the short span of time for hospitalization or else some orderly procedure devised for follow-up demonstration in the home.

Table 3 illustrates the types of questions submitted by the primigravida mothers in relation to feeding. There was evidence that better teaching methods need to be devised if these new mothers are to be prepared to assume the responsibilities for the care of the baby. From the data presented in Table 3, it can be seen that two-thirds
<table>
<thead>
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<th>Information</th>
<th>Number</th>
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<tbody>
<tr>
<td>Length of feeding time</td>
<td>10</td>
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<tr>
<td>Burping</td>
<td>9</td>
<td>15.5</td>
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<tr>
<td>Amount of each feeding</td>
<td>8</td>
<td>13.8</td>
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<tr>
<td>Preparation of formula</td>
<td>6</td>
<td>10.3</td>
</tr>
<tr>
<td>Definition of demand feeding</td>
<td>6</td>
<td>10.3</td>
</tr>
<tr>
<td>Re-heating formula</td>
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</tr>
<tr>
<td>Giving water</td>
<td>5</td>
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</tr>
<tr>
<td>Omission of 2 AM feeding</td>
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<td>6.9</td>
</tr>
<tr>
<td>Quantity of breast milk</td>
<td>2</td>
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</tr>
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<td>Supplementary feeding for breast baby</td>
<td>2</td>
<td>3.5</td>
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<td>Rinsing baby's mouth with water after each feeding</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Totals</td>
<td>58</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Computed from forty-four types of voluntary questions.

Of these ten mothers were concerned with the practical problems of the feeding process. In the hospital, the nurse
assumes responsibility for dealing with these problems. Whether or not these new mothers have the same incentive for learning while in the hospital as they have when they are faced with the reality of the problem in the home situation, will be looked at subsequently in this study when the responses to the directed interview are analyzed. Is there the same incentive for learning about the care of the infant when the mother has the security of qualified nursing available as when she is faced with the complete responsibility after discharge?

Table 4 shows that 78.8 per cent of the mothers had no understanding or knowledge relative to types of crying, hiccoughing, sneezing, care of baby clothes, amount of bed covering for the infant and the patterns and positions necessarily involved with sleep. This is significant as it seems to imply that home from the hospital adjustments are complicated. The primagravida needs help to know what to do. Many new mothers are confused over how to perform and meet the varying needs of the infant. Table 5 indicates that 66.6 per cent of the mothers' questions were related to elimination.

Evidence of the Primagravida Mothers' Needs Revealed by Directed Interviews

The total number of ten interviews were conducted forty-eight hours after discharge of the primagravida mothers from the maternity unit of Hospital X.
TABLE 4
INFORMATION RELATIVE TO BEHAVIOR PATTERNS, CLOTHING, AND SLEEP REQUESTED BY TEN PRIMAGRVIDAS IN TERMS OF THE NUMBER AND PERCENTAGE

<table>
<thead>
<tr>
<th>Areas</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Types of crying</td>
<td>10</td>
<td>13.4</td>
</tr>
<tr>
<td>Hiccoughing</td>
<td>7</td>
<td>9.4</td>
</tr>
<tr>
<td>Sneezing</td>
<td>6</td>
<td>8.0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Cross-eye Development of sight</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing baby clothes</td>
<td>10</td>
<td>13.4</td>
</tr>
<tr>
<td>Amount of bed covering</td>
<td>9</td>
<td>12.0</td>
</tr>
<tr>
<td>Care of diapers</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td>Frequency of changing baby clothes</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patterns</td>
<td>9</td>
<td>12.0</td>
</tr>
<tr>
<td>Positions</td>
<td>8</td>
<td>10.6</td>
</tr>
<tr>
<td>Length of sleep time between feedings</td>
<td>6</td>
<td>8.0</td>
</tr>
<tr>
<td>Totals</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from forty-four voluntary types of questions.
TABLE 5
INFORMATION RELATIVE TO ELIMINATION, EQUIPMENT AND OTHER PROBLEMS REQUESTED BY TEN PRIMAGRAVIDAS IN TERMS OF THE NUMBER AND PERCENTAGE

<table>
<thead>
<tr>
<th>Area</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td>Appearance of stools</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best type of nursing bottle</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>Nipple testing</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrician vs. general practitioner or well baby clinic</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>Whom to contact for changes</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>Totals</td>
<td>27</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from forty-four voluntary questions.

In presenting the questions for the directed interview, it was deemed advisable for the most part to have them appear independent rather than to structure them in a definitely designed organization, as mentioned previously. In presenting these data, however, they have been organized
into major areas and further studied in terms of the types of responses in each of these major areas.

Analysis of the interviews revealed the following major areas: attitudes toward hospital experience, attitudes toward the infant within the hospital, attitudes toward teaching devices, and attitudes toward ability to handle and care for infant at home.

The distribution of the responses in terms of the number and percentage in each major category can be clearly seen in Table 6.

The question posed by the investigator relative to the hospital experience was in terms of satisfactions and dissatisfactions. The types of responses for both seemed to be related to nursing service, attitudes of nurses and diet. Table 7 indicates the percentage of responses in terms of satisfactions and dissatisfactions related to the hospital experience.

It is evident from the data that a high percentage of the responses presented were in terms of nursing service and the attitudes of nurses. The comments of satisfaction in relation to the preceding factors are as follows:

"Service very good."

"Pinkies (nurses' aides) are very willing to do things for you."

"Nurses were very good. They used to come to me and ask me what I wanted."
TABLE 6

MAJOR AREAS RELATIVE TO TYPES OF RESPONSES EXPRESSED BY TEN PRIMAGRAVIDA MOTHERS IN TERMS OF THE NUMBER AND PERCENTAGE IN EACH CATEGORY

<table>
<thead>
<tr>
<th>Major Area</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes toward Hospital Experience</td>
<td>21</td>
<td>35.6</td>
</tr>
<tr>
<td>The Infant within the Hospital</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>Attitudes toward Teaching Devices</td>
<td>20</td>
<td>33.9</td>
</tr>
<tr>
<td>Attitudes toward Ability to Handle and Care for Infant at Home</td>
<td>10</td>
<td>16.9</td>
</tr>
<tr>
<td>Totals</td>
<td>59</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

"Nurses very accommodating."

"The hospital is to be complimented on the courtesy and attention given me by the personnel.

"I didn’t ask for too much but always got what I wanted."

"The nurses who have children are more sympathetic."

It should be noted that on the basis of 100 per cent, 33.3 per cent of the responses referred to satisfactions whereas 57.1 per cent of the statements were relegated to dissatisfaction with the nursing service and the attitudes of nurses.
### Table 7

Responses relative to the hospital experience expressed by ten primagravida mothers in terms of number and percentage in each category

<table>
<thead>
<tr>
<th>Area</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing service</td>
<td>6</td>
<td>28.5</td>
</tr>
<tr>
<td>Attitude of nurses</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Diet</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Dissatisfactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing service</td>
<td>7</td>
<td>33.3</td>
</tr>
<tr>
<td>Attitude of nurses</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>Diet</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

Utterances which were noted by the investigator in relation to dissatisfactions with nursing service and the attitudes of nurses were:

- "We had to wait a long time for service."
- "Our requests were acknowledged but not fulfilled."
- "Why can't we be given explanations for things?"
- "Nurses don't get together. One says one thing,
one says another."

"There were days when there were not enough nurses."
"I disliked the early and noisy awakening time in the early A.M."
"Nurses are flippy."
"Personality of nurse determined type of care."
"Nurses were mad if bedpan asked for other than routine time."

"Nurses act as if you are not sick unless you have an operation."

"The nurses' attitudes seemed to be 'you got yourself into this, so'--"

It would appear that interpersonal relationships and environmental factors have a positive or negative effect on the primagravida mother. The following are some of the additional remarks:

"I know they were busy but they forgot a lot."
"They have so much to do. The nurses said they were short of help."

"The poor nurses are run ragged."
"The poor nurses run back and forth."
"They have so much to do."
"I understand there is a shortage of nurses."
"I hated to ask too many questions because I thought the nurses would think I was a pest."

"The nurses seem to get cross if you become upset about the baby."
"I know they are terribly busy and there is a shortage of nurses."

"Nurses would do things willingly if they wanted to but if they didn't you would know it or they just wouldn't do it."

"I felt I had to be apologetic when asking questions."
Several of the primagravida mothers disclosed that their requests for nursing service were rejected for such reasons as:

"Just a minute, we have more important things to do."

"Right now that is a trifle request."

"I only have two hands."

"The doctor ordered it and you have to take it."

These findings relative to satisfactions and dissatisfactions of primagravida mothers with the hospital experience have implications for those who are responsible for the administration of maternity units and those involved with teaching nursing students. The types of responses presented to the investigator can be assumed to be representative of the meaning the hospital experience has had for one small consumer group of maternity care. The postpartum woman, for many reasons, including physiological motivations, has a regressive tendency, and therefore has
a great desire to be mothered. Therefore, the patient's feelings are important elements in her physical well being during the postpartum period. The inference seems to be that the emotional needs of the postpartum patient are great and require skillful and understanding nursing care.

Because over fifty per cent of the responses of dissatisfaction within the hospital related to nursing service and the attitudes of nurses this would seem to suggest that meeting only the physiological needs of the postpartum patient is not enough. This has an implication that often nurses fail to recognize that mothers they are serving are also people. The nurse should have a significant role in aiding the new mother.

Deep regard has been given to maintaining a reduced infant and maternal mortality and morbidity rates in many prevailing maternity units. Experiences of the nursing personnel have been in terms of caring for either the mother or infant without a consideration as to the relationship of one to the other. In relation to the infant within the hospital situation the mothers advanced a variety of comments which follow:


"I wish the nursery nurses would have told us what to do, they just throw the baby at you."

"It would have been helpful to have had a nursery nurse available at feeding time to answer questions."

"It was upsetting to see the baby dressed in stained and torn shirt."

"The baby was well taken care of."

"I had so many questions. I felt I had to be apologetic when asking questions. Nurses seemed to be in such a rush - makes you feel as though you don't want to bother them."

"I disliked the method of showing babies. Would have been nice to have a larger area and more privacy."

"It was tiring to have the baby for such a long time."

These preceding comments seem to lend themselves to the fact that the primagravida mother needs and wants help with the baby. Answers to the question, "Would you have liked baby 'rooming-in' with you in your hospital room?" follow. The first group of answers are by mothers who said "Yes."

"Become accustomed to him before you have to care for him on your own. Learn how to feed, bathe and diaper him."

"Personal care of baby within hospital gives you confidence and greater sense of security when you get home. When you are occupied with your own baby think less of own discomfort."
"A mother needs rest but I also think she needs the confidence which comes from having her baby with her."

"I would have been happier and more contented. I would have gotten a chance to observe my baby's individual needs and physical processes while we were both under competent care. There would have been an unhurried relaxed start in nursing with plenty of time for cuddling."

"I have always thought that if you nurse the baby it would be much better to have the baby in the room with you. It gives you more confidence. Not seeing the baby oftener in the hospital makes it much harder to care for him all alone after you get home."

"It is a wonderful way to get acquainted with the baby, for the hospital staff helps with the work, leaving you free to relax and enjoy your baby."

Table 8 illustrates the responses to the preceding question.

The following are answers of mothers who answered "No" to the query, "Would you have liked baby 'rooming-in' with you in your hospital room?"

"Babies get better care in the nursery. The temperature is more even and the conditions more sanitary. I needed my rest the few days I was in the hospital in order to store up energy for the first days at home."

"I think a baby's crying would disturb the rest during those first days after delivery. I was too weak to
TABLE 8
REASONS IN FAVOR OF ROOMING-IN AS STATED BY TEN PRIMAGRAVIDA MOTHERS IN TERMS OF THE NUMBER AND PERCENTAGE

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gives Confidence and Greater Security</td>
<td>5</td>
<td>33.3</td>
</tr>
<tr>
<td>Learn How to Bathe, Feed and Diaper</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Observe Individual Behavior and Physical Processes</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Better Chance to Nurse</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Think Less of Own Discomfort</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Husband Could Have Closer Association with Baby</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>15</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

care for my baby immediately. Time enough when you get home to be with the baby and care for him."

"I didn't feel equal to it. I don't think a mother should have a baby all the time with her. She is recuperating. I looked forward to the times I could see her in the hospital and when I got home. I really was too tired to care for her."

"I don't think I was up to having her too long but
I would have liked having her long enough to learn some of the tricks of baby care. I felt badly also that my husband couldn't see her longer and for a closer association."

The negative reactions to the question on rooming-in are found in Table 9.

**TABLE 9**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed the Rest</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Too Weak to Care for Baby</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Time Enough to Care for Baby at Home</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Better Care in Nursery</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Nursery Sanitary and Temperature Stable</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>10</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

It is interesting to note the types of favorable reasons relative to rooming-in which were expressed by sixty per cent of the primagravidas. They believed that such a provision would have given them greater confidence and a sense of security in giving care to the baby. Forty per cent of the mothers were adverse to the "rooming-in"
plan primarily because of limited physical resources and need for rest. It should be noted that one mother who was opposed to "rooming-in" answered "No" with a reservation. Physically she did feel equal to such a program but did state, "I would have liked having the baby long enough to learn some of the tricks of baby care." The investigator would like to note also that three of the four mothers who disapproved of "rooming-in" were age thirty-four, thirty-five and thirty-seven respectively.

The evidence seems to indicate that the primagravida mother needs and wants actual practice in infant care which no amount of preliminary theory can give. The comments relevant to "rooming-in" which seem to indicate the mothers' need for support were present also in the voluntary questions. The apparent remarks regarding "rooming-in" would reinforce the observations of the investigator that most primagravida mothers are curious and eager. They have many unanswered questions. They are in a mood to learn because of their desire to care for their infant.

The question, "Would you have enjoyed attending a daily class, demonstration or mothers' group on the ward which would have been devoted to the questions and problems of motherhood?" was asked to determine the primagravida mother's attitude towards a type of teaching device. These reactions are found in Table 10. Seven mothers, or seventy
### TABLE 10

THE NUMBER AND PERCENTAGE OF PRIMAGRavidas FOR AND AGAINST AN ORGANIZED TEACHING PROGRAM WITHIN THE HOSPITAL SITUATION

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

per cent, answered "Yes." Two of these seven mothers added the following comments:

"Mothers could help each other. Tips and tricks of the trade could be shared. Experience is so essential."

"If demonstrations and things could be more realistic, more in keeping with what is really used in the home. More individual attention to individual needs."

Three primagravidas, or thirty per cent, who answered "No" to the latter question said:

"Too lazy. I wouldn't put myself out to go to one. I'm just not one of those people who goes in for lectures and things. I would like individual help better. A mother does pretty much as she feels is right without listening."
to a lot of experts."

"I didn't feel up to it. When you don't feel up to it you just don't learn. Just one demonstration is confusing and upsetting. There is just so much to learn."

"I didn't feel strong enough. Where I had had mother's classes I didn't attend the demonstration in the hospital because it was only my third day and I was weak and tired. I would have liked more individual help."

It is interesting to note that although there are three negative answers, the statements imply a desire for teaching but only on an individual basis. With due regard for individual differences the evidence seems to indicate that an organized teaching program for primagravida mothers within the hospital situation is worthy of some consideration. Provisions would be necessary for adaptation of the content to meet the needs of the individual mother and her family.

The following are the opinions of the mothers in answer to the question, "When do you think instruction on the care of yourself and baby should have begun?"

"Know things right from the beginning. You see the baby for such a short time and wonder what you are going to do when you get home."

"As soon as possible. Prenatally would be fine."

"About the third day postpartum I was really equal to instruction."
"As soon as possible. I just got the baby and nobody told me how to burp him or anything. I just had to use my common sense. The nurses just breeze in and out."

"As early as possible. I think most new mothers lack self confidence. They do not seem to have the confidence to try."

"I don’t know. I was equal only to individual instruction. What I needed most was to be told what to expect at home so I wouldn’t have been so alarmed."

"The sooner the better, even during pregnancy."

"Prenatally, during the fourth to the eighth month.

Have it for both husband and wife. My husband is very interested in knowing things. It’s a big help for the husband to know."

"I attended 'Mothers' Classes' in my seventh month. It was ideal because it was at a time near enough the actual delivery for me to retain the information and yet not late enough in pregnancy for me to be uncomfortable."

"About the fifth day in the hospital I was equal to listening and learning."

Analysis of these opinions reveal that the primagravida mothers vary as to when instruction should begin. The findings are indicated in Table 11. One mother mentioned, "Right from the beginning," which could be interpreted to mean either during pregnancy or immediately after the birth of the baby. Four mothers suggested the prenatal
TABLE 11
OPINIONS OF TEACHING PROGRAM AS STATED BY TEN PRIMAGRAVIDAS IN TERMS OF NUMBER AND PERCENTAGE

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin during Prenatal Period</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>As Soon as Possible</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Right from the Beginning</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>About the Third Day Postpartum</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>About the Fourth Day Postpartum</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Doesn't Know</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>10</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Compiled from information obtained from ten directed interviews.

period. Two mothers stated that instruction for them should start about the third and fourth day postpartum. One mother said she didn't know and two primagravidas said "as soon as possible." The inference seems to be that the new mother needs and wants instruction. It would seem that the obstetricians, the maternity nurses and the organizations concerned with maternity care should get together in their thinking and planning so that the particular needs of this group can be met more adequately.
Answers to the question, "Did you feel comfortable handling and doing things for your baby when you got home?" follow:

"Because of previous experience holding small babies I wasn't as nervous coming home and caring for as I thought I would be."

"Knowing that you were coming made it easier for me as I knew I could ask you questions."

"I was scared to death. In the hospital they just said he was a good eater. If I could have been told what to expect when I got home I would have felt better. My mother has cared for the baby mostly as I have been frightened to handle him. The thing that kept me going was that I knew you were coming and could help me. I think it would be a wonderful thing to have the nurse come to the home."

"I didn't mind handling him but I didn't know what to do for him. In the hospital you are just given the baby and the nurse leaves. Very little help is given unless you ask questions. The nurses seem to get cross if you become upset about the baby. I hated to ask too many questions, because I thought the nurses would think I was a pest."

"I don't think I would have had so much confidence if you hadn't been coming and had as much confidence in giving the baby a bath without your presence."
"Because of my maternity experience as a licensed attendant I was very confident."

"I have had plenty of experience taking care of my nieces and nephews as I have been married nineteen years. Of course it is difficult with your own."

"I was not comfortable about caring for him. I did not feel confident. I only fed him for awhile and my mother did all the other necessary things."

"It was quite difficult for me to handle the baby. I was very nervous at first just picking her up and changing her."

"I approached my return home with apprehension. Having an understanding husband helped. As long as you were coming I wasn't so upset. If only more help could be given the mother in the hospital, you would feel that you had done the various things in relation to baby care which would make it easier for you at home."

These preceding responses in relation to the handling of and caring for the infant within the home seems to reiterate the fact that the primagravida experiences a multitude of problems and uncertainties in relation to newborn care. Home from the hospital adjustments were minimized for three mothers because of previous experiences with infants whereas four primagravidas were frightened at the prospects of handling a newborn. The four frightened mothers stated that adaptation to their new situation was
diminished by the knowledge of the investigator's pending visit. It is interesting to note that four mothers suggested that the hospital should provide the primagravida with more help in preparation for discharge.

Despite the limited sampling the evidence seems to indicate that the primagravida mother should be given more support and offered more satisfactory guidance. It should be noted that the ten mothers interviewed had no one in the home to help them. The inference seems to be therefore that the primagravida needs knowledge, understanding and simple skills in order to assume, with a comfortable degree of confidence, the care of her newborn infant upon their return home. In advance of experience it is hard to develop an awareness of needs.
CHAPTER IV

SUMMARY OF FINDINGS, CONCLUSIONS
AND RECOMMENDATIONS

Summary

This was a study to ascertain, in terms of the opinions of primigravida mothers the needs of this group immediately after discharge from the hospital situation. To accomplish this two data collecting devices were utilized, namely: voluntary questions and directed interviews.

Ten primigravida mothers participated in this study. The mothers' voluntary questions were recorded by the investigator. The findings from these questions were classified according to appropriate categories and studied in terms of evidence of need. Mothers were interviewed relative to attitudes they had in regard to their hospital experience and how the nurse could be helpful to them. The data collected by this device were categorized also, and studied. The interest of the mothers in the study was influential in the success of data collection.

The data presented showed areas of need for help by the discharged primigravida mother. Certain areas of need were common to the two groups of data, while some needs were identified in only one area. The major evidence of need for the primigravida after she is discharged from the hospital
was shown regarding dexterity and confidence in handling the infant and with the rudiments of infant hygiene.

From the presentation and study of the data it revealed a desire for knowledge and a beginning skill in the recognition of the physical and other needs of the infant. Many problems that often develop in the early days at home could be prevented if the mother were really prepared for infant care. Help for the primagravida with certain physical aspects of infant care might add to comfort and safety of mother and infant and also contribute immeasurably to emotional security. The nurses do too much for the infant. The mother goes home and takes the baby out of an artificial environment and it is expected that the mother and infant will adjust themselves in a short time. It is evident that increased contacts with the baby and opportunity to observe his behavior stimulates many questions.

The findings in the study indicate the profound importance of incorporating the emotional aspects into the care given during the postpartum period. There is a need for the maternity personnel to know more about the fundamentals of human relations as well as the scientific facts of good maternal and infant care. The accomplishments of a maternity unit should be recorded not only in terms of a successful war waged against disease or the achievement of a living mother and baby, but also in terms of the degree of satisfaction and emotional security achieved by the
parents. It would appear that the nurse needs to understand her own attitudes. The maternity nurse should have a liking for new mothers, and understanding of the mother and her needs, and be able to deal effectively with her queries and manifestations of need. Meeting only the physiological needs of the primagravida mother is not enough.

**Conclusions**

There is evidence that consideration needs to be given to further strengthening several areas of postpartum care for the primagravida mother:

1. Increased sensitivity to the primagravida mother's attitude toward the infant and the subsequent problems and questions which are necessarily involved.

2. Greater consideration of the psychological aspects of the postpartum period.

3. More stress on the importance of the mother participating in the care of the infant. This would aid in meeting her need for information and help in planning for the infant's care at the most appropriate time, when the instruction has immediate significance.

4. Deeper appreciation of the need for establishing a good working relationship with a mother, skill in establishing rapport abetted by the nurse's understanding of how she relates to mothers and
reacts to situations. Understanding and skill in the use of non-directive technics of interview and less emphasis on didactic teaching.

5. There is a need to prepare parents to assume the care of a newborn infant. This teaching needs to start during the prenatal period. This would release time to discover the broader problems and to plan for remedial activities.

6. The present hospital policies regarding the help and information needed by the primagravida mother does not seem to satisfy the mother. If the hospital cannot provide the primagravida with the help she needs it would seem advisable to refer her to a Visiting Nurse Service for continued care and supplemental teaching.

7. There is a need for a quality of maternity service which will meet the needs associated with increased hospitalization and early discharge. The teaching done by the nurse within the hospital should be correlated with that done by the nurses in the community to avoid duplication and overlapping and to assure that the methods taught in the hospital are adaptable to the home.

8. It is essential that it be recognized that good maternity care is dependent upon the establishment of good inter-personal relationships and the
concomitant realization that mothers are human beings each with her own distinctive personality. Skill in the technical aspects of maternity nursing is not being minimized but the nurse needs both.

**Recommendations**

The findings from the study indicate the following recommendations.

1. Plans for group teaching, either during the antepartum or postpartum period, should be considered particularly in the area of infant care. The leader might utilize home equipment in teaching and demonstrating. The classes should be informal, characterized by a permissive atmosphere, group discussion and a sharing of problems.

2. Husbands need to be included in antepartum or postpartum teaching. It would seem advisable to suggest that some arrangements be made for combined classes for husbands and wives. The hospital, the public health nurses, and other agencies involved could offer such courses to the community at a time when most of these people could be reached. Such cooperation in planning would save duplication of efforts as well as reach a larger proportion of new parents.

3. There exists a need to acquaint the doctors with
needs of the primagravida mother at home and to
discover the attitudes of the medical staff
towards prenatal or postnatal classes for parents.

4. Prior to discharge from the hospital suggest to
the physician that he order referral to the com-
munity nursing service. These referrals could
include not only a report of the physical event
of delivery, but a summary of the parents' adjust-
ment to the new baby and a resume of learning
experiences.

5. Joint planning by hospital nursing administra-
tors and educators for desirable policies directed
toward student learning and patient satisfaction.

6. Teaching instruction of nurses on levels con-
cerned with maternity in terms of the known needs
of primagravidas as the mothers themselves ver-
balized. This might include the development of
skill in the use of the directive and non-direc-
tive interview technique.

7. Pamphlets, leaflets, and booklets available in
the maternity unit might be supplemental with
equipment. The parents or mothers could study
them and raise questions. Someone should be
available to follow through on any question they
might have. A strategic area might be selected
on the unit for a teaching display. Suggestions
might be made as to where further information could be obtained. The displays should be evaluated on the basis of appeal and degree of interest shown by parents. Revisions could be made on the basis of these experiences and observations. The cooperation and advice of the medical staff should be sought in developing these teaching projects.

8. There is a need for the maternity service to provide a practical environment for the mother to learn the principles and details of infant care by continuous observation, daily instruction, practice under supervision and a sharing and comparing of experiences. However, if this is difficult to accomplish the maternity nurse needs to know that her teaching will be correlated with that done by the nurses in the community, to avoid duplication and overlapping.
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APPENDIX A.

Voluntary Questions

1. When will the cord drop off?
2. How soon after the cord drops off can I put the baby in water?
3. How many times a day should the baby move its bowels?
4. What should the B.M. look like?
5. How long does it take a circumcision to heal?
6. How soon after a circumcision can I give the baby a tub bath?
7. Please explain the idea of demand feeding?
8. Is it all right if I put the baby on a schedule?
9. Is it safe to put a new baby on its stomach?
10. Should my baby empty the bottle at each feeding?
11. Why does the baby sleep all day but is fussy and won't sleep at night?
12. What position should a baby be in when sleeping?
13. How can you tell if the baby is really hungry?
14. How many times can I re-warm the bottle on self demand?
15. How long should I let the baby sleep before I should feed him?
16. How am I supposed to know whether his crying is from hunger or something else?
17. How many minutes should I take feeding the baby?
18. How many bottles a day should the baby take?
19. Would you please show me how to bathe the baby?
20. Can I use oil or powder on the baby's skin?
21. What is cradle cap? How is it caused? What can I do to prevent it?
22. What should the temperature of the baby's room be?
23. Where is the soft spot?
24. When does a baby begin to see?
25. Why does a baby hiccup?
26. Does sneezing mean a cold?
27. Is it all right that my baby spits up once in awhile?
28. How should I pick up and hold the baby?
29. How should I burp him?
30. How should I care for the diapers?
31. Who do I contact about changing the formula, giving vitamins and orange juice?
32. When should I give the baby water?
33. How am I supposed to care for the buttocks?
34. How should I care for the nose and ears?
35. How can I tell whether the baby is getting enough milk from me?
36. Should I give the baby a formula after he nurses? How much?
37. Should I change his shirt and nightie each time if they are slightly damp?
38. Can I wash the baby's clothes in the washing machine with the rest of the family wash?
39. Is it necessary to have the baby rinse his mouth with water after each feeding?
40. How should a girl's genitals be taken care of?
41. Is there any best type of nursing bottle?
42. When should the "2 A.M." feedings be stopped?
43. Would you show me how to cut the baby's nails?
44. How can you tell if the nipple is right?
APPENDIX B.

Questions Used for Directed Interview

1. What were the most satisfying things in your hospital stay? What were the least satisfying?
2. Would you have liked to have had the baby with you most of the time?
3. Did you feel comfortable handling and doing things for your baby when you got home? If not what could we have done?
4. Would you have enjoyed attending a daily class or demonstration or mothers' group on the ward which would have been devoted to the questions and problems of motherhood? As a new mother what problems or questions would you like to have had discussed?
5. When do you feel instruction on the care of yourself and the baby should have begun?