Attitudes and practices of nurses dealing with the older (ages 20 to 40) un-wed mother in the state of Montana
by Roxie Milburn Anderson

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University

Abstract:
The purpose of this study was to determine the attitudes of rural Montana maternity nurses toward the older (ages 20 to 40) un-wed mother and to determine the implications of such attitudes upon referral and the establishment of adequate support systems.

This study was also to determine beliefs and practices of these same nurses in the use of referral. The problem was investigated by: (a) a review of literature related to the problem; (b) a survey of a specific population of nurses regarding their attitudes, beliefs, and practices in relation to the older un-wed mother; and (c) a tabulation, analysis, and comparison of the data gathered.

The population was limited to three groups of nurses -community health, hospital maternity, and obstetrical office - and to all of the geographical areas within the state of Montana containing all three groups of nurses. The survey questionnaire was developed from information gathered through the review of literature and was tested for validity and reliability. It was then submitted to the designated population.

The study revealed a similarity of attitudes between the three groups of nurses. It also revealed that the attitudes demonstrated were favorable to the un-wed mother regardless of age and fell within the more recent theories and research.

There was a significant difference between the three groups of nurses in the area of beliefs and practices. Generally, the obstetrical office nurses felt that the nurse was less important as a referral agent. Practices followed this belief closely with the obstetrical office nurse utilizing the referral process less than either the community health nurses or the hospital maternity nurses.

There were less regulations about referral present in the employment situations of the obstetrical office nurses.

All three groups of nurses were in agreement on the need for earlier referral. It was felt that there was a great need for continuing education on the referral process with emphasis on need, process and knowledge of the agencies available for referral.

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Date May 5, 1980

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A thesis submitted in partial fulfillment
of the requirements for the degree

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ABSTRACT

The purpose of this study was to determine the attitudes of rural Montana maternity nurses toward the older (ages 20 to 40) un-wed mother and to determine the implications of such attitudes upon referral and the establishment of adequate support systems. This study was also to determine beliefs and practices of these same nurses in the use of referral. The problem was investigated by: (a) a review of literature related to the problem; (b) a survey of a specific population of nurses regarding their attitudes, beliefs, and practices in relation to the older un-wed mother; and (c) a tabulation, analysis, and comparison of the data gathered.

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Chapter 1

INTRODUCTION

During most of the written history of mankind, the problem of the un-wed mother has been present. The age of liberation has made society even more aware of this presence. The adolescent un-wed mother has been the subject of much research, increasing governmental focus and funding, and the establishment of more readily available support systems. Colleges are becoming more aware of the presence of the out-of-wedlock pregnancies within the student population and are now beginning to establish programs to provide guidance and counseling. Beyond these attempts, there has been very little research and very few attempts to provide special services or understanding for the un-wed mother who is not an adolescent.

As cultural norms have been changed in our society, there has emerged a greater tendency on the part of many un-wed parents to keep their children and raise them. There has been a slow but steady acceptance of single parenting and an acceptance of both single men and women as adopting parents of the older or handicapped "hard to place" children. Both the women's movement and the counter-culture middle-class student were strong agents in making parenthood a possible choice whether or not the woman is married. Young women from middle class families, in ever larger numbers, are allowing their pregnancies to continue to term and are choosing to keep their children.

Although society has been undergoing a change in its sexual attitudes and behavior, in which there has been a relaxation of taboos, and, although extramarital sex experiences are accepted among many older women, this professed code of behavior has not kept pace with changing practices. The idea of chastity and marriage is still the prevailing norm. Even though permissiveness, self-expression, sexual adjustment, and freedom from inhibition have been said to be the mark of the well-adjusted American, the violation of the traditional value system, unless covert, is still considered to be under both societal and cultural restrictions.

For most un-wed mothers this is a first experience in motherhood and, as such, will be an important influence in the shaping of the self-concept of the woman. Pregnancy constitutes a continuing experience in both physiological and emotional change. Many professionals feel it is extremely important for those in supporting positions to de-emphasize the unmarried, socially deviant aspect of the problem and to exphasize the normal motherhood components.

Bernstein (1965) has found that the un-wed mother is in a crisis situation in which both the maturational and the developmental types of crisis are present. McCarthy and Brown (1974) have found that the personal crisis the woman experiences when she finds that she is unhappily pregnant can precipitate a breakdown in her normal ways

of functioning and can cause psychological trauma and guilt which may plague her for years. On the other hand, a person undergoing a crisis will often be receptive to outside help and, if the crisis is then satisfactorily resolved, there is no lasting psychological or emotional sequel (Osofsky & Osofsky, 1972).

The nurse dealing with the un-wed mother will often find herself in the role of counselor. McCarthy and Brown (1974) have found that one of the most important functions of the counseling process is to have referral sources to help the client carry out decisions, to provide sources for financial support where possible, and to provide any such services which may be needed.

The un-wed mother presents many problems, whether she is a teenager or older. There is much more written and more research about the teenage un-wed mother. There also seem to be more support systems available to the teenager. She also has more ready support from the family unit, in spite of the social stigma. The older woman may be sometimes cut off from family support because of her age, her independence, economic situation, and her own pride in her independence.

Hallan (1967) has found some of the most common obstacles to good nursing care of the un-wed mother are the thoughts, feelings, and values of the nurse herself. The nurses's behavior, as well as the patient's, is based on teachings and experiences which have influences

on the nurse's intellect, knowledge, emotions, and spiritual and moral values. In order to understand the un-wed mother, every attempt should be made to increase the knowledge of the circumstances surrounding this very special phenomenon.

Attitudes of professional personnel toward un-wed motherhood directly influence the care the mother receives. Positive attitudes encouraging gentle handling and provision of social supports and referral to the human resource agencies can help toward the goal of the individual decision-making which is best for the mother and her baby.

Statement of the Problem

The problem of this study will be two-fold:

1. To determine the attitudes of rural Montana maternity, obstetrical, and community health nurses toward the older (ages 20 to 40) un-wed mother.

2. To determine the implication of such attitudes upon referral and the establishment of adequate support systems.

Need for the Study

In order to understand the un-wed mother's problems, every attempt should be made to increase the knowledge of the circumstances surrounding this phenomenon. Present literature does give some theories as to psychological causation, but there are many unanswered

questions. In view of the increasing numbers of un-wed mothers and the societal problems facing this group, the nursing profession has a definite obligation to work toward a means of providing the best possible help to the un-wed mother.

Roberts (1966) suggests that what appears to be needed is a long-term collaborative research effort involving theorists from many areas of knowledge. He proposes that the first step be a scientific examination of the attitudes and behaviors of various groups in our society directed toward the problem of the un-wed mother.

Attitudes of professional and non-professional personnel toward the un-wed mother directly influence the care the mother receives. The nursing profession has more direct contact with the problem area of un-wed pregnancy than any of the other disciplines; therefore the need for positive attitudes is extremely important. Bernstein (1965) has found that increased knowledge of the factors effecting the un-wed mother can reduce negative attitudes of support personnel.

As previously stated, there are numerous studies and much research directed toward the adolescent un-wed mother. Since the problems the older un-wed mother faces are unique in many ways, more research needs to be directed to that age group. Although recent legal abortion laws have made abortion a viable alernative, the older

un-wed mothers more often tend to take advantage of cultural value change to have greater control over their own lives. This alternative may sometimes mean a voluntary seeking of help from the professions.

General Questions to be Addressed

1. Is there a similarity of attitudes between the community health nurse, the hospital maternity nurse and the obstetrical office nurse toward the older un-wed mother?

2. Are referrals to and the establishment of adequate support systems of high importance to these three groups of nurses?

3. If referrals for the older un-wed mother are important, what types of referrals are made by the three groups of nurses?

4. If referral to and the establishment of support systems for the older un-wed mother are not important, are any referrals made?

5. Do the employment situations of these nurses provide any specific regulations about referral?

Methodology

A data gathering instrument in the form of a questionnaire was constructed for distribution to the selected population of nurses in Montana. Items which dealt with identified attitudes were selected so that responses would indicate either positive or negative attitudes. Additional items were included which provided information about

referrals made and steps taken to provide support systems for the older (ages 20 to 40) un-wed mother. A cover letter was sent with the questionnaire explaining the study. A stamped return-addressed envelope was also included. The survey was conducted during December and October of 1979 and January of 1980.

The sample population included those registered nurses employed full-time by those community health agencies recognized by the state of Montana. Registered nurses employed in individual maternity units in the hospitals in those same geographic locations and registered nurses employed by obstetrical physicians within those same geographic locations were also included in the population.

Limitations and Delimitations

Limitations:

1. The study was confined to the community health agencies recognized by the Montana State Board of Health.

Delimitations:

1. The study was confined to those hospitals within the same geographic areas which have separate maternity units.

2. The study was confined to nurses employed within those maternity units and to nurses employed by obstetrical specialists within the same geographic location.

3. The study was limited to nurses in Montana only.

4. Validity was established through a panel of experts.

5. Reliability was established through a test, re-test conducted under the same circumstances as the total study.

6. Interpretation of responses may have been subjected to the biases of the investigator, even though every effort was directed toward an objective analysis of data.

Definition of Terms

1. Attitudes are the inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, and convictions derived from past experiences, about specified topics, by which the individual brings himself into adjustment with his world (Funk & Wagnall, 1965).

2. Contraception is the prevention of pregnancy by either natural or mechanical means.

3. Counseling is an interrelationship between two factions - communication network - involving an attempt to enable an individual or a group to better function or handle his or her situation. It is a growth producing situation which involves problem-solving techniques (Funk & Wagnall, 1965).

4. Crisis is a stressful event or turning point in which there is a loss or a threat of loss that will disrupt the system's equilibrium (Aguilara, 1974).

5. Crisis intervention focuses on the immediate cause of the

disturbed equilibrium and the processes necessary to regain a level of function at least as high as before the crisis (Aguilara, 1974).

6. Illegitimacy is the production of offspring without the benefit of matrimony.

7. A nurse is a professional graduated from an accredited school of nursing and licensed by the state in which she is practicing. A community health nurse is employed by a recognized community health agency. A maternity nurse is employed by a hospital and working in a maternity unit in a hospital. An obstetrical office nurse is employed by an obstetrical and/or gynecologic physician with a practice in obstetrical care.

8. A referral is to direct or send for assistance, information, or services not supplied by the referring source (Funk & Wagnall, 1965).

9. Stereotyping is a conventional or hackneyed expression, custom, or mental image of a person possessing characteristics that typify a particular group (Funk & Wagnall, 1965).

10. Stigma is a mark of infamy or a token of disgrace - a mark indicating a defect or something not normal (Funk & Wagnall, 1965).

11. A support system is to hold, bear or sustain, to provide with maintenance, to give approval or assistance, or to uphold. The system can be family, significant others, or resources provided by community services or agencies (Funk & Wagnall, 1965).

12. Un-wed mother is to be used interchangeably in this paper with out-of-wedlock mother to denote the condition of pregnancy and childbearing without the condition of marriage.

13. Adolescent is to be used interchangeably with teenager, to denote the un-wed mother through the age of nineteen.

14. Older is to be used to denote the un-wed mother from twenty years of age through forty years of age.

Summary

Because of society members' tendency to stereotype the un-wed mother, the attitudes of professional personnel and their willingness and/or ability to refer or foster the provision of adequate support for this client are extremely important. In order to help the older un-wed mother, the professional needs to be able to deal directly and effectively with the immediate problem so that the experience enhances the mother's psychological growth rather than traumatizing her with feelings of guilt. This study attempted to find out if the nurses of Montana are fulfilling the older un-wed mother's needs. Jones (1972) points out that the traditionally negative place of the unwanted pregnancy in society has created social, moral, and psychological pressure on the unmarried pregnant woman. Therefore, the role of the professional nurse in helping alleviate this pressure may be of crucial importance if the un-wed mother is to have a positive experience.

Chapter 2

REVIEW OF LITERATURE

Introduction

The purpose of the review of literature is (1) to develop a greater understanding of the problems encountered by the un-wed mother regardless of age with special emphasis on the changing moral scene and the psycho-social aspects, (2) to review research findings which analyze attitudes related to the general problems of un-wed mothers, (3) to develop a greater understanding of the differences in the attitudes of nurses toward the older (ages 20 to 40) un-wed mother, and (4) to identify research studies which indicate a correlation between the attitudes of nurses and the effects of these attitudes on the process of referral and the provision of support systems to the older un-wed mother.

The literature was organized according to the purposes stated above and was intended to be comprehensive within these areas. As very little research was found in relation to the older un-wed mother, an attempt was made to include research in relation to the adolescent un-wed mother when it could logically pertain to the older un-wed mother. Also, because of the paucity of research on the older un-wed mother, it became necessary to utilize expert opinion to clarify some of the sociologic and psychologic aspects of the problem.

The presence of the un-wed mother in modern society is becoming more evident and more open, and the subject is very complex as to underlying psychological and sociological motivation. In order to understand the problem, it is necessary to investigate many categories of knowledge.

The Un-wed Mother -
Profile and Statistics

The birth of illegitimate children has been regarded as a serious problem for hundreds of years. In spite of the changing moral scene and the relaxing of attitudes toward sex, the illegitimate pregnancy engenders a high degree of concern. The actual figures on the extent of illegitimate births can be very complex and misleading. There has been a substantial rise in all measures of this illegitimacy since 1940, and the available data has certain limitations. The figures represent only an estimate. Statistics were gathered by the National Vital Statistics Division, Public Health Service, United States Department of Health, Education, and Welfare from information recorded on birth certificates. It must be noted, however, that all states do not require that a child's legitimacy status be recorded. Even in the states that do record illegitimate births, many women conceal the facts. Women who do not belong to a minority, who are older, who are better educated, or in higher social classes are more able to manipulate the

facts to their own advantage. Thus illegitimate births among the middle and upper classes are probably underreported.

As the 1970 White House Conference on Children (1970:96) has found, in spite of limitations in data, there has been a substantial increase in illegitimate births in the United States. From 1940 to 1957 the rise in the illegitimate birth rate was, in general, a rise in the percentage of illegitimate births in comparison to other births. From 1957 to 1965, the number of illegitimate births increased largely because the number of unmarried women had increased in proportion to the historical population distribution.

The White House Conference on Children (1970:97) also discovered that it is not teenagers who show the highest rates of illegitimacy in spite of the fact that they constitute a majority of unmarried females of childbearing age.

The figures on the incidence of illegitimacy for all groups in the United States show an overall upward trend. The White House Conference (1970:6) has stated:

> (But) even if these rates remain the same, or even decrease over the next 25 years, the numbers of illegitimate children born each year are likely to increase. This prediction is chiefly based on the fact that, owing to the high over-all birth rates between 1940 and 1957, there are far more women of childbearing age in the population today and this will continue to be the case for at least the next 25 years.

In Table 1, which follows, illegitimate births are shown.

These statistics are for the United States. In Montana, over the last 15 years, the number of illegitimate births to women over the age of 40 were in such very small numbers as to be insignificant. As a result, this study will utilize the ages 20 to 40 as the base.

Table 1

Illegitimate Births: United States, 1968

Age (years)	Rate per 1000 unmarried women 15-44 years of age
15-19	19.8
20-24	37.7
25-29	38.6
30-34	28.2
35-39	14.9
40-44	3.8

In an attempt to understand illegitimate childbirth, many selected factors have been put forward as major causes. Herzog (1967: 105-106), through her research, has found that when other relevant variables are carefully controlled, low intelligence, broken home, geographical mobility, and psychological or interpersonal disturbances do not stand up as major causes. She was unable to determine exact causative factors.

In an extensive study of more than 1,000 un-wed mothers in

California, Vincent (1954) found that contrasts and contradictions in norms contribute towards a high rate of illegitimacy. He found that society implicitly encourages the cause of illegitimacy and explicitly censures the result. He concluded that un-wed motherhood is not the result of any one personality type, intra-familial relationship or social situation. His studies show a wide variation among the un-wed mothers in such areas as their religious background, acquisition of sex information, dating patterns, and types of love, reward, or discipline shown in the home. He found that the way in which these factors were combined in the individual un-wed mother's experience was more important than any single factor. If the way traditional sex norms are taught are dependent on authoritarian methods or on negative sanctions or prohibitions, these norms may be discarded when the individual is faced with contrasts and contradictions and finds that there is as much or greater values and rewards associated with nontraditional sex behavior.

Human behavior can be interpreted in a way that is acceptable to modern statistical methods only when it is compartmentalized. The research is difficult, and the data are hard to define or identify. Because the observers are themselves part of the scene that is being observed, bias from preconceived ideas, beliefs, assumptions, attitudes to life and to other human beings is unavoidable. In the absence of

exact data, understanding of the causes of illegitimacy is slow and efforts at prevention and helpful management are often ineffective.

Psycho-social Aspects of Illegitimacy

The single or un-wed mother is not a new phenomenon in our society. In her studies of stereotying, Bernstein (1965) found that the un-wed pregnancy in our society is looked upon as a definite violation of cultural norms and that those norms will vary according to cultural and ethnic groups, social or educational sophistication, peer practice and age groupings. She has also found that the costs of reproduction in these cases is financial in some ways, but the highest cost is not monetary, but psychological, especially among the 40 percent who are teenagers, many of whom are immature physically and emotionally. The un-wed female must face the fact of pregnancy, which, to some, is proof of her violation of our societal mores.

In spite of statements that there is less societal pressure on the un-wed mother today, a great part of society looks on the un-wed mother state as a violation of a cultural norm. Bernstein (1965) also found that the theory of out-of-wedlock pregnancy currently accepted among many social workers and members of other helping disciplines is that it is a symptomatic and purposeful attempt by the individual to ease societal conflict. It could not be clarified as to whether the goal should be prevention of unsanctioned sex experience or of the

prevention of the out-of-wedlock pregnancy.

The findings also indicated that the social stigma and the discriminatory legal, social, and economic penalties that our society still imposes on the un-wed mother and her child affect her entire future in an adverse way.

Shapiro (1967) found that although people seem to "accept the event of illegitimacy," no one is actively in favor of it. She also found that the un-wed mothers thought that they were expected to feel guilty. All of the clients studied expressed varying degrees of disapproval of premarital sexual activity and the responses suggested mixed feelings and confusion.

Other findings by Shapiro (1967) indicated that the respondents considered a teenager just as responsible for her pregnancy as an older girl and that there really was not much of a difference between a girl who is illegitimately pregnant by someone for whom she feels a deep attachment or a girl who is pregnant as a result of a casual and short relationship. One of the general conclusions was that the cause of the problem was not a defect in themselves as individuals or in their families, nor was it the fault of society as a whole. They did, however, accept the idea that something is wrong in the way their generation or their peers handle the problems of sexual relations.

According to Bernstein (1965), the teenager whose group of

family loyalties precludes sexual experience may be safer from out-of-wedlock pregnancy at that time than she is at the age of twenty-two when her major satisfaction may reside in a group whose climate sanctions or invites such activity. As society has been undergoing a change in its sexual behavior in which there has been a relaxation of taboos, extramarital sex experiences are accepted among many college students. This professed code of behavior has not kept pace with the changing practices, and the idea of chastity and marriage is still prevalent. The birth of an illegitimate baby is thought by much of society to be visible evidence of a failure by mother and father or a fault in one or more portions of their lives. It is felt that all who form a part of society have legal, moral and social obligations, but it has been fashionable not to accept them all, but rather to select those which are found agreeable and to reject the rest. The general view that most un-wed pregnancies are coming from the lower class, economically deprived, and ethnic backgrounds is, according to Bernstein (1971), being shown as a fallacy. The extension of the out-of-wedlock pregnancy into our upper and educated classes in sizeable numbers has become marked in its occurrence. The classifications of the un-wed mothers must be broadened to include all races, creeds, and classes of society.

The National Council on Illegitimacy (1970) has found that it is important to know that there are many implications in the rearing of a

child in a one parent family in relation to the impact upon both the parent and the child. There are implications that affect both the mother and the child with respect to employment, heterosexual relations, and peer support. The possibility of implications for the child as illegitimate, for the growth of the child's identity formation and personality development, sexual identity formation, and general life coping skills, is accepted by the council's findings. It is essential to realize that increased knowledge of self, including the sexual self, is elementary in fostering the positive choice of parenthood based upon the adult's ability to resonsibly rear a child. Each individual situation is somewhat unique but each will fall into one of the National Council on Illegitimacy's (1970:90) categories which are as follows:

1. Some women who have been reared in one-parent homes or in unstable homes themselves become adequate parents.

2. A one-parent home may not necessarily be an unstable home; and a two-parent home may not necessarily be a stable home.

3. Identification of a family as a one-parent home does not necessarily imply that the one parent has never been married.

4. Many women who have never been married and who have borne one or more children out of wedlock are adequately rearing their children.

5. Among a group of women, all of whom have borne a child and have not married, one can find a wide range of psychological characteristics from the normal to the observable pathological.

Clothier (1943) states that no single explanation accounts

fully for a psychological phenomenon. Findings indicate the presence of a type of unconscious feelings and motives. It is also found that similar determinants do not always produce the same results. Loneliness and emotional starvation or hostility toward parents have been found to be the causes of un-wed pregnancies. Whatever the cause, the concept of legitimacy, by society, is based on married parents and deviations from this structure presents a problem. Sexual laxity has been found to be accountable for a part of the increased numbers of un-wed mothers and those factors related to the affluent society are operating and contribute to the combinations of circumstances which constitute increased opportunities for the event of illegitimacy and its accompanying problems, both for the individual and for society.

The Adolescent Un-wed Mother

The young girl growing up in our society is oriented primarily toward the adult role of wife and mother. As Bernstein (1971) has found, nonmarital sex has become increasingly audible and visible in our own time. When motherhood occurs outside of marriage, however, it loses much of its traditionally accepted meaning. In many respects, teenage un-wed mothers face the same tasks as do other un-wed mothers. However, factors peculiar to this developmental stage often present special problems in diagnosis and treatment. The pregnant adolescent must deal simultaneously with two developmental tasks that ordinarily would have

occurred in sequence and would have stretched out over several years. Biologically, her body has to cope with the stresses of pregnancy before it has accomodated itself fully to the demands of puberty. Psychologically, she has to cope with the adult tasks of motherhood while still acculturing herself to the problems of her adolescence. As a minor, she is legally under her parents' control. In many states, she is not permitted to marry, relinquish her baby, or receive medical care without the consent of her parents. Thus, biologically about to become a mother, she is a socially dependent child, prevented from making decisions that are ordinarily considered part of parental rights and responsibilities.

Findings by the Conference on Adolescent Fertility (1976:5) give an overview of the problems of adolescent pregnancies which is as follows:

> Close to 13 million of the 60 million women who became mothers in 1975 became parents before they became adults. . . . Early childbearing is increasing everywhere, is emerging as a serious problem in many countries, and has reached alarming levels in others (where it is associated) with serious health, socio-economic and demographic implications for young women, young men, their off-spring, and, indeed, for the whole society. . . . Adolescent pregnancy is a serious threat to the life and health of a young woman . . . whether the birth occurs in or out of marriage.

The Alan Guttmacher Institute (1976) has shown, through its own research and through its data gathering from other research projects, that the adolescents in the United States have rates of

childbearing that are among the world's highest. Over half of the adolescents in the United States are sexually active. An interesting fact is that 87 percent of the adolescents that give birth to out-of-wedlock babies keep the child. The non-marital birthrate among eighteen and nineteen year olds is becoming higher than among women twenty to twenty-four, reversing the trend that prevailed until the early 1970s.

Campbell (1968) has shown that when we study the girl who has had an illegitimate child we find that she suddenly has almost 90 percent of her life's script written for her. She will probably drop out of school, even if someone else in her family helps to take care of the baby; she will probably not be able to find a steady job that pays enough to provide for herself and her child; she may feel impelled to marry someone she might not otherwise have chosen; and she will find that societal acceptance may be hard to regain. It has been found that her life choices are few, and most of them are bad.

The United States government has become increasingly involved in the questions and problems related to the adolescent un-wed mother. In 1960, the White House Conference on Children and Youth made the following recommendations:

> A national program should be instituted to explain the needs of children born out of wedlock, the unmarried mother should have available, from public and voluntary agencies, medical, psychiatric, casework, group work, legal and financial services, vocational

> guidance, education, living arrangements, and early planning for the baby; services should be extended also to the biological father and to the parents of minor unmarried parents. Restrictions on public assistance and other services to, and particularly residence requirements for, needy children born out of wedlock and their mothers, should be removed. Research is recommended into the causes of the rising rate of illegitimacy, and into the cultural pattern into which many illegitimate children are born, which conflict with the values of society; and as part of the program of prevention, an effort would also be made to identify youngsters who are likely to become unmarried parents.

A survey conducted by Malo-Juvera (1970) of 100 pregnant adolescents' sexual activities and knowledge of and attitudes toward reproduction shows the need for earlier and better sex education at home and in school. Although sex education is being rapidly integrated into the school curriculum, it meets opposition from some who think that the total responsibility rests with the family. Another alarming finding is that everyone and anyone seems to be giving sex education, including untrained teachers, themselves naive about sex and the process of reproduction, and sophisticated professionals with special graduate preparation in this area are not being fully utilized. The availability of an instructor was found to be the main factor in the selection.

The Maternal and Infant Care Project (1970) in Newark, New Jersey reported the following. The problem of pregnancy in un-wed teenage girls concerns almost every family in the United States today. Although families higher on the economic scale may have the resources to hide a pregnancy and subsequent adoption, or secure an expensive

abortion, the inner-city pregnant adolescents could not escape either the expense or the stigma. The findings concluded that the pregnant, un-wed, adolescent girl had the greatest need of all clients and posed the highest obstetrical risk. The adolescent girl is living through a maturational crisis and pregnancy superimposed at this time doubled the pressures.

Mercer (1976) has found that her studies on the obstetrical and sociological hazards of teenage pregnancy showed that there are higher rates of toxemia and prematurity for this group, concomitant with late or little prenatal care. In addition, the young parent often drops out of school, placing herself at an economic disadvantage. Yet, even within this high-risk group, there are qualifications; certain demographic characteristics, such as race and socioeconomic status, are more important determinants of obstetrical complications than is age alone. Because pregnancy of the un-wed teenage girl is a universal problem, health care providers must find new methods for helping adolescent parents to cope effectively.

Adolescent girls are receiving inadequate sex education and contraceptive information is inadequate. It is also clear that pregnant adolescents are high risks not only because of their age and socioeconomic background, but because of their susceptibility to disease and nutritional problems. They need preventive information before

contraception and they also need intensive, personalized, comprehensive care during their pregnancies, deliveries, and postpartum periods.

The Older Un-wed Mother
(Ages 20 to 40)

Although much interest is centered on the health of the pregnant adolescent and although the highest perinatal mortality occurs in mothers fifteen to nineteen years of age, other age groups have individual needs which greatly influence the type of maternity care which should be provided. The second most rapid climb is in mothers who are over thirty. Clausen (1971:120) provided data which reveals that the major causes of maternal morbidity are more prevalent in the age groups beyond adolescence.

Table 2

Maternal Deaths - 1973

Ages (years)	No. of deaths
10-14	6
15-24	175
25-34	213
35-44	81
45-54	2
	477 Total

It must also be stated that these figures would be affected by the fact that there are a larger number of pregnancies in the twenty-five to thirty-four age groups.

Using the maternal death rate of 1973 as a starting place, the following table will illustrate a slight decrease in numbers for the ensuing years.

Table 3

Maternal Mortality: Selected Years

Year	No. of maternal deaths	Rate per 100,000 live births		
		Total	White	All Others
1973	477	15.2	10.7	34.6
1974	462	14.6	10.0	35.1
1975	403	12.8	9.1	29.0
1976	390	12.3	9.0	26.5

The above data were taken from the information released by the United States Department of Health, Education, and Welfare (1978). It should be stated, however, that the lower figures of maternal mortality may be affected by the fact that the birth rate has also declined for the years cited.

In certain women over thirty-five years of age, there is a much greater tendency to develop toxemia than in those who are twenty to thirty-four. This is especially true when there is an impoverished background and five or more previous pregnancies.

Russel and Schild (1977), in their work with college women, found that although 80 percent of the women stated that they used birth control, most were actually casual and erratic contraceptive users. The reasons are complex and address the need for increased understanding of the role of psychological needs and the resulting behaviors surrounding the use of contraceptives. Lydia Rapaport and Leah Potts (1971) have speculated that this behavior may be directly related to the unresolved tasks of adolescence. Russell (1976) feels that the problems presented by the group of women she studied indicate that they are often still dealing with unresolved adolescence or with incomplete mastery of adolescent tasks such as the formation of identity, capacity for intimacy, and the formation of stable affectional bonds. In addition, the problems are complicated by concurrent maturational tasks of emancipation from parents, vocational selection, and the forging of a new independent value system. Students are still struggling to develop competency in basic life skills.

It is important to bear in mind that there is very little research done in the field of the older un-wed mother. Most of the

information on this topic is expert opinion rather than research findings and provable data.

As the Women's Liberation Movement has progressed, the newer concepts of equality and personal choice have led to changes in the outlook of many older single women. Case studies in the social work milieu have presented numerous illustrations where the pregnancy in the un-wed woman was planned; furthermore, these same studies indicate that the independent financial and personal status of these mothers has made for a much more positive outlook for both mother and child. When the pregnancy is planned, the need for referral and support may be lessened, but it is very seldom that all possible decisions and their many ramifications have been investigated by these mothers.

It must be remembered that there are as many problem pregnancies among the older un-wed mother as among the adolescent population and that, often, the tendency for social stigmatization may be greater as the older un-wed mother "should have known better."

Pregnancy of the Un-wed Woman as a Crisis Situation

As the focus of this study is to determine the attitudes of nurses toward the older un-wed mother and the effects of these attitudes on the processes of referral and provision of adequate support systems to the un-wed mother, it becomes important to investigate the reasons support is so necessary. As knowledge of the phenomena of the un-wed

mother increases, it becomes apparent that the un-wed mother needs much help to enable her to face her situation and make the necessary decisions which affect both the mother and the child. Most of the information available in this field is expert opinion rather than sound research and statistical analysis.

The non-marital pregnancy as a crisis situation shows very clearly the need for referral and support systems. Most of the research done on the un-wed mother has found that the pregnancy itself creates a maturational crisis at the same time as the marital status adds a situational crisis. In most current literature on crisis intervention, the one source always cited is Caplan's theory on crisis intervention. Caplan (1964) feels that, in emotional functioning and performance as part of the social structure, an individual operates in a certain consistent pattern with very little self-awareness of the process and not much sense of strain. The person solves the problems by habitual mechanisms and reactions which usually involve the problem solving process. As in the systems approach, the person is usually in equilibrium with the system, the suprasystem and the subsystems. The normal patterns are maintained in equilibrium by a variety of habitual problem-solving processes and coping mechanisms. These processes and mechanisms have solved problems similarly and in approximate lengths of time and equilibrium has been re-established. In a crisis, the above

process has become much more complicated because the stimulus is larger and the usual mechanisms are unsuccessful within the time range.

The important factor influencing the occurrence of the crisis is an evident imbalance between the difficulty and the importance of the problem and the resources available to counteract the imbalance. At this time, other methods do not seem to be available. Functioning is interfered with according to the intensity and the importance of the problem and the resulting anxiety and strain.

Clark (1967) has found that the crisis of the un-wed pregnancy is closely related to culture itself. Culture is maintained through prescribed pressures and privileges, which have been carried from generation to generation, with some variations. The American culture identifies the family as the core institution through which society is perpetrated. In times of crisis, the individual relies much on the external support of culture or tradition. The concept of culture and family and the concept of culture and crisis are intermixed for the female pregnant out-of-wedlock. The problem the female now faces constitutes stress. Usual coping mechanisms are no longer effective. External support, cultural and interpersonal, is also now needed. The girl who is attempting to free herself from family dependency must now submit herself to her parents and others for help in resolving the crisis.

In crisis intervention, recognition of behavioral patterns is an important aspect of preventive mental health. Direct encouragement of adaptive behavior, environmental manipulation, general support, and anticipatory guidance are the general factors involved. The individual approach focuses on the immediate cause of the disturbed equilibrium and the processes necessary to regain a level of function at least as high as before the crisis and, if possible, a higher level of function.

It is especially important for the individual in the helping profession to recognize the interrelationships of persistence, change, and crisis which are also interrelated with a system. This individual must recognize the importance of these factors and be able to use them to provide support. The system must want to change. Much of the effectiveness of the intervention lies in the empathy of the interventionist and upon their attitude and support of the strengths of the person in crisis. Aguilar (1974) has found that anticipation of doubts, concerns, and worries will help response and the implication that feelings do exist is important in helping to make them more viable and acceptable.

As Clark (1974) has also found, the achievement of satisfying relationships with the un-wed mother depends on the interventionists' ability to evaluate their own behavior in relation to the mother and

to perceive their own capabilities and limitations correctly. In crisis intervention, the ability to project one's self as a caring person to the un-wed mother is one of the most effective tools with which to give help. The need for the provision of support and the need for referral cannot be overemphasized in the problem of the un-wed mother.

Alternative Actions for Resolution of the Problems of Illegitimacy

The role of the individual in the helping profession when dealing with the un-wed mother can be of extreme importance. The involvement of this individual may be direct or may be one of referral. Whichever it may be, the guidance of the un-wed mother to medical services is only a part of the overall helping relationship. The helping professional has to offer psychological support, help reduce pressures and understand, accept, and interpret the mother's feelings toward herself, her parents, the father of the child, and society in general. They must realize that there are many alternative actions available to the mother and these choices must be studied in order to enable the un-wed mother to chose the most appropriate alternative. The implications for the child are as important as the implications for the mother.

McCarthy and Brown (1974:443) have examined the alternatives offered and categorized them as follows:

a. to have a therapeutic abortion;

b. to have the baby and marry the father;

c. to have the baby and marry someone else;

d. to have the baby and live with the father or someone else, but not to marry;

e. to have the baby and keep it herself;

f. to have the baby and give it up to an adoption agency, relatives, or friends.

In order to understand and provide guidance to the un-wed mother, Miller's (1974) description of the periods in the life cycle when a woman is more vulnerable psychologically to unwanted pregnancy may be helpful. The first of the five periods is early adolescence when the girl begins to develop a sense of identity and is relatively ignorant of adequate birth control techniques. Her ability to relate pregnancy to intercourse may be limited emotionally, in spite of intellectual knowledge.

The second vulnerable period is late adolescence when she begins more regular sexual activity. There may be a gap before the girl actually realizes that she is a sexual person and can make choices and plans in regard to her reproductive future.

The third period is early adulthood when she has begun a relationship with a stable partner. Her pregnancy may result in relation to keeping the partner, or, if there is separation, during the period of loss and establishment of her relationships.

Adulthood is the fourth period and is a period of major life changes such as new jobs, marriage and moving to new communities. The pregnancy may occur with altered patterns of contraception and sexual activity. These times involve greater anxiety and less contraceptive vigil.

The fifth period is menopause, when the end of childbearing begins to become a reality. There may be present a sense of loss, a need to test the reproductive functions and a desire to re-prove her own sexuality.

Thus, the motivations for the pregnancy may be varied and are often not immediately obvious. It is important to recognize these factors when investigating alternatives.

Russell (1973:324) has found that there are actual changes in the attitude of the community toward illegitimacy in recent years and the primary motive seems to be now the protection of the child and the development and social adjustment of the mother. Russell states that the change in attitudes may be ascribed to several causes:

1. A realization of the higher rate of infant mortality among illegitimate children.

2. The publication of facts regarding certain types of commercial agencies which aroused public opinion as to the responsibility for safeguarding the unmarried mother.

3. Demonstration in certain areas that, by case work through individualized treatment, satisfactory results can be attained in the placing of responsibility for the child's care and in the rehabilitation of the mother.

The focus is on providing support for the un-wed mother which will enable her to find the alternative which will best fulfill her needs and the needs of the child. The life situation is the important problem rather than the unwanted pregnancy of the mother. Russell (1973) has found that this focus enables the woman to see the pregnancy in a better perspective and to explore alternatives in relation to both the pregnancy and her own current situation. The exploration of what the pregnancy means for her has implications in terms of her relationships with others, her goals and values, her identity, and her ability to cope effectively with the situation. This is important in the choice of alternatives and the necessary actions which may be involved.

Referral and Support Systems for the Un-wed Mother

Referral and support systems are the basic ingredients in a social case work approach. Social casework, as Russell (1973) has found, with the un-wed mother, is an enabling process for developing and engendering self-respect and a sense of responsibility. The mother must be helped to arrive at a point where she is able to proceed with safety to herself, the baby, and the community; or, when incapable of managing her life, to the point of securing adequate protection and supervision.

The task of providing mother and child with proper medical,

social, and legal treatment constitutes a problem which demands the understanding and cooperation of public and private agencies within the community. This focus does not change the situation, but it does help the individual to change her own situation.

If the nurse in contact with the un-wed mother cannot provide the above, she can be instrumental in finding these services and can help the client to obtain them.

Summary

Although there are technological advances and increased availability of birth control, a high number of unwanted, unplanned pregnancies continue to occur. There is still very little solid research in the determination of cause. In spite of the increased sexual freedom of our society, there is actually very little change in the stereotyping attitudes of society.

Although there are large amounts of research in relation to the adolescent un-wed mother, there is a paucity of research on the older un-wed mother. The review of literature revealed the need for cooperative and extensive research into the problem of the un-wed mother regardless of age. Only knowledge of the causes, the psychological processes, and sources of possible help can provide the nurse with the resources necessary to provide individual intervention, to make referrals, or to take the steps necessary to provide adequate

support for the un-wed mother.

Chapter 3

INTRODUCTION

The problem of this study was to determine the attitudes of rural Montana hospital maternity nurses, communith health nurses, and obstetrical office nurses toward the older (ages 20 to 40) un-wed mother and to determine the implications of such attitudes upon referral and the establishment of adequate support systems. A questionnaire was prepared and submitted to a selected sample of maternity, community health, and obstetrical office nurses throughout the state of Montana to ascertain these attitudes. The survey questionnaire method proved conducive to data collection over a large geographic area with relative speed and ease.

In this chapter the outline of the study is presented in the following sequence:

1. The population is defined and procedures for sampling are examined.
2. The investigation categories are defined.
3. The method of collection of data is discussed.
4. The method of data organization is outlined.
5. The statistical hypotheses are stated.
6. The data analysis is outlined.
7. The precautions taken for accuracy are described.

8. The chapter summary is presented.

Population Description and Sampling Procedures

The population consisted of three segments of the nursing population of Montana. The first group of registered nurses was those employed full time in public health departments recognized by the state of Montana. The second group of registered nurses were those employed by a hospital maternity unit. The third group were those registered nurses employed by obstetrical physicians. The locations involved were determined by the presence of the above three groups. These geographical units in Montana which contained all three groups of nurses were Billings, Bozeman, Butte, Great Falls, Havre, Kalispell, Miles City, and Missoula. The only other city in the state which filled the conditions was Helena where the pre-test and post-test were done. The Montana State Board of Health and Environmental Sciences, the Montana Licensing Board, and the Montana Hospital Board were utilized to obtain locations and names as was Elizabeth Richter's book (1977) on the Montana State Public Health Services.

Description of Investigative Categories

The problem was categorized into areas involving (1) attitudes of community health, hospital maternity, and obstetrical office nurses

toward the older (ages 20 to 40) un-wed mother, (2) priorities of these nurses in relation to referrals and provision of adequate support systems, (3) specific regulations on referrals in each employment situation, and (4) types of referrals made.

Method of Collecting Data

A questionnaire was designed to determine attitudes, use of referral, and certain demographic information. This questionnaire was first submitted to a panel consisting of two graduate students in nursing, two doctoral candidates, and two professors from the school of nursing. This was done to determine if the questions were valid and unambiguous. This was also done to provide information about the length of time it took to complete the questionnaire. Of prime importance, this panel helped to determine if the questionnaire did elicit the information needed. Necessarily, adoption of the questionnaire was based on this. Face and content validity were established at this time.

A pre-test, post-test was then conducted in Helena, Montana to provide further refining of the instrument and to establish the reliability of the items. The pre-test, post-test was conducted in the same way and under the same conditions as the study and reliability was established.

When the final questionnaire was ready, introductory contact

with public health departments, hospital maternity units, and the offices of obstetrical physicians was made to determine protocol and to elicit cooperation. The resulting protocols then determined the next step as to whether it was personal appointment, specific application procedure, or letter. The questionnaire, along with a cover letter was then hand-delivered to the nurses involved in the study. A self-addressed, stamped envelope was included with the questionnaires. Because of personal contact established during the hand-delivery of the questionnaires, follow-up to insure adequate return was accomplished by telephone. Where necessary, telephone calls were made three weeks after the suggested return dates. In two hospital settings, an additional telephone call two weeks after this became necessary.

Method of Organizing Data

Tables were constructed to display data concerning the questions in the study. The tables were constructed to provide information concerning nurses' attitudes, the provision of support systems and the need for and the use of referral.

Statistical Hypotheses

The questions to be answered by the study suggested the following hypotheses which were tested at the 0.05 level of significance.

1. (H_o) The attitudes toward the older (ages 20 to 40) un-wed mother are independent of specific group nursing membership (community health, hospital maternity, or obstetrical office nurses).

2. (H_o) Use of the referral process is independent of the attitudes of the community health, hospital maternity, or obstetrical office nurses.

3. (H_o) The referral process is independent of the community health, hospital maternity, or obstetrical office nurses' concept of the importance of this process.

Analysis of Data

Statistical analysis methods were used to test the stated hypotheses. Results were arranged in tables as follows:

1. Numbers, percentages, and frequency of response were used when appropriate.

2. The Chi Square test of independence was used to test the data to determine if a statistical significance exists between the attitudinal variables.

The 0.05 level of significance was used to test the hypotheses.

Precautions Taken for Accuracy

The data compiled from the questionnaire was double checked to guard against error. The data was analyzed by computer at Montana

State University with an appropriate program to avoid computational errors. Open ended questions were tabulated.

Summary

As indicated by the outline of procedures, this study proposed to determine the attitudes of registered nurses working in community health departments, hospital maternity units, and in the offices of obstetrical physicians toward the older un-wed mother and to determine the referral process and provision of support systems. To accomplish the purpose of the study, a questionnaire was designed to obtain this information. The questionnaire was divided into the following categories: (1) attitudes of nurses toward the older (ages 20 to 40) un-wed mother, (2) priorities of these nurses in relation to referral and provision of adequate support systems, (3) types of referrals made, (4) specific regulations on referrals of each employer, and (5) demographic information specific to the investigation.

The instrument was hand-delivered to the selected population and returned by mail. The data was compiled and analyzed to test the stated hypotheses. The Chi Square test of independence was used to analyze the data at the 0.05 level of significance. The data was presented in appropriate tables, conclusions were drawn and recommendations were made.

Chapter 4

ANALYSIS OF DATA

The purpose of this study was to determine the attitudes of rural Montana community health nurses, hospital maternity nurses, and obstetrical office nurses toward the older (ages 20 to 40) un-wed mother and to determine the implications of such attitudes upon the process of referral and the establishment of adequate support systems. The data and its analysis are presented in appropriate form for the areas under investigation.

Tables are presented to analyze each individual item of the questionnaire with regard to differences in practices and attitudes between the three groups of nurses - the community health nurses, the hospital maternity nurses, and the obstetrical office nurses - regarding the items under investigation. The tables contain the number and percentages of the nursing groups responding to the scale of each item. The items, other than the demographic data, also include the calculated value of chi square, the critical value of chi square, the degrees of freedom, the level of significance, the decision made for each item, and the comments on the significance or non-significance of each item.

Method of Sampling and Number Sampled

The population consisted of three segments of the active nurses of Montana. The nursing groups were registered nurses employed

full-time in public health departments recognized by the State of Montana, registered nurses employed by individual hospital maternity units, and registered nurses employed by obstetrical physicians. The presence of all three groups within a given geographical location determined the sample. The areas involved were Billings, Bozeman, Butte, Great Falls, Havre, Kalispell, Miles City, and Missoula, Montana. The questionnaires were then hand-delivered to all nurses within the three groups in those locations. A total of 213 questionnaires were delivered along with self-addressed envelopes for mailed returns.

Table 4 reveals the number of nurses who were delivered instruments and the number and percentage of returns usable for the purpose of this study, as well as the number and percentages of unusable returns. The return which was unusable was submitted by a licensed practical nurse rather than a registered nurse.

The high percentage (79.34) of returned, mailed questionnaires was probably due to the fact that the questionnaires were hand-delivered and resulted in personal contact with the respondents.

Data Tabulated

The responses of all three groups of nurses - community health, hospital maternity, and obstetrical office - involved in the study were carefully checked and scores for the questionnaire were tabulated. These individual scores were combined and computed to establish chi

square tables for those questions not demographic. The demographic information was tabled according to numbers and percent. The chi squares were established for all questions dealing with attitudes and practices. Tables were constructed for each of these items of the questionnaire from individual scores obtained by carefully pairing the frequency of responses to each scale between the three groups of nurses. The tabulated scores were analyzed by an appropriate program of chi square run at the Montana State University Computer Center. All of the computed statistical values were compared to the appropriate critical values at the 0.05 level of significance.

Table 4

Number and Percent of Nurses and Instruments Involved in the Study

Items	No.	%
Community health nurses - instruments delivered	68	100
Community health nurses - instruments returned	59	86.7
Hospital maternity nurses - instruments delivered	116	100
Hospital maternity nurses - instruments returned	87	75
Hospital maternity nurses - instruments unusable	1	1.14
Obstetrical office nurses - instruments delivered	29	100
Obstetrical office nurses - instruments returned	23	79.3
Total questionnaires delivered	213	100
Total questionnaires returned	169	79.34
Total questionnaires unusable	1	.59
Total questionnaires usuable	168	78.87

Demographic Information

The demographic information as to time in present position, time as a maternity nurse, educational degree, choice of nursing specialty, and age will be analyzed in Tables 5 through 9.

Table 5

Item 2A: Length of Time in Present Position

	1 year or less		1 to 3 years		3 to 5 years		5 to 10 years		Over 10 years		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	17	29	16	27	9	15	12	20	5	8	59
Hosp. mtnty.	25	29	34	40	7	8	13	15	7	8	86
O.B. office	3	13	8	35	6	26	2	9	4	17	23

Over 50 percent of the community health nurses and hospital maternity nurses have been in their positions less than three years with only 8 percent at over ten years. On the other hand, over 50 percent of the obstetrical office nurses have been in their position from one to five years. These figures do tend to indicate a larger turn-over in employment in public health and the hospitals than in the obstetrical physician offices. Following this, there is also an indication of this in the fact the 17 percent of the office nurses have also been in that position for over ten years.

Table 6

Item 3A: Length of Time as a Maternity Nurse

	1 year or less		1 to 3 years		3 to 5 years		5 to 10 years		Over 10 years	
	No.	%	No.	%	No.	%	No.	%	No.	%
Comm. health	12	20	10	17	6	10	9	15	6	10
Hosp. mtnty.	17	20	31	36	8	9	14	16	16	19
O.B. office	3	13	4	7	3	13	4	17	9	39

It became obvious from results and remarks from the questionnaire that the question regarding the length of time as a maternity nurse was not a good one for the community health nurse. Of the fifty-nine community health questionnaires returned, sixteen or 28 percent of these nurses omitted this question. The general comments were made that the community health nurse was a generalist rather than a specialist and dealt with many other areas along with the maternity.

It was also noted that a much greater percent (39 percent) of the obstetrical office nurses had been in maternity nursing for over 10 years.

Table 7

Item 4A: Highest Degree Held

	Associate		Diploma		Bachelors		Masters		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%
Comm. health	0	0	7	12	47	80	2	3	3	5
Hosp. mtnty.	18	21	37	43	29	34	1	1	1	1
O.B. office	4	17	12	52	6	26	1	4	0	0

The trend of the public health departments to hire no nurses below the bachelor's level with a preference for a master's level education became very evident with 88 percent of their nurses having a bachelors or better. Both the hospitals and the obstetrical offices had more than 50 percent of their nurses with education levels under the bachelors degree. The other category involved nurses with one of the degree levels plus. Two were working on a master's in nursing, one had a family nurse practitioner certification, and one had a bachelor's degree in another discipline (education).

Table 8

Item 5A: Choice of Maternity Nursing as Specialty

	Yes		No		Omitted	
	No.	%	No.	%	No.	%
Comm. health	11	19	44	75	4	7
Hosp. mtnty.	70	81	16	19	0	0
O.B. office	13	57	10	43	0	0

Of the community health nurses who answered no to the question "Did you choose maternity nursing as your specialty?", 70 percent stated that they had chosen community health as a specialty with maternity nursing as only a part of the generalist role. Of the hospital maternity nurses and the obstetrical office nurses, 76.23 percent chose maternity nursing as a specialty. Other than the community health nurses, the remaining negative answers listed employment need as the reason most often listed. Advancement, need for change, and job benefits were also listed. Several respondents emphasized that smaller towns and smaller hospitals tend to ban specialization.

Table 9

Item 6A: Individual Ages of Respondents

	20 to 25		25 to 30		30 to 40		40 to 50		Over 50	
	No.	%	No.	%	No.	%	No.	%	No.	%
Comm. health	6	10	23	39	12	20	12	20	6	10
Hosp. mtnty.	25	29	22	26	20	23	9	10	9	10
O.B. office	1	4	5	22	9	39	2	26	2	9

As the table shows, the largest numbers and percentages of the nursing groups were under the age of forty with only 9 to 10 percent over the ages of 50. The hospital maternity departments have, by far, the largest numbers of the younger (ages 20 to 24) nurses. This could be due to two factors: the larger number of positions available to the nurses and the large amount of time needed to obtain a higher degree level.

Employment Practices

Employment practices and beliefs will be covered in Tables 10 through 15. These will include the calculated value of chi square, the critical value of chi square, the degrees of freedom, the level of significance, the decision made for each item, and the comments on the significance or non-significance of each item.

Table 10

Item 7A: Importance of the Nurse as an Agent in the Referral Process

	Unimportant		Marginal		Moderate		Important		Very		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	0	0	3	5	10	17	46	78	59
Hosp. mtnty.	0	0	0	0	6	7	40	47	38	44	86
O.B. office	0	0	4	17	1	4	10	43	8	35	23

Comparison: Calculated value of x^2 = 23.94

Critical value of x^2, df - 4, = 9.488 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 7. How important is the nurse as an agent in the referral process?

Comments: There is a significant difference between the perceptions of the three groups of nurses regarding their agreement. While a high percentage of the three groups of nurses felt that the nurse was either important or very important as a referral agent, 17 percent of the obstetrical office nurses felt that the nurse was only marginally important.

Table 11

Item 8A: Specific Orders in Relation to Referral and the Un-wed Mother

	No		Yes		Omitted		Total No.
	No.	%	No.	%	No.	%	
Comm. health	26	44	33	56	0	0	59
Hosp. mtnty.	33	38	48	56	5	6	86
O.B. office	17	74	5	22	1	5	23

Comparison: Calculated value of x^2 = 14.846

Critical value of x^2, df = 2, = 5.991 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 8. In your employment situation, are there any specific rules or orders in relation to referral and the un-wed mother?

Comments: There was a significant difference between the three groups of nurses. A much higher percentage of the obstetrical office nurses had no rules or orders available to them in relation to referral.

Summary of Responses to Item #8A on
Specific Rules or Orders for Referral

8. In your employment situation, are there any specific rules or orders in relation to referral and the un-wed mother?

Of the total responses to the questionnaires, 51 percent of the respondents stated that there were specific rules or orders on referral for the un-wed mothers. A breakdown of these orders by nursing group follows:

Community health nurses - N = 33

10 - referrals suggested for all un-wed mothers
8 - confidentiality must be maintained
5 - home visits to be made for all high-risk un-wed mothers
3 - referrals mandatory for un-wed mothers
2 - home visits on referral by hospital
2 - referral with consent of the patient
1 - release forms must be obtained for shared information

Hospital maternity nurses - N = 48

8 - all un-wed mothers to be referred to public health
4 - refer to social workers at hospital
4 - refer only on doctor's orders
4 - refer all primiparas to public health
3 - free to refer as nurse feels necessary
1 - consent of doctor and patient required
1 - refer to medicaide
1 - must maintain confidentiality

Obstetrical office nurses - N = 5

3 - refer to office manager for decision on referrals
1 - refer to public health
1 - automatic referral to welfare and public health

Table 12

Item 9A: Freedom to Determine the Needs of the Un-wed Mother

	No		Yes		Omitted		Total No.
	No.	%	No.	%	No.	%	
Comm. health	0	0	59	100	0	0	59
Hosp. mtnty.	8	9	76	88	2	2	86
O.B. office	5	22	18	78	0	0	23

Comparison: Calculated value of x^2 = 11.50

Critical value of x^2, df = 2, = 5.991 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 9. Does your employment situation allow you freedom to determine the needs of the un-wed mother in relation to referral or to the provision of adequate support systems?

Comments: There was a significant difference between the three groups of nurses with a larter percentage of the obstetrical office nurses stating there was less freedom to determine the needs of the un-wed mother.

Table 13

Item 10A: With Freedom - Is Referral Attempted
Teen-age Un-wed

	No		Yes		Omitted		Total No.
	No.	%	No.	%	No.	%	
Comm. health	1	2	58	98	0	0	59
Hosp. mtnty.	8	9	76	88	2	2	86
O.B. office	5	22	14	61	4	18	23

Comparison: Calculated value of x^2 = 10.582

Critical value of x^2, df = 2, = 5.991 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 10. If freedom to determine needs is present, do you attempt to refer the teen-age mother to other agencies?

Comments: There is a significant difference in relation to the use of referral between the three groups of nurses. A larger portion of the obstetrical office nurses answered in the negative and a large percentage of these nurses also omitted this question.

Summary of Responses to Item #10A
Referrals for the Teenage Un-wed Mother

10. If freedom to determine needs is present, do you attempt to refer the teenage un-wed mother to other agencies? If yes, please list agencies utilized.

A total of 88 percent of the three groups of nurses - community health, hospital maternity, and obstetrical office - stated that they were free to refer the teenage un-wed mother. It became obvious that more referrals were done by the community health nurses with the hospital maternity nurses doing more referrals than the obstetrical office nurses. The community health nurses also utilized a wider variety of referral sources. A breakdown of the referrals made revealed many multiple listings and are as follows:

Community health nurses - N = 58

29 - social services or welfare
24 - teenage pregnancy projects
24 - WIC
18 - family planning
16 - continuing education
12 - well-child clinics
11 - mental health programs
8 - religious groups
7 - CETA
5 - human resource councils
4 - 4 C's
4 - parenting groups

Hospital maternity nurses - N = 76

30 - public health
15 - welfare

12 - WIC
3 - well-child clinics
3 - family planning
2 - religious organizations
1 - day care
1 - teen-age pregnancy groups

Obstetrical office nurses - N = 14

6 - public health
3 - welfare
3 - religious groups
2 - la maze classes
1 - teenage, pregnancy groups

It also became evident that the community health nurses used more resources with the hospital maternity nurses second and the obstetrical office nurses utilizing the least number of sources for referral of the teenage un-wed mother.

Table 14

Item 11A: With Freedom - Is Referral Attempted Older Un-wed Mother

	No		Yes		Omitted		Total No.
	No.	%	No.	%	No.	%	
Comm. health	0	0	59	100	0	0	59
Hosp, mtnty.	14	16	66	77	6	7	86
O.B. office	5	22	14	61	4	18	23

Comparison: Calculated value of x^2 = 13.998

Critical value of x^2, df = 2,=5.991 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 11. If freedom to determine needs is present, do you attempt to refer the older (ages 20 to 40) un-wed mother to other agencies.

Comments: There is a significant difference in relation to the use of referral for the older un-wed mother. Again a larger percentage of the obstetrical office nurses answered in the negative and 18 percent of these same nurses omitted the answer.

Summary of Responses to Item #11A

Referrals for the Older (Ages 20 to 40) Un-wed Mother

11. If freedom to determine needs is present, do you attempt to refer the older (ages 20 to 40) un-wed mother to other agencies? If yes, please list the agencies utilized.

Again, a total of 88 percent of the three groups of nurses - community health, hospital maternity, and obstetrical office - stated that they were free to refer the older (ages 20 to 40) un-wed mother. Again it was obvious that more referrals were made by the community health nurses and more sources were utilized. In the case of the older un-wed mother, when considering the number of respondents, the obstetrical office nurse were somewhat higher than the hospital maternity nurses in the number of referrals. The two groups were comparable in the numbers of agencies utilized. Multiple listings were found and a breakdown of nurses attempting referrals is as follows:

Community health nurses - N = 59

22 - social services or welfare
12 - family planning
12 - WIC
8 - religious groups
5 - well-child clinics
3 - other health agencies
2 - single parent classes
2 - adoption agencies
1 - Florence Crittendon Home
1 - RCC agency

Hospital naternity nurses - N = 66

21 - home health or public health

13 - welfare
8 - WIC
2 - family planning
1 - single parent organizations
1 - well-child clinic
1 - religious organizations

Obstetrical office nurses - N = 14

3 - office manager
4 - welfare
4 - religious organizations
2 - WIC
1 - childbirth classes
1 - la maze classes

There are not quite as many sources or agencies utilized for the older (ages 20 to 40) un-wed mothers as for the teen-age un-wed mother. Conspicuously absent are continuing education and mental health programs which should be important for both groups.

Table 15

Item 12A: Estimation of Percentage of Un-wed Mother Referrals

	Less than 10%		10% to 30%		30% to 50%		Over 50%		Unable to Estimate		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	3	4	9	15	15	25	21	36	11	19	59
Hosp. mtnty.	3	3	9	10	16	19	31	36	27	31	86
O.B. office	1	4	4	17	8	35	5	22	5	22	23

Comparison: Calculated value of x^2 = 14.281

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Question: 12. Can you estimate the percentage of the older (ages 20 to 40) un-wed mothers that have been referred to other resources from your employment base?

Comments: There was no significant difference between the three groups of nurses in response to the question. All three groups had the largest percentages in the areas of 30 percent to 50 percent and over 50 percent.

Table 16

Item 13A: Counseling the Older Un-wed Mother

	Never		Occ.		Moderately		Often		Always		Omitted answers		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	19	32	3	5	9	15	24	41	4	7	55
Hosp. mtnty.	3	3	33	38	18	21	18	21	10	12	8	10	78
O.B. office	4	17	7	30	3	13	7	30	2	9	0	0	23

Comparison: Calculated value of x^2 = 36.330

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Reject the null hypothesis

Question: 13. As a nurse dealing with maternity patients, do you counsel the older un-wed mother?

Comments: There is a significant difference in the counseling done by the three groups of nurses with the majority of the public health nurses counseling often or always and 17 percent of the obstetrical office nurses never counseling.

Attitudinal Responses

Attitudinal responses will be covered in Tables 17 through 37. These responses will include the calculated value of chi square, the critical value of chi square, the degree of freedom, the level of significance, the decision made for each item, and the comments on the significance or non-significance of each item.

Table 17

Item 1B: Out-of-Wedlock Pregnancy Theory

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	1	2	10	17	19	32	17	29	12	20	0	0	59
Hosp. mtnty.	5	6	12	14	31	36	23	27	12	14	3	3	83
O.B. office	1	4	3	13	7	30	5	22	6	26	1	5	22

Comparison: Calculated value of $x^2 = 4.021$

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 1. The theory of the out-of-wedlock pregnancy currently accepted among the helping professions is that it is a symptomatic and purposeful attempt by the personality to ease unresolved conflict.

Comments: There is no significant difference in current theory among the three groups of nurses. Many more of the nurses disagreed with the statement rather than agreed.

Table 18

Item 2B: Pregnancy of the Un-wed Mother as a Symptom

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	3	5	9	15	15	25	31	36	11	19	59
Hosp. mtnty.	3	3	9	10	16	19	31	36	27	31	86
O.B. office	1	4	4	17	8	35	5	22	5	22	23

Comparison: Calculated value of x^2 = 6.988

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement 2. Pregnancy for the unmarried woman, regardless of age, is a symptom of underlying emotional difficulty.

Comments: There is no significant difference in the three groups toward the question and a greater percentage of the nurses did not agree with the statement.

Table 19

Item 3B: Cultural Norms and the Un-wed Mother

	Strong agree		Moderate agree		Niether		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	4	7	26	44	20	34	8	14	1	2	59
Hosp. mtnty.	7	8	27	31	28	33	20	23	4	5	86
O.B. office	7	17	3	13	8	35	7	30	1	4	23

Comparison: Calculated value of x^2 = 10.882

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 3. The un-wed mother is looked upon by society as having violated a cultural norm.

Comments: There is no significant difference between the three groups of nurses with the larger number of nurses in agreement with the statement than in disagreement. A large number of the nurses neither disagreed nor agreed.

Table 20

Item 4B: Responsibility of the Teen-age Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	1	2	6	10	5	8	30	51	17	29	59
Hosp. mtnty.	0	0	7	8	13	15	36	42	30	35	86
O.B. office	1	4	1	4	4	17	2	9	15	65	23

Comparison: Calculated value of x^2 = 15.568

Critical value of x^2, df = 6, - 12.592 at 0.05 level of significance.

Decision: Reject the null hypothesis

Statement: 4. The teenage un-wed mother is not responsible for the problems that ensue because of her lack of knowledge and inability to control her life.

Comments: There is a significant difference between the three groups of nurses but the difference is one of degree with the community health and hospital maternity nurses more in moderate disagreement and the obstetrical office nurses more in strong disagreement.

Table 21

Item 5B: Responsibility of the Older Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	3	5	10	17	13	22	25	42	8	14	59
Hosp. mtnty.	11	13	20	23	17	20	22	26	16	19	86
O.B. office	5	22	7	30	3	13	6	26	2	9	23

Comparison: Calculated value of x^2 = 11.317

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 5. The older un-wed mother is usually totally responsible for her condition.

Comments: There is no significant difference between the three groups of nurses although the obstetrical office nurses did show a slightly higher percentage in strong agreement than did the other two groups. The community health nurses showed a slightly higher percentage in disagreement.

Table 22

Item 6B: Age and Crisis Situation

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	0	0	0	0	16	27	43	73	59
Hosp. mtnty.	1	1	0	0	4	5	20	23	61	71	86
O.B. office	0	0	0	0	0	0	9	39	14	61	23

Comparison: Calculated value of x^2 = 6.830

Critical value of x^2, df = 4, = 9.488 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement 6. Because of her age, the older un-wed mother does not face a crisis situation.

Comments: There is no significant difference between the three groups of nurses who were largely in either moderate or strong disagreement.

Table 23

Item 7B: Promiscuous Females

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	3	5	6	10	21	36	29	49	59
Hosp. mtnty.	2	2	6	7	7	8	19	22	52	60	86
O.B. office	0	0	2	9	4	17	4	17	13	57	23

Comparison: Calculated value of $x^2 = 6.396$

Critical value of x^2, df = 6, = 12.529 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 7. There does not seem to be much difference between the un-wed mother and other promiscuous females.

Comments: There is no significant difference between the three groups of nurses but it is important to realize that the large percentage of all three groups were in strong disagreement with the statement.

Table 24

Item 8B: The Un-wed Mother and Hostility

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	4	7	10	17	28	47	17	29	59
Hosp. mtnty.	0	0	1	1	16	19	26	30	43	50	86
O.B. office	0	0	2	9	4	17	10	43	8	35	23

Comparison: Calculated value of x^2 = 10.215

Critical value of x^2, df = 8, = 15.507 at the 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 8. The unmarried mother is usually bitterly hostile.

Comments: There is no significant difference between the three groups of nurses. The groups of nurses were, by a large majority, in moderate or strong disagreement with the statement.

Table 25

Item 9B: Responsiveness to Therapy

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	1	2	2	3	7	12	30	51	18	31	1	1	58
Hosp. mtnty.	2	2	6	7	17	20	33	38	28	33	0	0	86
O.B. office	0	0	1	4	3	13	10	43	9	39	0	0	23

Comparison: Calculated value of x^2 = 3.936

Critical value of x^2, df = 6, = 12.592 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 9. The un-wed mother is not responsive to therapy because she usually denies her problem for as long as possible and rejects help.

Comments: There is no significant difference between the three groups of nurses in their response. Again, the largest percentages of all three groups were in either moderate or strong disagreement.

Table 26

Item 10B: Decisions about the Baby

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	2	3	7	12	12	20	21	36	16	27	1	2	58
Hosp. Mtnty.	2	2	6	7	17	20	33	38	28	33	1	1	85
O.B. office	1	4	3	13	4	17	8	35	6	26	1	5	22

Comparison: Calculated value of $x^2 = 1.648$

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 10. The decisions about the future of the baby are not based upon the un-wed mother's feeling for the baby, but upon the basic reason which prompted the pregnancy.

Comments: There is no significant difference between the three groups of nurses and the larger percentage of all three groups of nurses were either in moderate or strong disagreement.

Table 27

Item 11B: Adoption as the Preferred Plan

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	1	2	8	14	16	27	16	27	18	31	59
Hosp. mtnty.	1	1	13	15	22	26	25	29	25	29	86
O.B. office	3	13	3	13	8	35	4	17	5	22	23

Comparison: Calculated value of $x^2 = 3.175$

Critical value of x^2, df = 6, = 12.592 at 0.05 level of significance.

Decision: Retain the null hyphothesis

Statement: 11. Adoption is the preferred plan for the babies of un-wed mothers.

Comments: There is no significant difference between the three groups of nurses. The larger percentage of the community health nurses and the hospital maternity nurses were in moderate or strong disagreement while 35 percent of the obstetrical office nurses neither agreed nor disagreed.

Table 28

Item 12B: Relinquishment of the Baby

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	2	3	17	29	18	31	21	36	1	2	58
Hosp. mtnty.	0	0	5	6	18	21	26	30	36	42	1	1	85
O.B. office	0	0	3	13	7	30	6	26	6	26	1	5	22

Comparison: Calculated value of $x^2 = 5.252$

Critical value of x^2, df = 6, = 12.592 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 12. The un-wed mother who relinquishes her baby is healthier than the one who keeps the child.

Comments: There is no significant difference between the three groups of nurses. The larger percentages of the three groups were in either moderate or strong disagreement with the statement.

Table 29

Item 13B: Referral to Appropriate Agencies

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	46	78	12	20	1	2	0	0	0	0	59
Hosp. mtnty.	70	81	11	13	4	5	0	0	1	1	86
O.B. office	17	74	4	17	2	9	0	0	0	0	23

Comparison: Calculated value of $x^2 = 3.527$

Critical value of x^2, df = 6, = 12.592 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 13. Referral to appropriate agencies is very important to the teenage un-wed mother.

Comments: There is no significant difference between the three groups of nurses. In the case of this statement, the majority of all the nurses were in strong agreement.

Table 30

Item 14B: Need for Referral for Older Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	1	2	3	1	2	19	32	37	63	59
Hosp. mtnty.	1	1	2	2	3	3	27	31	53	62	86
O.B. office	0	0	0	0	3	13	11	48	9	39	23

Comparison: Calculated value of $x^2 = 4.777$

Critical value of x^2, df = 4, = 9.448 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 14. The older un-wed mother is better prepared to handle her own situation and does not really need referral.

Comments: There is no significant difference between the three groups of nurses. The majority of all three groups were in either moderate or strong disagreement with the statement.

Table 31

Item 15B: Decisions as to Adoption

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	12	20	23	39	14	24	7	12	3	5	59
Hosp. mtnty.	17	20	24	28	21	24	7	8	17	20	86
O.B. office	12	52	4	17	4	17	3	13	0	0	23

Comparison: Calculated value of x^2 = 21.925

Critical value of x^2, df = 8, = 15.507 at 0.05 level of significance.

Decision: Reject the null hypothesis

Statement: 15. Decisions as to adoption or retention of the baby should be made by the un-wed mother prior to birth.

Comments: There is a significant difference between the three groups of nurses. Over 50 percent of the obstetrical office nurses were in strong agreement while 20 percent of the hospital maternity nurses were in strong disagreement. At least 48 percent of all three groups of nurses were in moderate to strong agreement.

Table 32

Item 16B: Counseling and the Older Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	1	2	0	0	0	0	7	12	51	86	0	0	59
Hosp. mtnty.	1	1	0	0	0	0	12	14	73	85	0	0	86
O.B. office	0	0	0	0	1	4	5	22	16	70	1	5	22

Comparison: Calculated of $x^2 = 2.596$

Critical value of x^2, df = 2, = 5.991 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 16. If the older un-wed mother is committed to abortion, the counseling process will not be needed.

Comments: There is no significant difference between the three groups of nurses. Of the three groups of nurses, 70 percent or more were in strong disagreement to the statement.

Table 33

Item 17B: Support Systems and the Teen-age Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	55	93	4	7	0	0	0	0	0	0	0	0	59
Hosp. mtnty.	75	87	8	9	1	1	1	1	0	0	1	1	85
O.B. office	21	91	2	9	0	0	0	0	0	0	0	0	23

Comparison: Calculated value of $x^2 = 1.023$

Critical value of x^2, df = 2, - 5.991 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 17. The support system offered to the teenage un-wed mother by her family and friends is important.

Comments: There is no significant difference between the three groups of nurses. From 87 percent to 93 percent of the three groups of nurses were in strong agreement with the statement.

Table 34

Item 18B: Support Systems and the Older Un-wed Mother

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	0	0	0	0	0	0	6	10	53	90	0	0	59
Hosp. mtnty.	0	0	1	1	2	2	12	14	70	81	1	1	85
O.B. office	0	0	0	0	0	0	6	26	17	74	0	0	23

Comparison: Calculated value of $x^2 = 3.373$

Critical value of x^2, df = 2, = 5.991 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 18. The sypport system offered to the older un-wed mother by family and friends is much less important.

Comments: There is no significant difference between the three groups of nurses and from 74 percent to 90 percent were in strong disagreement to the statement.

Table 35

Item 19B: Health Care Providers as Support System

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm health	0	0	1	2	3	5	30	51	25	42	0	0	59
Hosp. mtnty.	2	2	5	6	8	9	37	43	33	38	1	1	85
O.B. Office	0	0	0	0	4	17	10	43	9	39	0	0	23

Camparison: Calculated value of $x^2 = 7.773$

Critical value of x^2, df = 6, = 12.592 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 19. If this support system is not available, the cooperative efforts of health care providers and other appropriate agencies are relatively ineffectual as a substitute.

Comments: There is no significant difference between the three groups of nurses. The large majority of all the nurses were in either moderate or strong disagreement with the statement.

Table 36

Item 20B: The Nurse as a Positive Force

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	47	80	10	17	0	0	0	0	2	3	0	0	59
Hosp. mtnty.	58	67	20	23	3	3	1	1	1	1	3	3	83
O.B. office	18	78	3	13	2	9	0	0	0	0	0	0	23

Comparison: Calculated value of $x^2 = 2.968$

Critical value of x^2, df = 4, = 9.488 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 20. The nurse providing direct care to the older un-wed mother should be a positive force in both referral and the provision of adequate support systems.

Comments: There is no significant difference between the three groups of nurses. From 68 percent to 80 percent of all the nurses were in strong agreement to the statement.

Table 37

Item 21B: The Nurse as Pivotal Point

	Strong agree		Moderate agree		Neither		Moderate disagree		Strong disagree		Omitted answers		Ttl. No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Comm. health	37	63	18	31	3	5	1	2	0	0	0	0	59
Hosp. mtnty.	47	55	24	28	10	12	1	1	2	2	2	2	84
O.B. office	11	48	7	30	5	22	0	0	0	0	0	0	23

Comparison: Calculated value of $x^2 = 4.169$

Critical value of x^2, df = 4, = 9.488 at 0.05 level of significance.

Decision: Retain the null hypothesis

Statement: 21. The nurse can be a pivotal point in helping the unmarried pregnant woman to weather her experience with a minimum of physical or emotional damage.

Comments: There is no significant difference between the three groups of nurses with the larger percentage of nurses in strong agreement with the statement. Of the office nurses, 22 percent were neither in agreement nor disagreement.

Summary of Responses to Item #22B
Suggestions for Improvement of Care and Referrals

22. If you have any suggestions on how to provide better care, to handle referrals, and to provide support systems to the older (ages 20 to 40) un-wed mother, could you please give them here?

The three groups of nurses - community health, hospital maternity, and obstetrical office - were in general agreement that the greatest need was earlier referral from the doctor's offices with a more adequate knowledge of the resources available. Some representative statements are:

1. There needs to be a better system of liason in the community with both hospital and community seeing that the patients get referred to the appropriate agency as needed and as early in the pregnancy as possible.

2. Clients do not always know the support systems - both nurses and doctors need to expedite.

3. Nurses, especially in the hospital, do not always know of the agencies so there needs to be a better referral system, and more education on what the nurse can do to help the un-wed mother.

4. There is a crying need for better referral from doctors.

5. Work with the doctors to encourage more referrals. Picking up a patient in the hospital after delivery is too late to give referrals that will help.

6. Support systems are often not here or not recognized. Efforts must be made to fix bonds or find support systems. To do this referrals must be made from the first contact with the doctor.

7. More information needs to be available to the nurse - no inservice is given on agencies available. Continued

education of nurses in this phase need to be emphasized.

A large number of the three groups of nurses mentioned the importance of counseling at an early stage of the pregnancy. It was felt that this counseling process must come from both the nurses and the doctor. Some representative statements are:

1. Motivation is the primary concern. If we are to initiate support groups, a person must feel a need. I feel that one of the most beneficial types of help would be some type of counseling service.

2. A better system of counseling is definitely needed. The patient must be able to work through her feelings before delivery.

3. Counseling and support should be given time; i.e., care for the whole person and not just the pregnancy. The nurse should be a friend and teacher to the patient. This does take time, but it is certainly worth the effort as far as the patient is concerned and gives the nurse 'pleasure in process' and an excellent opportunity to teach 'good health habits'.

Referral to appropriate agencies and the establishment of adequate support systems is of prime importance to the older (ages 20 to 40) un-wed mother and the three groups of nurses agreed on the need for more cooperation and coordination of the individuals and agencies available for these services. Emphasis was placed on awareness of agencies by all participants in the care of the un-wed mother and a combined cooperative effort which would encourage more comprehensive care and would help to eliminate both duplication of services and conflicting plans. Improved communication between

agencies will result in improved care of the patient.

Summary

In general, the opinionnaire on attitudes, the second part of the questionnaire, indicated that there was no significant difference between the attitudes of the community health nurses, the hospital maternity nurses, and the obstetrical office nurses. Of the twenty-one items used to determine attitudes, only two indicated a difference. In the case of Item 4, the area of disagreement was in the degree of agreement rather than the dichotomy. In the case of Item 15, a larger percentage (20 percent) of the hospital maternity nurses felt that the decision on whether to keep the baby or put it up for adoption should be made prior to delivery. As the hospital nurses have the direct contact with the patient at this time, it is not surprising that their feelings might be stronger.

The attitudinal questionnaire also showed that the majority of the nurses' attitudes seemed to be favorable to the un-wed mother regardless of age and seemed to indicate that the nurses were operating within the perimeters of the newer research and literature.

As to the question determining the community health nurses, hospital maternity nurses, and obstetrical office nurses concept of the referral process, there was a significant difference. The community health nurses (78 percent) felt that the nurse was a very

important agent in the referral process with only 44 percent of the hospital maternity nurses and 35 percent of the obstetrical office nurses deeming the process as very important. In addition to these facts, 17 percent of the obstetrical office nurses felt that the nurse was only marginally important in the referral process.

When the significant difference in importance of the nurse as a referral agent were followed it was found that practices and referrals were directly related. The less importance placed on the nurse as a referral agent, the less referrals were made.

Comments made indicated a great need for more education on referrals and the agencies and sources available. Further emphasis was placed on the need for the doctor to be involved in this process and for more cooperation and coordination to be developed between the different agents of referral.

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was an effort to determine the attitudes of rural Montana community health nurses, hospital maternity nurses, and obstetrical office nurses toward the older (ages 20 to 40) un-wed mother and to determine the implications of such attitudes upon the process of referral and the establishment of adequate support systems. The need for the study was based on the increasing numbers of un-wed mothers and the societal problems facing this group. The nursing profession has a definite obligation to work toward a means of providing the best possible help with this problem. To develop understanding of the un-wed mother, every attempt should be made to increase the knowledge of circumstances surrounding this problem. A first step can be a scientific examination of attitudes and behaviors of the nurses in our society directed toward the problem of the un-wed mother.

This study was developed in the following manner. A review of literature was made to provide a background for the study. The review of literature was undertaken to develop a greater understanding of the problems encountered by the un-wed mother, to analyze attitudes related to the general problems of the un-wed mother, and to discover research which indicated a correlation between attitudes of nurses and the effects of these attitudes on the process of referral and the provision of support systems to the older un-wed mother. Although there

is much research in relation to the adolescent un-wed mother, little research was found about the older un-wed mother. The literature did reveal the need for cooperative and extensive research into the problem of the un-wed mother regardless of age. Only knowledge of the underlying reasons, the psychological processes, and the sources of possible help can provide the nurse with the resources necessary to provide individual intervention, make referrals, or take the steps necessary to provide adequate support for the un-wed mother.

From the information elicited in the review of relevant literature, the two-part survey questionnaire was developed. The first part of the questionnaire was developed to ascertain certain demographic information and information about beliefs and practices in relation to referral and the provision of adequate support systems. The second portion was an opinionnaire designed to elicit attitudes toward the older un-wed mother.

The instruments, along with a cover letter, were delivered by hand to three groups of nurses - community health nurses, hospital maternity nurses, and obstetrical office nurses in all geographic locations in the state of Montana which contained all three groups. Self-addressed envelopes were included for mailed returns.

The responses of the three groups of nurses - community health, hospital maternity, and obstetrical office - who completed the

questionnaires were carefully checked and frequency scores for each questionnaire were paired and tabulated. The entire set of tabulated scores for each instrument was analyzed by an appropriate program of numbers, percentages, and by chi square where appropriate. This was done at the Computer Center at Montana State University.

Results from the questionnaires were arranged in tables and the following statistical methods were employed:

1. numbers and percentages were presented as needed;

2. frequency of responses was indicated where appropriate; and

3. chi square was used to test the data where appropriate to determine if a statistically significant difference existed between the attitudes of the nurses, between attitudes and practices, and between the belief of each group of nurses as to the importance of the referral practice and their actual use of referral;

4. the five percent level of significance was selected to test the hypotheses of the study.

Tables were presented to show and compare the number and percentages of responses to each item on the questionnaire. Where appropriate, the tables also contained the calculated value of chi square, the critical value of chi square, the degrees of freedom, and the level of significance. The tables were followed by a decision on the null hypothesis and comments on the significance or lack of significance for each item.

The analysis of data pointed out that there was a relatively high level of agreement between community health nurses, hospital maternity nurses and the obstetrical office nurses in relation to their attitudes toward the older (ages 20 to 40) un-wed mother. It also showed that these attitudes did not have a noticeable effect upon the practices of these same nurses; however, individual group membership did effect practices in relation to referral and the establishment of adequate support systems. The nurses' opinions as to the importance of referral were also a determinant in the use of referral.

Conclusions

Three hypotheses were tested in this research using chi square.

(H_o) The attitudes toward the older (ages 20 to 40) un-wed mother are independent of specific group nursing membership (community health, hospital maternity, or obstetrical office nurses).

Of the twenty-one statements on the opinionnaire, there was no statistical differences on nineteen items, which indicated general agreement. On Item #4 (Table 20, page 68) relating to the teenage un-wed mother not being responsible for the problems that ensue because of her lack of knowledge and inability to control her life, the difference was in strength of disagreement rather than in dichotomy.

The community health nurses were 51 percent in disagreement and 29 percent in strong disagreement; the hospital maternity nurses were 42 percent in disagreement and 35 percent in strong disagreement; the obstetrical office nurses were only 9 percent in disagreement and 65 percent in strong disagreement.

There was a significant difference in Item #15 (Table 31, page 79) on the statement that decisions as to adoption or retention of the baby should be made by the un-wed mother prior to birth. While the community health and hospital maternity nurses were each 20 percent in strong agreement, the obstetrical office nurses were in strong agreement 52 percent of the time, while the hospital maternity nurses were in strong disagreement 20 percent of the time, with the community health and obstetrical office nurses less than 6 percent in strong disagreement. As the hospital maternity nurses are present at delivery and personally see the problems faced by the new un-wed mother, this can be significant. As the newer literature does suggest that this decision should, in many cases, be postponed, it would seem to indicate that the hospital maternity nurses are more current in their thinking on this subject.

(H_o) The referral process is independent of the community health, hospital maternity, or obstetrical office nurses' concept of the importance of this process.

As Item #7-A (Table 10, page 52) indicated, there is a

significant difference between the three groups of nurses (community health, hospital maternity, and obstetrical office). Of the community health nurses, 17 percent felt that the nurse was an important agent and 78 percent felt that she was a very important agent in the referral process. The hospital maternity nurse felt 47 percent important and 44 percent very important. The obstetrical office nurse, on the other hand, felt 43 percent that she was important, 35 percent very important, but 17 percent felt that the nurse was only marginally important. From this point on with items #8, #9, #10, #11, and #13-A, the analysis of data was consistent with the obstetrical office nurse using less referral and counseling. Item #12-A (Table 15, page 62) showed no significant difference between the three groups of nurses. As this was an estimation of the percentage of older un-wed mothers referred from the office it indicated a difference between actual practice and personal opinion.

(H_o) Use of the referral process is independent of the attitudes of the community health, hospital maternity, or the obstetrical office nurses.

As the attitudes of the three groups of nurses were in agreement, but the employment practices and beliefs apparently were determined by group nursing membership (community health, hospital maternity, and obstetrical office nurses), it would follow that the referral process was independent of the attitudes but dependent upon

the nurse's opinion of her own importance as a referral agent. It was also dependent on nursing group membership (community health, hospital maternity, and obstetrical office). The obstetrical office nurse held referral by a nurse less important and utilized the process less, but it should be remembered that she is working closely under the supervision of a physician and his attitudes and practices would govern the nurse's to a great extent. The demographic data showed that 69 percent of the obstetrical office nurses held a diploma or associate degree, that 74 percent were over the age of thirty, and that they had been in their present positions much longer than the other two groups of nurses.

Recommendations

In view of the findings of this study, the following recommendations for further research are made:

1. To replicate this study in the future (2 to 5 years) to determine if the newer theories on the importance of referral and practices would influence the outcome.

2. To further refine the information obtained in this study by devising a study aimed at the demographic characteristics of age, education level, and time in present position as variables to determine reasons for the lesser utilization of referral by the obstetrical office nurses.

3. As Montana is a predominantly rural state and as the

majority of the maternity care is actually done by general or family practitioners, the population should be broadened to the nurses working for these doctors to discover if the beliefs and practices on referrals are similar.

3. The population and the survey could be broadened to a selected sample of all doctors' offices to determine if the beliefs and practices of the nurses working in this situation were similar on the subject of referral.

4. A review of research and literature could be compiled on past efforts of various agencies to develop coordination and cooperation with the possible development of strategies and methods of improvement.

The findings of this study have indicated that there are several important needs in the referral system within the state of Montana. Some recommendations to meet these needs are as follows:

1. To develop a statewide task force to determine what is needed to enhance the referral process and to encourage it.

   a. The community health nurse is probably better able to spearhead this group, but there must be representation from all groups who care for the maternity patient.

   b. The nurses would be aware of the physicians who are most involved in the referral process and, if the membership of these physicians could be obtained, they could

perhaps influence other doctors more than anyone else.

c. Input from the client should be obtained.

2. To emphasize continuing education of all nurses involved in the care of the maternity patient.

a. The Montana Nurses Association and their progress of continuing education could be utilized.

b. In-service directors and programs within the hospitals could be expanded to include nurses outside the hospitals. Both (a) and (b) would have to extend personal invitations to the office nurses. The continuing education would need to include knowledge of the need for and use of referral, knowledge on how to refer, and knowledge of agencies available both on the local and the state level.

3. To develop coordinating agencies in the geographic locations where none are available.

a. These coordinating agencies would probably involve all areas of service in the community.

b. The community health nurse would again be in a good position to institute this as she is usually in contact in some way with the majority of agencies.

c. The un-wed mother would only be a part of the clientele involved with the coordinating agency, but fliers or newsletters could be developed specific to this population

which could inform the maternity nurse of resources or programs available.

d. This coordinating agency could help to facilitate the access to counseling early.

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APPENDIXES

APPENDIX A: COMMITTEE ON HUMAN SUBJECTS

Roxie M. Anderson
501 D. So. 19th
Bozeman, MT 59715
October 30, 1979

Dr. George Shroyer
Committee on Use of Human Subjects in
Experimental Research
Department Head
Health, Physical Education, & Recreation
Montana State University
Bozeman, MT 59715

Dear Dr. Shroyer,

As a graduate student in Nursing with a specialty area in Community Health, I am applying for permission from the Committee on Use of Human Subjects in Experimental Research to conduct the survey necessary for the completion of my thesis.

My thesis, Maternity, Community Health, and Obstetrical Nurses and the Older Un-wed Mother, will involve a questionnaire to be submitted to nurses working on hospital maternity units, nurses working in community health, and nurses working for obstetrical physicians. The areas in Montana containing all three are Billings, Bozeman, Butte, Great Falls, Havre, Kalispell, Miles City, and Missoula. Helena will not be included as it was the pre-test and post-test site.

I am enclosing the following information:

a. an introduction to the study
b. an abstract for the projected study
c. a rough draft of the methodology of the study
d. a respondent consent form
e. a copy of the cover letter and the questionnaire.

I sincerely, hope that this information is sufficient for the Committee to make its decision. If it is not, please call me at 587-1857.

Page Two
Dr. Shroyer

Thanking you very much for your consideration and your most needed cooperation, I remain,

Sincerely,

Roxie M Anderson

Roxie M. Anderson
Graduate Student, School of Nursing
Montana State University
Bozeman, MT 59715

RESPONDENT CONSENT FORM

I am willing to participate in this research project concerned with nursing practices and attitudes in relation to the older (ages 20 to 40) un-wed mother. I am aware that the researcher is Roxie M. Anderson, a nurse and a graduate student at Montana State University and I am aware of the purpose of the study. It is my understanding that to participate in the project, I will answer a two-part questionnaire. I am clearly aware that all responses will be treated in a confidential and a professional manner and that the information given will remain anonymous and will be used only as group data to aid in the identification of beliefs and practices in the care of the older (ages 20 to 40) un-wed mother.

Signed: _____

Witness: _____

Date: _____

msu
COLLEGE OF EDUCATION

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION

MONTANA STATE UNIVERSITY, BOZEMAN 59717

November 15, 1979

Roxie M. Anderson
School of Nursing
Montana State University
Bozeman, MT 59717

Dear Ms. Anderson:

You have the approval of the Human Subjects Committee to do your research study on Maternity, Community Health and Obstetrical Nurses and the Older Un-wed Mother.

Please have the release forms filled out and send them to me.

Good luck with your research project.

Sincerely,

George Shroyer

George Shroyer, Chairman
Human Subjects Committee

GS:bam
cc: Dr. John Jutila, Vice President for Research

TELEPHONE (406) 994 4001

APPENDIX B: QUESTIONNAIRE ON NURSING ATTITUDES AND PRACTICES TOWARD THE OLDER UN-WED MOTHER

SECTION I

PERSONAL AND EMPLOYMENT INFORMATION

The following list of questions is important to this project. Please check the appropriate blank or fill in your response as indicated.

1. Position now held in relation to maternity nursing.

   ____a. Community Health Nurse
   ____b. Hospital Maternity Unit
   ____c. Office Nurse for Obstetrician

2. How long have you been in your present position?

   _____ a. one year or less
   _____ b. one to three years
   _____ c. three to five years
   _____ d. five to ten years
   _____ e. over ten years.

3. How long have you been a maternity nurse?

   _____ a. one year or less
   _____ b. one to three years
   _____ c. three to five years
   _____ d. five to ten years
   _____ e. over ten years

4. What is the highest degree that you hold?
   _____ a. AD
   _____ b. Diploma
   _____ c. BS
   _____ d. Master
   _____ e. Other (please list including any special training)

   _____
   _____

5. Did you choose maternity nursing as your specialty?
   _____ a. yes
   _____ b. no (please list reasons ie. employment need.

   _____

6. What is your age?
   _____ a. 20 to 25 years of age
   _____ b. 25 to 30 years of age
   _____ c. 30 to 40 years of age
   _____ d. 40 to 50 years of age
   _____ e. over 50 years of age

7. How important is the nurse as an agent in the referral process?
   _____ a. Unimportant
   _____ b. Marginally important
   _____ c. Moderately important
   _____ d. Important
   _____ e. Very important

8. In your employment situation, are there any specific rules or orders in relation to referral and the un-wed mother?
   _____ a. No
   _____ b. Yes (please list)

   _____

   _____

   _____

   _____

   _____

9. Does your employment situation allow you freedom to determine the needs of the un-wed mother in relation to referral or to the provision of adequate support systems?
   _____ a. No
   _____ b. Yes

10. If freedom to determine needs is present, do you attempt to refer the teen-age un-wed mother to other agencies?
   _____ a. No
   _____ b. Yes (please list agencies utilized)

   _____

   _____

   _____

11. If freedom to determine needs is present, do you attempt to refer the older (ages 20 to 40) un-wed mother to other agencies?
   _____ a. No
   _____ b. Yes (please list agencies utilized)

   _____

   _____

   _____

12. Can you estimate the percentage of the older (ages 20 to 40) un-wed mothers that have been referred to other resources from your employment base?

_____ a. Less than 10%
_____ b. 10% to 30%
_____ c. 30% to 50%
_____ d. Over 50%
_____ e. Unable to estimate

13. As a nurse dealing with maternity patients, do you counsel the older un-wed mother?

_____ a. Never
_____ b. Occasionally
_____ c. Moderately
_____ d. Often
_____ e. Always

SECTION II

OPINIONAIRE ON THE OLDER (AGES 20 TO 40)

UN-WED MOTHER

Directions:

The following statements represent beliefs and practices in relation to the older un-wed mother. As a health care provider, please indicate your agreement or disagreement with the statements listed.

Example:	Strong agreement				Strong disagreement
Extensive education in the various methods of contraception is very important in the prevention of the out-of-wedlock pregnancy	1	2	3	4	5

If you strongly agree with this statement, you would circle "1"

If you neither agree or disagree, you would circle "3".

Statements:	strong agreement				strong disagreement
1. The theory of the out-of-wedlock pregnancy currently accepted among the helping professions is that it is a symptomatic and purposeful attempt by the personality to ease unresolved conflict.	1	2	3	4	5
2. Pregnancy for the unmarried woman, regardless of age, is a symptom of underlying emotional difficulty.	1	2	3	4	5
3. The un-wed mother is looked upon by society as having violated a cultural norm.	1	2	3	4	5
4. The teenage un-wed mother is not responsible for the problems that ensue because of her lack of knowledge and inability to control her life.	1	2	3	4	5

Statements:	strong agreement				strong disagreement
5. The older un-wed mother is usually totally responsible for her condition.	1	2	3	4	5
6. Because of her age, the older un-wed mother does not face a crisis situation.	1	2	3	4	5
7. There does not seem to be much difference between the un-wed mother and other promiscuous females.	1	2	3	4	5
8. The unmarried mother is usually bitterly hostile.	1	2	3	4	5
9. The un-wed mother is not responsive to therapy because she usually denies the problem for as long as possible and rejects help.	1	2	3	4	5
10. The decisions about the future of the baby are not based upon the un-wed mother's feeling for the baby, but upon the basic reason which prompted the pregnancy.	1	2	3	4	5
11. Adoption is the preferred plan for the babies of un-wed mothers.	1	2	3	4	5
12. The un-wed mother who relinquishes her baby is healthier than the one who keeps the child.	1	2	3	4	5
13. Referral to appropriate agencies is very important to the teenage un-wed mother.	1	2	3	4	5
14. The older un-wed mother is better prepared to handle her own situation and does not really need referral.	1	2	3	4	5
15. Decisions as to adoption or retention of the baby should be made by the un-wed mother prior to birth.	1	2	3	4	5
16. If the older un-wed mother is committed to abortion, the counseling process will not be needed.	1	2	3	4	5

Statements	strong agreement				strong disagreement
17. The support system offered to the teenage un-wed mother by her family and friends is important.	1	2	3	4	5
18. The support system offered to the older un-wed mother by family and friends is much less important.	1	2	3	4	5
19. If this support system is not available, the cooperative efforts of health care providers and other appropriate agencies are relatively ineffectual as a substitute.	1	2	3	4	5
20. The nurse providing direct care to the older un-wed mother should be a positive force in both referral and the provision of adequate support systems.	1	2	3	4	5
21. The nurse can be a pivotal point in helping the unmarried pregnant woman to weather her experience with a minimum of physical or emotional damage.	1	2	3	4	5

22. If you have any suggestions on how to provide better care, to handle referrals, and to provide support systems to the older (ages 20 to 40) un-wed mother, could you please give them here. Use the back of this page if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX C: LETTERS

Roxie M. Anderson
501 D. So. 19th
Bozeman, Montana 59715
October 30, 1979

To Hospital Director of Nursing:

Pursuant to our telephone conversation about submitting any request for permission to do any research involving the personnel of your hospital, I am submitting the following information.

a. a general introduction to the study
b. the methodology to be followed
c. the literature cited in the study
d. a copy of the cover letter and the questionnaire

It is my hope to submit this questionnaire to the nurses working on maternity units, nurses working for obstetrical physicians, and nurses working in community health in those areas in Montana which have all three. The areas involved will be Bozeman, Billings, Butte, Great Falls, Havre, Kalispell, Miles City, and Missoula. At the present time, I do have permission from the other hospitals, and it is my sincere hope that the Bozeman Deaconess Hospital will allow me to present this questionnaire to the nurses of the maternity unit of the hospital.

The questionnaire is a fairly simple one calling for mostly checks and circles and, when checked for validity, took between 10 and 15 minutes to complete.

Thank you so very much for your consideration in this matter and I hope that I have included enough information. If you wish to talk to me personally or have me submit my project to your committee, please call me. I would be very glad to do this. My home telephone number is 587-1857.

Sincerely,

Roxie M. Anderson

Roxie M. Anderson

msu

SCHOOL OF NURSING

MONTANA STATE UNIVERSITY BOZEMAN 59717
October 5. 1979

The age of liberation has made society very aware of the age-old problem of the un-wed mother. The adolescent un-wed mother has been the subject of much research, increasing governmental focus and funding, and the establishment of more readily available support systems. Colleges are beginning to establish programs to provide guidance and counseling for these students. Beyond these attempts, there has been very little research and very few attempts to provide special services or understanding for the un-wed mother who is not an adolescent.

As health care providers in a setting that brings you in constant contact with the older un-wed mother, I feel sure that you are aware of the special problems facing her. The purpose of this study is to obtain an accurate picture of the practices and beliefs of the maternity care nurses in the state of Montana. This information will be included in a thesis under the direction of the School of Nursing of Montana State University.

To enable the researcher to obtain an accurate picture, it is very important that a high percentage of responses from the nurses be obtained. Your support and cooperation are needed to make the study a success. I am very aware of the constant demands on your time, however, your answers are extremely important to this study and I would be very grateful for your cooperation. The questionnaire will take only ten or fifteen minutes of your time. A stamped, self-addressed envelope is included for the return of your completed questionnaire.

I assure you that all responses will be treated in a confidential and a professional manner. The information you give will remain anonymous and will be used only as group data to aid in your identification of beliefs and practices in the care of the older (ages 20 to 40) un-wed mother.

Thank you very much for your time and cooperation. I will greatly appreciate your help and effort in this matter.

Sincerely,
Roxie M Anderson

Roxie M. Anderson, R. N.
501 D South 19th. Street
Bozeman Montana 59715

Roxie Anderson is currently registered as a full time student in the Master of Nursing Program. Any assistance and cooperation you can give her will be appreciated.

Anna M. Shannon

Dr. Anna Shannon
Dean of the School of Nursing
Montana State University

TELEPHONE (406) 994-3783

Anderson, Roxie M
Attitudes and practices of nurses dealing with theolder (ages 20 to 40) un-wed mother ...