



1977

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### Recommended Citation

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Meleis, A.I., & Swendsen, L. (1977). Does nursing intervention make a difference? A test of the ROSP. *Communicating Nursing Research: Nursing Research Priorities: Choice or Chance*, vol. 8, 308-324. Boulder, CO: Western Interstate Commission for Higher Education.

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### Comments

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# **Does Nursing Intervention Make a Difference? A Test of Role Supplementation**

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This paper presents a preliminary analysis of the effects of a theory-based nursing intervention—that of role supplementation—on the attitudes and behavior of couples having their first child. It is based on the premise that conceptual frameworks offer structure for nursing knowledge and that, without such frameworks, systematic knowledge of various phenomena could not be related and accumulated. Integrative framework was used in this research project to demonstrate its utility in practice, its effectiveness, and its essentiality in clinical nursing research.

The investigation itself centered on the question of whether a nursing intervention affects client behavior in a transitional situation, and, if it does, in what way?

The process of nursing assessment and ensuing intervention during role transition is an essential and unique nursing contribution. The need for such intervention is more acute in the more stressful, dynamic, and mobile societies characteristic of “developed” countries. The effects of the most simple role transitions are intensified in such societies because of the lack of a well-integrated network of social resources to provide models for alternate coping styles and/or continuous interaction to assist the role incumbents in an understanding of the meaning of the experiences.

## **Conceptual Framework**

This study is based on the pioneer work of such notable figures as

Dewey (16), Cooley (10), Mead (28), and Blumer (5), and on the most recent work of Rose (29) and Turner (36).

These scholars visualized roles as stemming from interaction with other factors in a social system; a role is thought of as a way of coping with an imputed other role (12, 35). This framework does not deny the importance of situation or culture, but considers them as additional factors in role definition. Turner (35:26) defined role as "not merely a set of behaviors or expected behavior, but a sentiment or goal which provides unity to a set of potential actions." Furthermore, each role created will create counterroles and will need to be modified in an interaction situation before both role and counterroles achieve stability.

This study explores the effects of nursing interventions in a situational transition. Situational transitions involve the addition or subtraction of roles from a preexisting constellation of roles and complements. An example of situational transition is the addition to or subtraction of a member from a tight-knit group such as the family. Each such situation requires definition and redefinition of the roles involved in the constellation of interactions (26).

The theoretical assumptions underlying this investigation are that, if conditions and processes surrounding role transitions are well defined and more or less predictable (17), the role transitions will be accomplished with relatively less friction and psychosocial discomfort. When role definitions of a role incumbent and significant others are consistent, personal and interpersonal role enactment problems emerge. Such problems are manifested in states of anxiety, depression, irritability, lack of confidence, and a general lack of well-being.

The transition from nonparental to a parental status is of well-recognized cultural and psychosocial importance. It has been analyzed thoroughly in the writings of Simmel and others with respect to the shift of the structure of the family group from a dyad to a triad with the addition of a third person (the infant) (11:135-170).

Early parenthood has the potential for the development of a conflict and it is laden with severe stress (4, 7, 20, 22 25). For example, LeMasters noted that most couples found the transition to parenthood difficult and that the birth of a first child constitutes a crisis event (24). Caplan found pregnancy and the development of the mother-child relationship stressful (7). Dyer's data indicated that the majority of the couples in his sample experienced a severe crisis (14). More recently, Shereshefsky and Yarrow, in studying the psychological aspects of the first pregnancy and postnatal adaptation, observed that members of their study population needed psychological support during this period (33). Others have reported similar findings (9, 18, 23, 30, 37).

Nurses have been leaders in assisting couples coping with the crisis of pregnancy, childbirth, and infant care. Traditionally, they have taught expectant and new parents about pregnancy, childbirth, and infant care on an individual basis and in groups. More recently, nurses have recognized the importance of the individual concerns and feelings of patients. Now, many feel that the nurses' responsibility extends not only to patient education but also to assessment of psychosocial needs and implementation of

interventions according to those needs (1, 2, 3, 15, 16, 25). As Acton has pointed out, the nurse acts as a patient advocate, teacher, and counselor concerned with the total experience of childbearing and childrearing (1:294).

### **Role Supplementation: (ROSP) A Nursing Intervention**

If by means of role supplementation, the ego is able to acquire and master the behaviors and sentiments of roles and transitional roles through (1) knowledge of what a particular role entails in terms of behaviors, (2) knowledge of what that role entails in terms of sentiments and goals, (3) knowledge of costs and rewards—hence whether or not a significant other will reinforce the role negatively or positively, and (4) knowledge of what counter- and complementary roles entail in terms of sentiments and goals, then role supplementation could be the means by which an integrative role transition is attained.

Role supplementation (ROSP) was defined by Meleis (26) as "any deliberative process whereby role insufficiency is identified by the role incumbent and significant others." It is "the conveying of information or experience necessary to bring the role incumbent and significant others to full awareness of the anticipated behavior patterns, units, sentiments, sensations and goals involved in each role and its complement." Preventive role supplementation is used as a way of clarifying roles for persons anticipating transitions (26).

The program was developed incorporating an appropriate reference group. On the assumption that roles develop in pairs, both wives and husbands participated in group meetings and in individual family sessions with the nurse clinician. Communication and interaction are central concepts in the symbolic interactionist (26) school and are "...important components of role supplementation, because it is through open and clear communication of symbols that roles evolve" (26).

The nursing interventions were based on the components of role supplementation. The theoretical basis of ROSP stresses the importance of the reference group—a group that provides a frame of reference within which individuals can develop a concept of their new role. This component of the program was supplied by a series of weekly group meetings through which the expectant couples served as the reference group for one another. As these meetings the nurses used role taking, a process in which individuals plan and enact their roles by vicariously assuming the role of another. Another basic component of the program was role clarification, which is the identification of role-linked behaviors, sentiments, and goals associated with role of significant others. Role modeling was used to facilitate communication and to demonstrate coping with various situations. Another strategy important to the program was role rehearsal in which, prior to overt interaction, the individual fantasizes, imagines, and mentally enacts an encounter and how such a role might evolve (27).

The intent of the ROSP program was (27): (1) not only to develop role clarity and role-taking skills but to provide couples in the program with a

framework for a continuous analysis of the new experiences and a continuous identification of roles and counterroles; (2) to acquaint participants with available resources; (3) to provide an array of alternate coping styles; (4) to provide them with the necessary knowledge resources for analysis of the uniqueness of the experiences.

## **Definitions of Concepts**

### **Attitudes toward Pregnancy**

As derived from the conceptual framework, expectant parents' attitudes toward pregnancy affect the role changes of both husband and wife, and these parental attitudes may also affect the transition process. The wife experiences the changes in her life from the standpoint of significant others. The measure of a woman's attitude toward her pregnancy and of her husband's attitude toward the pregnancy was used in this study to establish differences between potential experimental and control groups.

### **Role Incongruity**

The roles of wife-husband and mother-father are units that are defined in every interactional situation. The complementary and reciprocal relationship of role performance and role expectation causes incongruity or congruity in role behavior. Role strain is defined as incompatibility between role performance and role expectations. Lack of communication, lack of role-taking ability, and relative lack of role clarity should increase the disparity between role performance and role expectation.

### **Anxiety**

Anxiety is defined as "a reaction of apprehension ranging from uneasiness to complete panic preceded by a real symbolic condition of threat which the subject perceives diffusely" (19, 30). Social beings perceive and experience anxiety because they usually are reacting to emotionally charged symbols. Changes in role, role incongruity, role conflicts, or problems in interaction may be perceived as threats, thus increasing anxiety. As Sullivan indicated, anxiety in mothers and fathers, is, in turn, perceived by infants (6).

### **Depression and Irritability**

Depression and irritability are defined as perceptions of unhappiness and impatience. They denote the uncomfortable feeling of mood swings and the felt need to be left alone. If individuals are uncomfortable in their role spectrum, they may react by becoming depressed. There is abundant evidence of postpartum depression in women due to role transitions,

psychological changes, and increased demands. It is considered here in terms of transitional situations.

### **Objective and Subjective Evaluation of Baby's Health**

Both subjective and objective evaluation are based on parents' perceptions. The objective evaluation provides the parents with the parameters by which they could identify unhealthy behavior in their infants. Health behavior is defined in terms of the presence of moderation in basic needs of the baby such as sleeping, eating, and breathing, and in the absence of allergies, rashes, and other similar conditions.

### **Response to Baby**

Interaction and communication are two of the major tenets of symbolic interactionism as a conceptual framework. How persons respond to others determines the development of their role and that of significant others.

Crying is the first mode of communication between infants and their world. Crying is a behavior intended for the promotion of proximity or to make contact with a human being to fulfill the baby's needs. Previous studies have indicated that there is an inverse relationship between consistency and promptness of maternal responses to crying and the frequency and duration of infant crying (3). Responsiveness is defined in this study qualitatively in terms of ritualistic-ignoring and experimental problem-solving approaches. Ritualistic-ignoring responses do not take into account the particular needs of the infant as an individual. They derive from folkways and individual biases, with no direct consideration of the consequences. Conversely, the experimental problem-solving approach denotes adaptive, creative behavior: change based on the variables in the situation.

Data on responses to crying were gathered through open-ended interviews. In addition, data on responsiveness to the child in general, the level of protectiveness, and the level of ignoring behavior were gathered through use of the Postpartum Research Inventory (31).

## **Hypotheses**

The seven hypotheses underlying the basis of this study are:

1. There will be no differences between experimental and control groups (husbands and wives) in initial measurements of the following variables: demographic data and a number of attitudes toward pregnancy, such as the desire for pregnancy, fear for self and baby, dependency, depression, irritability and tension, and fatherly feeling.

2. Mothers and fathers who participate in ROSP will manifest less role strain and more role congruency than mothers and fathers who do not.

3. At the end of 6 wk, ROSP mothers will manifest less depression and irritability than will non-ROSP mothers.

4. At the end of 4 mo, mothers who participate in ROSP will manifest less anxiety than will mothers who do not.

5. Infants of ROSP parents will be perceived as more healthy (subjectively) at 6 wk and 4 mo and will present less "unhealthy" behavior (objectively) at 6 wk and 4 mo than will non-ROSP infants.

6. ROSP parents will exhibit a more experimental and problem-solving and less ritualistic response to crying than will the non-ROSP parents.

7. ROSP mothers will to a lesser degree ignore and be protective toward their infants and will be more responsive than the non-ROSP mothers.

## **Methodology**

### **Design of the Study**

The research design to permit testing of the above hypotheses involved use of two randomized groups, the experimental and the control.

### **Experimental Groups I and II**

These groups were composed of all those subjects who consented to participate in the study and who, after research visit I, consented to be part of ROSP. The two experimental groups were exposed to the ROSP program separately, according to the expected day of delivery. No significant differences were found between them in terms of the variables analyzed in this study; thus, experimental groups I and II were reconstituted to form experimental group I, which will also be referred to as the ROSP group.

### **Control Group**

This group was composed of all subjects who did not participate in the ROSP program. These subjects were exposed to other programs offered by Kaiser such as prenatal classes or Lamaze classes.

### **Family-centered Prenatal Program (FAMCAP) Group**

FAMCAP is a program developed by Kaiser clinical specialists to meet the individual needs of expectant parents and promote early hospital discharge. FAMCAP families are assigned to a clinical specialist early in pregnancy. They attend a group meeting to discuss the early discharge program, attend the prenatal program offered by Kaiser, and are discharged as early as 12 hr after delivery. The clinical specialist assigned to the



FAMCAP also was assigned to work with the ROSP group. This might have compromised the separation of study groups, as the control group contained a member of the FAMCAP families. To forestall this difficulty, the FAMCAP families were assigned to a separate group for the purpose of statistical analysis. FAMCAP data are considered and commented on only where they add to the analysis of the ROSP and control groups. Further analysis of the FAMCAP data will be considered in another paper.

To make use of parametric statistics, the initial goal for the experimental group was 20 and 40 for the control group. Instead, 12 couples were recruited for the experimental group and 46 for the control group. With the separation of the 10 FAMCAP families into a separate group, the control group was reduced to 36. A preliminary analysis was done using analysis of variance (F-test). The results should be considered with caution. For future analysis, other statistics will be used.

To test the effectiveness of ROSP, families were tested predelivery and preprogram and postprogram and postdelivery. Six research visits were made to each family (not all research visits are included in this report) from the second trimester to the fourth month postpartum.

## **Method of Data Collection**

### *Research Visits.*

1. All prenatal records were reviewed at the inception of the study.
2. All subjects who met the criteria were admitted to the sample at the beginning of their fifth month of pregnancy.
3. All subjects were contacted by phone and briefly told of the ongoing research project and were invited to participate.
4. All subjects who consented by phone to participate were recontacted by the research assistant to schedule research visit I. Research visit I was made around the beginning of the third trimester.
5. All participants were revisited 2 to 4 wk predelivery (for the experimental group, research visit II was done post-ROSP and predelivery).
6. All subjects were visited 1 wk postpartum for research visit III. (Data from the third visit are not included in this paper; this material will be included in a later publication.)
7. All subjects were visited 6 wk postpartum for research visit IV.
8. All subjects were mailed a research visit V protocol.

### *ROSP Visits: The Experimental Procedure.*

1. After research visit I, subjects were contacted by the clinical specialist, a short description of ROSP was offered, and they were asked whether or not both prospective parents were interested in participating in ROSP. This procedure was continued until a sample of eight was achieved for experimental group I and a sample of four for experimental group II. These subjects were then visited by the clinical specialist for orientation to ROSP.
2. Two prenatal home visits were made to each couple in the

experimental sample; the first meeting was to explain the program and enroll the couples, the second, after group meetings had ended but before delivery, was to discuss individual questions and concerns.

3. Eight weekly 2-hr group meetings were held during the last trimester of pregnancy. The meetings included dyadic material and discussions. The last 30 min of each class were devoted to prenatal exercises and breathing techniques utilized in labor.

4. Two clinical nurse specialists conducted the classes and one nurse made all the home visits. Couples were instructed to call one of the nurses after delivery.

5. A hospital visit with the husband present was made by one of the nurses to discuss the labor and delivery experience and its meaning.

6. One home visit was made 24 to 48 hr after hospital discharge; another was made 5 to 6 days later.

7. The clinical specialists were on call 24 hr before or after delivery.

8. Other home visits were made according to the needs and desires of the families; generally, the home visits were terminated about 4 wk postpartum, after the couple had visited a pediatrician or pediatric nurse specialist.

## **Sample**

The project sample consisted of normal couples undergoing a first pregnancy. The families were selected from this category who met the following criteria:

1. The mother was a primigravida and was a low risk medically, according to the physician responsible for her medical care.

2. The family residence was in Marin or San Francisco County.

3. The couples were English speaking.

4. The mother and father lived together at the inception of the study.

5. Any racial, ethnic, or cultural background was acceptable.

6. Neither husband nor wife was suffering from any physical handicap or deformity.

7. The age of the mother was 18 to 34 yr.

8. The mothers were in the fourth gestational month when accepted into the study.

All prenatal records at the chosen hospital were screened. All clients who met the criteria were invited to participate in the study; 58 couples were admitted to the sample.

## **Research Tools**

### **Prenatal Research Inventory**

This tool is composed of 68 statements denoting attitudes of mothers toward themselves and their pregnancies, husbands, and the forthcoming

child. Factors selected for this study were based on the need to establish lack of difference between the experimental and control groups (31).

### **Postnatal Research Inventory**

This tool, developed by Schaefer and Manheimer, is composed of 91 statements concerning behaviors and reactions of mothers related to the postpartum period (31). The inventory was subjected to factor analysis. Factors utilized in this study were those related to the mother—depression and irritability, and those related to the relationship to the baby—ignoring, protecting, and responsiveness (31).

### **Response to Crying**

Both spouses were asked in an interview to indicate their perception of how they coped with the persistent crying of their infant.

### **Marital Role Inventory**

This tool tests marital role congruency and strain within the theoretical framework of role theory and is based on the symbolic interaction view of the family as an organization of roles. Specifically, it permits comparison of the husband's and wife's assessments of the relative importance of the husband's and the wife's family roles. It is composed of four cards: two random lists of the wife's roles and two random lists of the husband's roles. Both spouses are given a list of the roles in their own role set, as well as a list of the spouse's role sets, and are asked to rank-order their roles and those of the spouse as they perceive them. The higher the correlation between role behavior of a spouse and how he or she is perceived, the higher the role congruency. Role strain is measured by the index of strain, which is defined as "the difference between the rank orders that a pair of spouses assign to the role in a particular role-set" (21:378). Reliability and validity have been established.

### **Taylor Manifest Anxiety Scale**

This is a revised form of 50 true/false MMPI items developed by Taylor (34) and judged by a panel of experts as being indicative of manifest anxiety. The scale provides a measure of such anxiety feelings and symptoms as nervousness, inability to sleep or concentrate, with fatigue and loss of appetite. The tools consist of 50 true/false items. The tool test, retest reliability, and validity have been established (34:285-289).

### **Baby's Health**

All parents were asked to evaluate the health of their baby from their

perceptions, objectively and subjectively. Subjective reactions were obtained simply by asking each spouse to rate the state of health of the baby. Objective reactions were obtained by giving the spouses (separately at 6 wk and jointly at 4 mo) a list of 40 characteristics relating to each area of the infant's health needs and asking the parents to indicate the presence or absence of these characteristics in their child. The higher the number of affirmative responses, the poorer the child's health was considered (31).

## **Results and Discussion**

Implications drawn from data analysis are necessarily qualified due to the size of the sample and disparity of the N values in the different cells and are to be viewed as merely a preliminary analysis of a limited study.

### **Concerning Hypothesis 1**

The mean age of wives was 26.36 yr and the mean age of husbands was 28.03 yr. There are no differences in the mean age of the wives between the three groups. The mean age of husbands participating in experimental group II was significantly higher.

About 60 percent of the sample were Caucasian and the remainder was made up of Chicanos, Blacks and Orientals. About 75 percent of the experimental group members were Caucasian. For purposes of preliminary analysis reported in this paper, no attempt was made to control ethnic background; further analyses will consider controlling for ethnicity and education. Whereas 37 percent of the wives in the experimental groups had completed college or attained graduate degrees, 43.5 percent of the control group had done so. Analysis indicated that this difference was not statistically significant. Sixty-three percent of the experimental group and 56.5 percent of the control group members had received high school or some college education. The husbands' education followed a pattern similar to that of their wives without any significant differences between the control and experimental groups.

All but two of the wives participating in the study were working, with the majority involved in sales, clerical, or craft-type of jobs as contrasted to professional, laborer, or service jobs. Forty-two percent of the husbands were professional and manager-administrators; 42 percent were in sales, clerical, and craft, whereas 16 percent were transport, labor, and service workers. The experimental and control groups had similar compositions.

Both the wife's and the husband's reactions to the pregnancy were analyzed through administration of the Pregnancy Research Inventory. There were no significant differences in the results of data generated as to the following variables: (1) depression and withdrawal (mother), (2) desire for pregnancy (mother and father), (3) fear for self (mother and father), (4) fear for baby (mother), (5) irritability and tension (mother and father), (6) dependency (mother), (7) fatherly feeling (father), and (8) support to mother (father). This indicates that prospective parents in the experimental and

control groups had similar attitudes toward the pregnancy, themselves, and their future baby. It also indicates that the level of support for the wife during pregnancy (and the transition period) did not differ between the groups.

### Concerning Hypothesis 2

Data related to this hypothesis were derived from the Marital Role Inventory, which was developed to measure role strain, role congruency, and the potential for marital adjustment. The instrument was administered during research visit II, which was post-ROSP and predelivery for the experimental group, and predelivery for the control groups. There was a significant difference ( $p > .01$ ) between the ROSP, control, and FAMCAP groups as to the strain in the wife's role set (Table 1). Preliminary consideration of the mean indicates that the difference was primarily between the ROSP and the control groups. Conversely, there were no significant differences between the study groups as to strain in the husband's role set (Table 2); however, the F-value of 3.05 approached the .05 level of significance.

**TABLE 1**  
**F-RATIO OF WIVES' ROLE STRAIN BETWEEN ROSP, CONTROL, AND FAMCAP GROUPS\***

Source	SS	d.f.	MS	F-Ratio
Between groups	348.9	2	174.5	6.4†
Within groups	899.74	33	27.26	
Totals	1248.64	35		

\*SS = sum of squares; MS = mean of squares.

† $p < .01$ .

**TABLE 2**  
**F-RATIO OF WIVES' ROLE STRAIN BETWEEN ROSP, CONTROL, AND FAMCAP GROUPS\***

Source	SS	d.f.	MS	F-Ratio
Between groups	380.45	2	190.23	3.05 (n.s.)
Within groups	2057.83	33	62.36	
Totals	2438.28	35		

\*SS = sum of squares; MS = mean of squares; n.s. = not significant.

These findings indicate that couples who participated in ROSP were in closer agreement as to the relative importance of each of the wife's family roles than were couples who did not participate in ROSP. Yet the FAMCAP group families also demonstrated more consensus in this area than was demonstrated by the control group. According to the author of the instrument, higher role congruency indicates lower role strain. Based on the assumptions underlying this instrument and role theory, ROSP families achieved better adjustment than was achieved by control group couples.

Further consideration of the mean index of strain indicated that the mean of role strain for husbands' roles was significantly higher than for the wives' roles in both the ROSP and the control groups, and that the differences most nearly approximated the means of a sample of 104 middle-class couples reported in the literature (21:379). Thus, findings in this study have replicated previous findings. Couples who participated in ROSP had role strain patterns similar to those of other populations, but couples in the control group had higher role strain than other populations (Table 3).

**TABLE 3**  
**MEAN OF INDEX OF STRAIN FOR HUSBANDS AND WIVES IN ROSP**  
**AND CONTROL GROUPS AS COMPARED WITH SAMPLE**  
**USED IN ACTIVITY STUDY**

	Hurvitz's Sample	ROSP Group	Control Group
Wives	5.26	5.27	6.95
Husbands	6.09	7.87	9.09

#### Concerning Hypothesis 3

There were no differences in the means of depression scores between the three groups. Although the means for the ROSP and FAMCAP groups were slightly lower than those of the control group, not even a trend could be detected. The same statement holds for irritability. Neither ROSP nor FAMCAP, then, affected postpartum depression or irritability at 6-wk and 4-mo levels as measured in this study.

#### Concerning Hypothesis 4

Mothers who participated in the experimental programs manifested less anxiety than did mothers who did not participate in any program in the FAMCAP program; however, the differences were not statistically significant ( $F = 0.61$ ), ( $d.f. = 2.38$ ). Preliminary analysis of preprogram and predelivery anxiety levels demonstrated that the anxiety levels of

mothers in the control groups (at 4 mo) had increased, whereas anxiety levels of ROSP mothers remained the same postdelivery (at 4 mo). Further analysis of these data is now underway. The hypothesis thus is rejected, because it is apparent that ROSP did not affect the level of anxiety in mothers when their babies were 4 mo of age.

### Concerning Hypothesis 5

The parents did not differ significantly in their perception of the extent of the health of their infants. Even when cells were dichotomized into good and excellent health, no differences were manifested between groups. Consistently, more families perceived their baby as being in excellent rather than good health. When the infants were 6 wk old, more fathers perceived their infants as being in excellent health than did the mothers (Table 4). The ROSP group, however, manifested more congruency between husbands and wives in the subjective evaluation of their babies.

**TABLE 4**

**FREQUENCY OF EVALUATION BY GROUPS OF SUBJECTIVE HEALTH BY HUSBANDS AND WIVES OF BABY AT 6 WK AND 4 MO\***

Subjective Health	ROSP Group			Control Group			FAMCAP Group		
	W/6 wk	H/6 wk	H/W/4 mo	W/6 wk	H/6 wk	H/W/4 mo	W/6 wk	H/6 wk	H/W/4 mo
Good	2	4	4	8	0	8	4	0	3
Excellent	8	7	6	13	23	13	6	10	7
Range of totals in groups	10-11			21-23			10		

\*W = wife; H = husband.

When husbands and wives were asked to evaluate the health of their baby, subjectively and together, the results indicated that their joint evaluation at 4 mo approximated more the wives' evaluation at 6 wk. In the ROSP group, the joint evaluation more resembled the husbands' perception at 6 wk than the wives'. It is speculated that this finding might indicate only that the husbands more actively participated in the response to this question in the ROSP group than in the other two groups. There are no data in the preliminary analyses to substantiate or refute such speculation.

Results from the babies' health inventory are presented in Table 5. When the infants were 6 wk old, there were no significant differences between the health of babies in the different groups as observed and reported by mothers or by fathers. The difference between groups did become significant after 4 mo, however.

TABLE 5

## F-RATIO BY GROUPS OF OBJECTIVE PARENT EVALUATION OF BABY'S HEALTH\*

Parent (Time of Testing)	Groups	SS	d.f.	MS	F-Ratio	$p^{\dagger}$
Wives (6th wk)	Between	60.26	2	30.13	1.9983	n.s.
	Within	648.35	43	15.08		
	Total	708.61	45			
Husbands (6th wk)	Between	44.94	2	22.47	2.3147	n.s.
	Within	398.034	41	9.71		
	Total	442.98	43			
Both (4th mo)	Between	108.36	2	54.18	3.8613	<.05
	Within	533.20	38	14.03		
	Total	641.56	40			

\*SS = sum of squares; MS = mean of squares.

$\dagger$ n.s. = not significant.



Upon further consideration of the data, it appears that the ROSP parents observed and reported more signs of ill health than did non-ROSP parents. This result contradicts the fifth hypothesis. The findings take on a different meaning, however, when interpreted in light of the conceptual framework guiding this study. The ROSP families had ample opportunity to develop role-taking abilities in their relationship to their spouses and their babies. Placing oneself in the position of the other and inferring feelings, attitudes, behavior, and sentiments makes one a better observer of the person whose role is taken. Others have found "the more maternally gratified mothers are generally more perceptive of and responsive to their child's cues and actions" (32:520). It is possible that the ROSP mothers were able to observe more, use role taking more, and thus, identified more unhealthy conditions than did the other mothers.

### Concerning Hypothesis 6

Crying begins as an expression of need in early infancy and later may become a mode of communication directed specifically toward the mother. Popular approaches to the issue of crying and how to respond to it have varied with the fluctuations from strict to permissive styles in rearing children.

This study focused on crying because of its communications function and because of its displeasing and alarming nature. The study specifically considered the coping styles of fathers and mothers in dealing with persistent crying. A coping style based on experimentation and problem solving takes into account the needs of both the giver and the receiver. It indicates a more humane, individualized approach to coping with a displeasing behavior.

As shown in Table 6, the frequency and prevalence of ritualistic or experimental and problem-solving styles in coping with persistent crying did not differ as between groups. A chi-square was calculated and indicated no significant difference. Still, it is interesting that a notable percentage of husbands in the control group utilized a ritualistic style, as compared with husbands in the ROSP and the FAMCAP groups. This might point to a potential effect of these two programs in a changing of men's styles of coping with crying.

TABLE 6

### FREQUENCY AND PERCENTAGE BY GROUPS OF QUALITY OF RESPONSE OF HUSBANDS AND WIVES TO BABY'S CRYING

Response to Crying	ROSP Group		Control Group		FAMCAP Group	
	Wives % (no.)	Husbands % (no.)	Wives % (no.)	Husbands % (no.)	Wives % (no.)	Husbands % (no.)
Ritualistic-ignoring	25 (3)	36 (4)	20 (5)	57 (13)	30 (3)	25 (2)
Experimental-problem solving	75 (9)	64 (7)	80 (20)	43 (10)	70 (7)	75 (6)

## Concerning Hypothesis 7

Parents who participated in ROSP manifested less ignoring behavior ( $F = 6.3650; p < .01$ ), fewer protective attitudes ( $F = 8.44; p < .01$ ), and more integrative behaviors in response to infants' needs ( $F = 5.98; p < .01$ ). These findings indicate that mothers who participated in ROSP were more responsive to their infants' needs and were more apt to consider them as entities with individualized needs who need communication above and beyond the physical level. ROSP mothers demonstrated less realistic protective attitudes than did non-ROSP mothers.

Non-ROSP mothers manifested a sense of urgency and immediacy in their responsiveness to their babies as compared to the ROSP mothers. The urgency attitudes were indicated in relations to diaper changing, feeding, crying, and in constant hovering over the baby's needs. A more integrative approach would take other needs into account in the care given and would exhibit a sense of caring with less urgency. Such were the attitudes of the ROSP mothers.

## Summary

This investigation considered the effect of a nursing intervention on the transition, on dyadic roles, and on a number of social and psychological variables appropriate for study of the change from dyadic to triadic role structure. It was postulated that role supplementation as a nursing intervention and as means to accomplish higher role clarity, higher skill in role-taking communication, would lead to a transitional period with less friction, strain, and anxiety. This, in turn, would ultimately have a significant positive influence on all members of a role set.

Results indicate that the nursing intervention did produce a difference in husband-wife role strain and in responsiveness to the baby but produced no difference in the anxiety and depression experienced by the parents after delivery. This preliminary analysis of the phenomena of nursing intervention through role supplementation suggests that the model has potential and deserves further attention.

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