

CONSTRUCT VALIDATION OF THE PERCEIVED MATERNAL TASK PERFORMANCE SCALE

Lidia De Simone and Laurie N. Gottlieb

The purpose of this study was to examine the psychometric property of construct validity for the "Perceived Maternal Task Performance Scale". The Perceived Maternal Task Performance Scale (PMPTS) (previously referred to as the MRPS) was developed by Perry (1985) and Gottlieb to measure a mother's self-reported performance in carrying out common infant care tasks. Maternal task performance refers to a mother's ability to assess infant care needs and to a mother's skill in performing activities in the areas of feeding, sleeping, crying, elimination, clothing, play, safety and illness (Chao, 1979; Roberts, 1983). "Assessment" refers to the mother's ability to recognize and to make judgements regarding her infant's needs (Perdue, Horowitz, & Herz, 1977), whereas "performance" refers to the mother's ability to carry out infant care activities.

The PMPTS was based on the assumption that maternal behaviours are learned in the process of caring for an infant and that, with caregiving experience, a mother will master these skills. As an evaluation of learning, the instrument measures both a mother's ability to assess her infant's needs as well as her ability to perform specific caregiving activities.

Maternal Behaviours and Learning

The acts or tasks a mother is expected to perform in relation to her child are referred to as the "Maternal role". The current view of the maternal role in the nursing literature focuses on the skills and tasks involved in fostering the physical, social and psychological development of the child (Perdue, et al., 1977; Rubin, 1975). Thus, early maternal behaviours related to maternal role performance involves tasks related to feeding, elimination, comfort, skin care, activity and health. Mothers themselves confirm that they feel like mothers in the process of caring for their infant (Chao, 1979; Gottlieb, 1978).

Lidia De Simone N., M.Sc. is currently working with Inuit patients at Baffin House in Montreal. Laurie N. Gottlieb, Ph.D. is Associate Professor in the School of Nursing at McGill University, Montreal, Quebec
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For adult roles, knowledge and skills necessary for performance of new behaviours within a role are learned through the process of socialization (Brim, 1976). Social learning theory proposes that behaviours are acquired through, among other things, a process of covert practice, until an internal model is formed (Bandura, 1977). As behaviours associated with a role are oriented and directed at other persons in a role relationship, Sarbin (1968) proposes that people evaluate the adequacy of their role behaviours according to information derived from the role partner. This feedback influences ongoing behaviour by functioning as acceptance, guidance, social reinforcement, and maintenance of the role behaviour (Sarbin & Allen, 1968).

Mothering behaviours related to caregiving acts become progressively more complex during the initial postpartum period (Rubin, 1967). Moreover, progress in learning maternal behaviours occurs as mothers test out and evaluate their caregiving (Chao, 1979; Rubin, 1967). Factors such as experience are related to the speed in which these behaviours are acquired (Curry, 1983; Rutledge & Pridham, 1987). For example, Rubin (1967) found that multipara produced more items relevant to acquiring mothering behaviours than did primipara in both the antepartum and postpartum periods. The number of items relevant to becoming a mother was considered to be indicative of the mother's motivation and commitment to attaining her maternal role. Chao (1979) noted that multipara frequently recalled specific caregiving behaviours from their past experience, and used these to devise and to test out present caregiving acts. Multipara were also more active than primipara in testing out ideas. The testing of ideas, and consequently, the possibility of benefiting from trial and error learning was suggested as an important factor in the multipara's ease with caregiving.

Another factor associated with the ease in which women perform maternal behaviours is the response of the infant. Chao (1979) noted that a mother's evaluation of her caregiving was dependent on how well her infant responded, (i.e., ease of feeding). Further, Perry (1985) found that mothers who perceived their infant's mood as negative and their care as being difficult, rated themselves lower in most areas of infant care on the Perceived Maternal Task Performance Scale. It should be noted that at this age the infant's responses may be closely related to the infant's temperamental characteristics (Rothbart & Derryberry, 1982; Worobey, Laub & Schilmoeller, 1983). Rothbart and Derryberry (1982) suggested that the infants who express a positive affect, provide the caretaker with valuable cues concerning their preferred modes of interaction and level of stimulation.

In summary, a mother's ability to assess infant needs and to perform infant care tasks is learned through caring for her infant. As such, perceived maternal task performance as measured by the PMTPS, was expected to vary according to a mother's past experience with infant care. We examined

scores of both multipara and primipara in Week 1 and Week 6 postpartum to assess the PMPTS's construct validity.

Method

It was hypothesized that (a) at Week 1 postpartum, multipara would score higher on the PMPTS than would primipara. (b) at Week 6 postpartum, both multipara and primipara would have higher PMPTS scores than at Week 1 postpartum. A comparative design was used to test the hypotheses.

Study Population

Mothers participating in the study were selected from the postpartum wards of three metropolitan university teaching hospitals. Mothers who delivered a single infant vaginally without any major complications, either for mother or for infant, were asked to participate. These selection criteria were chosen in order to control for health factors that may interfere with a mother's caregiving abilities (Caulfield, Disbrow & Smith, 1977; Mercer, 1977). Moreover, given the assumption that it is through direct acts of caregiving that caregiving skills are learned, mothers who intended to hire a baby-nurse were not asked to participate.

Of the 118 mothers who met the selection criteria, 116 mothers (Primipara: $n=59$ (50.9%) Multipara: $n=57$ (49.1%)) agreed to participate in the study. Of the 116 mothers, 92 (79.3 %) completed Phase 1 of the study when their infants were between 7 and 14 days old ($M=10.6$). Of the 92 mothers, 45 (49.5%) were primipara and 47 (50.5%) were multipara. Of these 92 mothers, 85 (93.5%) completed Phase 2 of the study when their infants were between 36 and 52 days old ($M=43$). The group of 85 mothers was composed of 42 (49.4%) primipara and 43 (50.6%) multipara.

At both Week 1 and Week 6, one multipara was dropped from further analysis because her scores were greater than three standard deviations from the mean of the multipara group. Consequently, the number of multipara for subsequent analysis at Week 1 was 46, and at Week 6 was 42.

Procedure

Potential mothers were approached on Day 3 postpartum and the study was explained. Mothers who agreed to participate were asked to sign a consent form and to complete the Background Characteristics Questionnaire.

The average stay in hospital was less than four days: as such, mothers were mailed the PMPTS at Week 1 postpartum. Important infant developmental milestones begin to emerge at 6 to 8 weeks, (i.e., increased alert states, and

discriminant sociability) (Emde & Robinson, 1979; Lamb & Bornstein, 1987). Therefore, mothers were mailed a second copy of the PMPTS at Week 5 postpartum, in order to minimize the infant's contribution to maternal task performance. In Week 1, mothers were instructed to complete the PMPTS within three days of receipt and to return the questionnaire in the stamped, addressed envelope provided. Four days following mailing, mothers were telephoned to remind them to mail back the questionnaire. At Week 5 postpartum, a second copy of the MRPS and the Infant behaviour Questionnaire (IBQ) was mailed only to those mothers who had returned the first PMPTS.

Instruments

Perceived Maternal Task Performance Scale (PMPTS). The PMPTS was designed to examine the relationship between maternal task performance and social support (Perry, 1985). The PMPTS is composed of 24 situational items and can be categorized according to common areas of infant care or according to the type of skill.

Areas of infant care, comprising four items each, are divided into the following six a priori subscales: *Feeding*, (e.g. knowing when to burp your baby); *Elimination*, (e.g. knowing what to do if your baby develops a diaper rash); *Comfort*, (e.g. knowing how to quiet your baby when s/he cries); *skin care*, (e.g. knowing how to protect your baby's skin from irritation); *Activity*, (e.g. knowing how much to stimulate your baby); and *Health*, (e.g. Knowing when to call a physician about your baby's health).

Categorization according to types of skill results into two subscales comprising twelve items each: *Assessment* (e.g. knowing when your baby is full); *Performance* (e.g. knowing what to do when your baby spits up). Further information about the categories used in the PMPTS is available from the authors.

Situational statements representing each behaviour were developed from an extensive survey of the lay and nursing literature. These items were then reviewed by a panel composed of nurses, first-time mothers and experienced mothers. Criteria for agreement amongst the panelists included the clarity of the statements, the area of infant care represented by an item and whether the item involved an assessment or performance skill. Internal consistency of the PMPTS, using Cronbach's Alpha, was calculated at .91 (Perry, 1985).

Mothers rated how competent they felt for each item during the past week. The responses were tied to the week just before being surveyed in order to increase the accuracy of reporting. Rating involved placing a slash (/) along a 10 cm. analogue line ranging from "very unsure" to "very sure". For purposes of scoring, the line was divided into 10, 1 cm. bins, numbered 0 for

"very unsure" to 9 for "very sure" responses. A continuous analogue line was deemed preferable to the five-point Likert format because of the difficulty in finding equally spaced response categories (Specter, 1976) and because of respondents difficulty in discriminating among five-point summated response categories (Ramsay, 1973). The items were then rated in terms of the bin in which the slash was located. The scores of the items belonging to a particular subscale were then summed to yield a subscale score. The theoretical scores range from 0 - 36 for each of the six area of care subscales, from 0 - 108 for the assessment and performance subscales, and 0 - 216 for the total scale.

Background Characteristics Questionnaire. Data on variables considered important in influencing maternal task performance included demographics, past caregiving experience, the birth history and infant behaviour characteristics. Infant behaviour characteristics or temperament was assessed with the Infant behaviour Questionnaire (IBQ). Rothbart and Derryberry (1982) defined temperament as individual differences in reactivity and self-regulation. The IBQ is made up of 94 items divided among the following six dimensions: *Activity*, (e.g. during feeding how often did the baby squirm or kick?); *Distress to limitations*, (e.g. when placed on his/her back, how often did the baby fuss or protest?); *Duration of orienting*, (e.g. how often during the last week did the baby stare at a mobile, crib bumper, or picture for five minutes or longer?); *Smiling and laughter*, (e.g. when put into the bath water, how often did the baby smile or laugh?); *Soothability*, (e.g. how frequently was the baby soothed when held?); and *Fear or latency to approach*, (e.g. how often did the baby cry or show distress at a loud noise?). Mothers rated the frequency of occurrence of specific infant behaviours observed in different stimulation situations (e.g., feeding, bathing), along a seven-point Likert scale ranging from "never" (1) to "always" (7). Stability of the measure was tested over a 12 month period at three month intervals. Scores at three months were predictive of scores at 12 months in the dimensions of activity ($r=.48, p<.001$) and smiling and laughter ($r=.57, p<.001$). Whereas, scores at 9 months were predictive of scores at 12 months in all dimensions (range of r 's $=.44 - .80, p<.01 - .001$). Internal consistency, using alpha coefficients, for each dimension, at each time period, ranged between .67 - .84. (Rothbart, 1981).

Results

Background characteristics

Mothers from each of the three hospital settings were compared on major demographic variables (age, education, family income etc.) With the exception of infant gender, mothers from the three settings did not differ on any major background characteristics. Therefore, the data for mothers from all

three settings were combined for subsequent analyses. Primipara (n=42) and multipara (n=43) were compared on selected background characteristics (Table 1).

Table 1
Comparisons Between Groups on Background Characteristics (N=85)

Variable		Primipara	Multipara	<i>t</i>	df	<i>p</i>
<i>Family Characteristics</i>						
Mother's age (Years)	M	26.5	29.9	-3.48	83	***
	SD	4.9	4.2			
	Range	17-41	20-37			
Mother's education (Years)	M	14.7	13.3	2.09	82	*
	SD	3.1	2.9			
	Range	9-22	9-20			
Infant age at Time 1 (Days)	M	10.67	11.15	-1.11	89	NS
	SD	2.19	1.98			
	Range	7-14	7-14			
Infant age at Time 2 (Days)	M	43.19	43.21	-0.03	82	NS
	SD	3.68	3.77			
	Range	37-52	36-52			
Variables		Primi- n(%)	Multi- n(%)	<i>X</i> ² (df, <i>N</i>)		<i>p</i>
Marital status				<i>X</i> ² (1, <i>N</i> =85)		= .68 NS
1. Single		5(12)	2(5)			
2. Married		37(88)	41(95)			
Occupation of working fathers				<i>X</i> ² (2, <i>N</i> =79)		=1.0 NS
1. Professional		19(51)	17(41)			
2. Skilled		17(46)	23(55)			
3. Unskilled		1(3)	2(4)			
Infant gender				<i>X</i> ² (1, <i>N</i> =85)		=2.7 NS
1. Girl		26(62)	18(42)			
2. Boy		16(38)	25(58)			
Feeding type				<i>X</i> ² (2, <i>N</i> =85)		=4.4 NS
1. Breast		33(79)	25(58)			
2. Bottle		5(12)	12(28)			
3. Both		4(9)	6(14)			

NS=nonsignificant; * $p<.05$, two-tailed; *** $p<.001$, two-tailed.

Table 2

Descriptive Statistics for the PMPTS

Scale/Subscale		Primipara		Multipara	
		Week 1	Week 6	Week 1	Week 6
Feeding	M	27.7	30.6	29.3	31.8
	SD	6.4	5.8	5.9	3.8
	Range	5-36	9-36	12-36	24-36
Elimination	M	23.4	30.1	28.1	29.9
	SD	6.9	5.3	6.2	4.7
	Range	9-36	17-36	10-36	20-36
Comfort	M	24.3	25.5	25.5	27.5
	SD	7.3	8.1	6.9	5.8
	Range	5-36	0-36	8-36	16-36
Skin care	M	26.6	30.4	30.5	31.5
	SD	6.3	4.7	4.9	4.5
	Range	11-36	18-36	19-36	21-36
Activity	M	23.8	26.9	27.0	27.7
	SD	8.7	6.6	7.0	6.5
	Range	0-36	11-36	11-36	14-36
Health	M	27.2	30.1	29.6	31.5
	SD	6.0	4.2	6.2	4.9
	Range	13-36	18-36	9-36	19-36
Assessment	M	76.5	87.1	84.4	89.2
	SD	17.3	13.5	14.3	12.3
	Range	32-108	57-108	46-107	62-108
Performance	M	77.5	86.6	85.9	90.6
	SD	15.8	12.6	15.3	12.4
	Range	25-105	60-108	49-108	65-108
<u>Total Scale</u>	M	153.1	173.8	170.2	179.8
	SD	30.3	25.0	30.0	23.8
	Range	57-213	117-216	90-215	135-216

Comparisons of labour and delivery experiences between the two groups showed primipara had more lacerations (over 2 cm.) than multipara (Primipara N : 13; Multipara N : 4, $X^2=4.9$, $p<.05$) and had also received more anaesthesia during delivery (Primipara N : 31; Multipara N : 20, $X^2=5.5$, $p<.05$). Further, a larger proportion of the infants born to primipara were postmature. Finally, temperament dimensions as assessed by the IBQ, revealed no significant differences between the parity groups (range of t 's=-1.3 -1, $p>.05$).

Descriptive statistics

The PMPTS is a new scale and as such, descriptive statistics are reported in Table 2. In Week 1 and Week 6, primipara and multipara area of care subscale scores were in the upper third of the theoretical range of scores.

Table 3

Rank Ordering for each Subscale of the PMPTS

Primipara		Multipara	
(a) Week 1			
	<u>M</u>		<u>M</u>
Feeding	27.7	Skin care	30.5
Health	27.2	Health	29.6
Skin care	26.6	Feeding	29.3
Comfort	24.3	Elimination	28.1
Activity	23.8	Activity	27.0
Elimination	23.4	Comfort	25.5
Performance	77.5	Peformance	85.9
Assessment	76.5	Assessment	84.4
(b) Week 6			
Feeding	30.6	Feeding	31.8
Skin care	30.4	Skin care	31.5
Health	30.1	Health	31.5
Elimination	30.1	Elimination	29.8
Activity	26.9	Activity	27.7
Comfort	25.5	Comfort	27.5
Assessment	87.1	Performance	90.6
Performance	86.6	Assessment	89.2

In Week 1, the exact rank order of area of care subscales was different, however, both parity groups rated their abilities in the feeding, health and skin care as highest and their abilities in comfort, activity and elimination as lowest (Table 3). Both parity groups rated themselves slightly higher on performance than assessment skills. In Week 6, the mean scores for the area of care sub-scale mean scores were in the exact same rank order for both parity groups, with feeding as highest and comfort as lowest. Furthermore, multipara continued to rate their performance skills higher than their assessment skills whereas primipara rated their assessment skills higher than performance skills.

Internal consistency.

The internal consistency of the PMPTS, using Cronbach’s alpha coefficients, was calculated at both times for the total scale, the area of care subscales and the type of skill subscales (Table 4). Overall, the alpha coefficients for the total scale was high (Week 1: .89; Week 6: .88), which was consistent with the results obtained by Perry at Week 4 postpartum (.91) (Perry, 1985).

Table 4
Cronbach’s Alpha Coefficients for Internal Consistency of the Total Scale and Subscales (PMPTS)

	Week 1 (N=92)	Week 6 (N=84)
Total scale	.89	.88
Feeding	.62	.60
Elimination	.60	.45
Comfort	.64	.79
Skin care	.57	.48
Activity	.71	.70
Health	.67	.60
Assessment	.80	.82
Performance	.79	.75

Hypotheses testing

Because the subscales were moderately correlated, (Area of care subscales; Week 1: range of $r(91)=.42$ to $.69$, $p<.001$; Week 6: range of $r(84)=.39$ to $.66$, $p<.001$; Type of skill subscales; Week 1: $r(91)=.78$, $p<.001$; Week 6: $r(84)=.86$, $p<.001$), the hypotheses were tested with multivariate analyses of variance (MANOVA) for each data set (Maxwell, 1977). Univariate analyses of variances (ANOVA) were then computed to explain further the factors that were significant on the MANOVA. When two-way interactions were involved, Tukey post-hoc tests were performed.

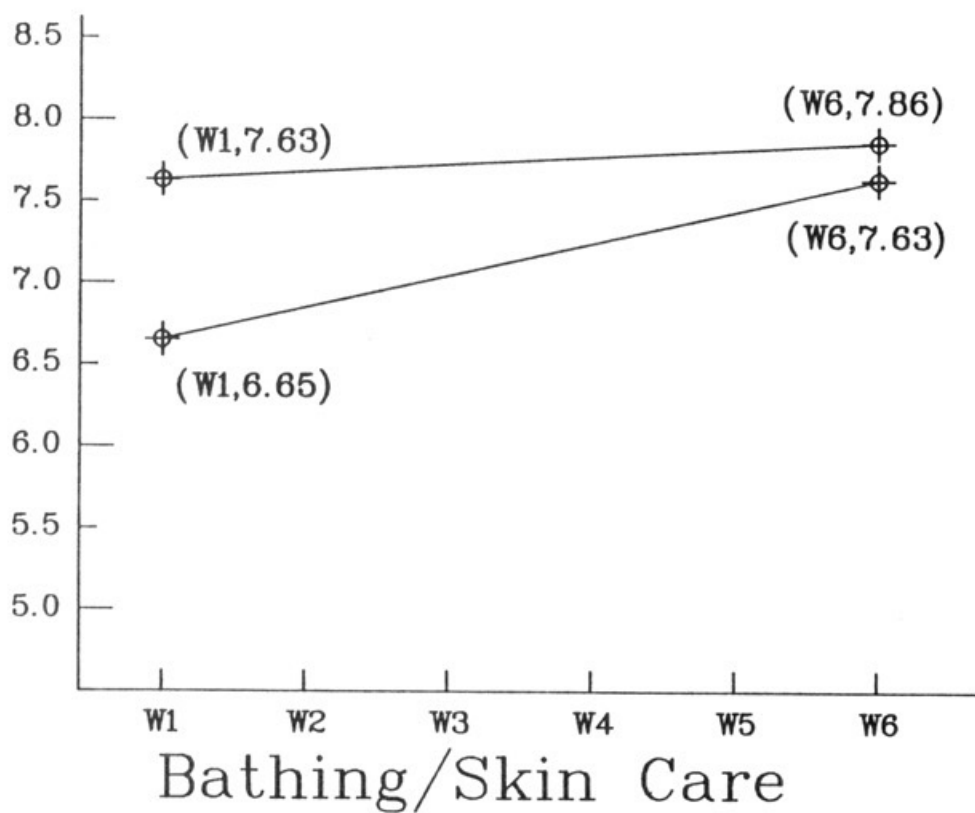
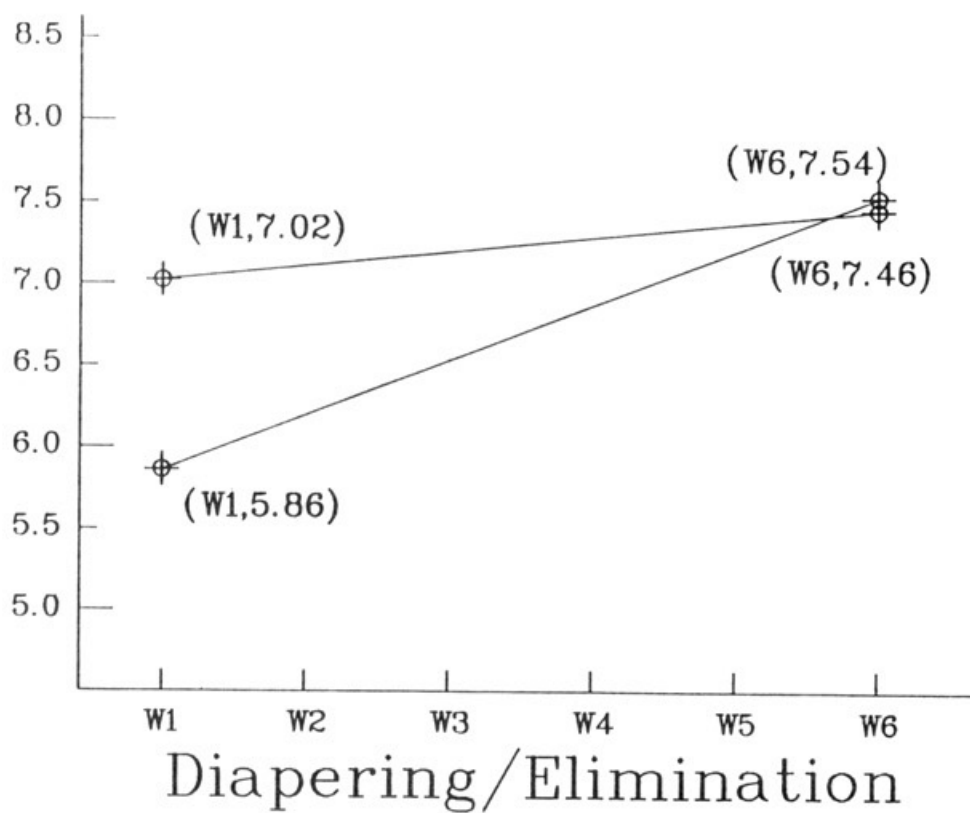
Hypothesis 1: Multipara would score higher on the PMPTS than primipara at Week 1.

The data for the six areas of infant care were subjected to a one-way MANOVA with Group (primipara and multipara) as a between-subjects factor. The analysis yielded a significant overall effect of Group, $F(6,84)=3.03$, $p<.01$. Univariate analysis for each area of infant care revealed that multipara rated their abilities significantly higher than primipara on activity, (M : 27.0 vs. 23.8, $p<.05$); elimination, (M : 28.1 vs. 23.4, $p<.001$); and skin care, (M : 30.5 vs. 26.6, $p<.001$).

The data for assessment and performance were also subjected to one-way MANOVA with Group (primipara and multipara) as a between-subjects factor. The analysis yielded a significant overall effect of Group, $F(2,88)=3.83$, $p<.05$. Univariate analysis for each type of skill revealed that multipara rated their abilities significantly higher than primipara on assessment skills (M : 6.37 vs. 7.00, $p<.05$) and performance skills (M : 6.39 vs. 7.18, $p<.01$). The hypothesis that multipara will rate their caregiving abilities higher than primipara in the initial postpartum period was supported. This was the case for elimination, skin care and activity but not for feeding, comfort and health.

Hypothesis 2: Both multipara and primipara would have higher PMPTS scores at Week 6 as compared to Week 1 postpartum.

The data for the six areas of infant care were subjected to a two-way repeated measures MANOVA with Group (primipara and multipara) as a between-subjects factor and Time (Week 1 and Week 6) as a within-subject factor. The analysis yielded a significant main effect of Time, $F(6,77)=8.34$, $p<.001$. Univariate analyses revealed that with the exception of activity, mothers rated their abilities higher in Week 6 than in Week 1 on feeding (M : 31.2 vs. 28.4, $p<.001$), comfort (M : 26.5 vs. 24.9, $p<.05$), elimination (M :



**Figure 1: Perceived changes in Diapering/
Elimination and Bathing/Skin Care**

30.0 vs. 25.7, $p < .001$), skin care (M : 30.9 vs. 28.9, $p < .001$) and health (M : 30.8 vs. 28.5, $p < .001$). The analysis was qualified by a significant Group X Time interaction, $F(6,77)=2.54$, $p < .05$. Univariate analysis for each subscale revealed that primipara rated themselves higher on Week 6 than Week 1, but lower than multipara at both times on elimination (Tukey: $p < .01$) and skin care (Tukey: $p < .01$). Primipara scores increased significantly from Week 1 to Week 6 but multipara did not perceive change in the areas of elimination and skin care (Figure 1).

The data for assessment and performance were subjected to a two-way repeated measures MANOVA with Group (multipara and primipara) as a between-subjects factor and Time (Week 1 and Week 6) as a within-subject factor. The analysis yielded a main effect of Time, $F(2,81)=16.09$, $p < .001$. Univariate analysis revealed that mothers rated their abilities higher in Week 6 than in Week 1 on assessment (M : 7.35 vs. 6.70, $p < .001$) and on performance (M : 7.39 vs. 6.81, $p < .001$).

The hypothesis that mastery of caregiving behaviours develops as mothers gain experience over the first six weeks postpartum was also supported in all area of care subscales except activity and in both type of skill subscales.

Discussion

Construct validation provides evidence for the theoretical interpretations given to test scores (Cronbach & Keehl, 1955). Theoretically, higher PMPTS scores to reflect a mother's perceived competence in performing common infant care tasks. As maternal behaviours are learned during caregiving, it was expected that PMPTS scores would increase with caregiving experience. The finding that PMPTS scores differentiated between mothers with various levels of caregiving experience supports the interpretation of PMPTS scores as being representative of mothers' feelings of competence with infant caregiving. Although the hypotheses were generally supported at both time periods, this was not the case across all areas of infant care.

In Week 1, primipara rated themselves significantly lower than multipara in the areas of activity, elimination and skin care, but not in the areas of feeding, comfort and health. The issue raised by this finding is: what distinguishes the areas in which multipara scored higher than primipara from those areas in which no differences were found? It may be that previous knowledge acquired about infant activity, elimination and skin care is more readily transferred to a new situation than knowledge obtained in areas of infant care related to feeding, comfort and health.

It should be noted that the difference between multipara and primipara scores in comfort were only .31 in Week 1. This suggests that past experi-

ence was of minimal use for multipara. It may be that understanding their new baby's characteristics is more critical in meeting comfort needs than knowledge acquired from past caregiving experience (Brazelton, 1977; Gottlieb, 1978). However, past experience did promote rapid development of feelings of competency in this area, as was reflected by the larger increase in multipara scores on Week 6 than primipara.

In addition, the failure of PMPTS scores to differentiate mothers with past experience from new mothers may be because the subscales are not uniformly sensitive in each of the six caregiving areas. For example, the item, "Knowing when to burp your baby," may not be appropriate but, "Knowing when your baby has been sufficiently burped," may be more sensitive for detecting differing levels of competency in feeding. With regard to health, comparability found between multipara and primipara scores may have occurred because these items may have been irrelevant to this particular time. In other words, mothers may not have, as yet, encountered situations that tested their ability. Therefore, some mothers may have responded hypothetically. Adding a non-applicable category to the scale may correct for this situation.

By Week 6, primipara and multipara reported feeling more competent in performing maternal tasks in all areas of infant care, except activity. Moreover, in the areas of elimination and skin care, primipara rated themselves significantly higher in Week 6 than in Week 1, whereas multipara rated themselves similarly at both times. These results demonstrate that although past experience with infant care positively affects activity subscale scores in Week 1, present and ongoing experience fails to improve mothers' feelings of competence in the area significantly. It has been reported that new mothers often lack knowledge of the newborn's social-perceptual capacities (Snyder & Eyres, 1979). The lower scores of primipara in Week 1 may reflect this finding. It may also be that the low activity scores at Week 6 reflect the infant's developing capacity for social interaction and stimulation. Mothers, therefore, may need to be constantly revising their approaches as infant needs for differing forms of activity become more complex.

In terms of elimination and skin care, primipara appear to acquire knowledge and skills in these areas in a relatively short period of time. Moreover, the finding that multipara were already at a ceiling effect at Week 1 suggests that a sense of competency in the area was easily transferred from past caregiving situations.

The comparatively lower scores of primipara and multipara in the areas of comfort and activity at both times highlight the importance of focusing on helping both primipara and multipara gain knowledge and skills in meeting comfort and activity needs of their infants. It may be that mothers' scores are

lower in the area of comfort because of their inability to deal with the infant's crying (Mortimer & Kevill, 1985; Newton, 1983) or unique characteristics. Nursing interventions aimed at increasing a mother's understanding of her infant's behaviour may result in meeting these needs.

As hypothesized, primipara scored significantly lower than multipara on both assessment and performance at Week 1; by Week 6, both groups significantly improved on both skills. In the early postpartum period primipara do not feel as comfortable in assessing and carrying out infant care tasks as their more experienced counterparts. Moreover, they feel less confident with performance than assessment skills. These findings suggest that attention should focus on helping primipara enlarge their repertoires of caregiving skills, both in the areas of assessment and performance.

The initial testing of the PMPTS's psychometric properties is encouraging. However, further psychometric testing, such as test-retest reliability over a stable period and predictive validity studies using mother-infant interaction as the criterion, is warranted before the PMPTS can be used as a research and clinical tool for assessing mothers' developing sense of competency in performing common mothering tasks.

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A copy of the PMPTS is available from the authors.

RÉSUMÉ

Validation du système de variables de l'échelle d'aptitudes à l'exécution des tâches maternelles telles que perçues par le sujet

Nous avons étudié la validité du système de variables d'une nouvelle échelle, la Perceived Maternal Task Performance Scale (PMPTS) (Perry, 1985 & Gottlieb). La PMPTS mesure, par le biais d'une auto-enquête, les aptitudes d'une mère à évaluer et à exécuter les tâches requises pour assurer tous les soins à son nourrisson. Dans la mesure où les comportements maternels sont acquis par la pratique, on a posé comme hypothèse que les multipares obtiendraient des notes plus élevées à l'échelle PMPTS que les primipares, une semaine après la naissance et que les primipares aussi bien que les multipares obtiendraient six semaines après la naissance des résultats plus élevés qu'une semaine après la naissance. Quatre-vingt-douze mères (45 primipares et 47 multipares) ont rempli la PMPTS une semaine après la naissance et 85 de ces 92 mères l'ont remplie 6 semaines après la naissance.

L'échelle PMPTS comporte 24 énoncés de mise en situation répartis sur 6 sous-échelles de soins (c'est-à-dire, alimentation, élimination, bien-être, soins de la peau, activité et santé). Les résultats appuient les hypothèses: la première semaine, les multipares ont obtenu des notes nettement plus élevées que les primipares, particulièrement au chapitre de l'élimination, des soins cutanés et de l'activité. A la sixième semaine, les primipares tout comme les multipares ont obtenu des notes nettement plus élevées à l'échelle PMPTS qu'à la première semaine pour tous les aspects des soins du nourrisson, exception faite de l'activité. Ces résultats apportent un appui préliminaire à la validité du système de variables de l'échelle.