



Case Report

# Case Study: Application of Ramona Thieme Mercer's Theory of Becoming a Mother in Nursing Care

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## Abstract

**Background:** Ramona T. Mercer describes becoming a mother as a continuing process shaped by maternal infant interaction, family, health professionals, community, and society. **Objective:** To describe theory informed nursing care for a primiparous woman during the early period after cesarean birth. **Methods:** This case report used interview, observation, and nursing records. The patient was assessed 6 to 7 hours after birth and received documented inpatient nursing sessions. **Results:** Before intervention, pain was 6 of 10, infant positioning and attachment were incorrect, the mother verbalized worry and appeared tense, and infant care required assistance. After breastfeeding assistance, she demonstrated correct positioning and attachment with nursing help. After anxiety reduction support, she reported feeling calmer and appeared less tense. After parenting promotion, she expressed realistic expectations, happiness in learning infant care, and greater readiness while still requiring support. All three nursing problems were partially resolved. No validated anxiety score, complete breastfeeding score, or post discharge follow up was available. **Conclusion:** Mercer's framework supported assessment of physical restoration, early maternal infant acquaintance, practice, and contextual support. Later normalization and maternal identity stages could not be established during the brief hospitalization.

**Keywords:** Becoming a Mother; postpartum motherhood; Ramona T. Mercer; cesarean section.

## Introduction

The transition to motherhood is a major developmental event that involves physical recovery, emotional change, new responsibilities, and reconstruction of personal identity. Mercer emphasized that becoming a mother is not a single achievement at childbirth but a continuing transformation in which the woman develops competence, confidence, attachment, and a maternal identity<sup>1</sup>. Longitudinal evidence shows that this process evolves throughout the first postpartum year rather than being completed during the first hours after birth<sup>2</sup>.

Mercer's framework distinguishes the temporal process of becoming a mother from the environmental systems that influence it. During pregnancy, commitment, attachment, and preparation begin. After birth, the mother becomes acquainted with the infant, learns and practices care, and undergoes physical restoration. Movement toward a new normal and integration of maternal identity develops over subsequent months<sup>1,2,3</sup>. Nursing support can facilitate this continuing process through empathic listening, education, skill development, and reinforcement of confidence<sup>3,4</sup>.

Maternal adaptation is shaped by the health of the mother and infant, maternal characteristics, family relationships, and the surrounding environment. Concept analyses identify maternal skills, confidence, resilience, social support, and responsive interaction with the infant as central features<sup>5</sup>. First time mothers may experience uncertainty as they interpret infant cues and develop practical caregiving abilities<sup>6</sup>. Nursing assessment should therefore distinguish the mother infant microsystem, links among family and health services in the mesosystem, and broader cultural and policy influences in the macrosystem from the temporal stages of maternal development<sup>3,7</sup>.

Theory informed nursing interventions have been associated with improved maternal confidence, adaptation, and interaction with the infant<sup>8</sup>. Indonesian nursing applications likewise suggest that Mercer's framework can organize physical, psychological, and social care<sup>9</sup>. Breastfeeding education and family support are particularly relevant because breastfeeding practice is affected by maternal knowledge, early initiation, access to counseling, employment, culture, and family involvement<sup>10</sup>. Anxiety surrounding childbirth and the postpartum transition may also be influenced by partner or family accompaniment<sup>11</sup>. After cesarean birth, pain and restricted mobility can delay independent infant care, making coordinated physical recovery and role support important<sup>12</sup>.

Mercer's theory is a middle range nursing theory that can guide individualized maternity care. The present case describes its application to one primiparous woman during the early period after cesarean birth. The report focuses on findings that were observable during hospitalization: physical restoration, acquaintance with the infant, initial practice of breastfeeding and infant care, emotional response, family involvement, and connections

with health services. It does not claim that later normalization or complete maternal identity was achieved within several hours postpartum. This theoretical boundary is clinically important. A mother can show affection, curiosity, and willingness to learn immediately after birth without yet having established a stable maternal identity. Early competence is also task specific: a woman may understand infant care instructions while still needing help because of pain, fatigue, limited mobility, or uncertainty. Mercer's framework invites the nurse to assess both observable caregiving behavior and the woman's subjective experience of confidence, satisfaction, and connection with the infant<sup>1,3</sup>. It also places nursing care within a network of family and community relationships. The value of the framework in a short admission is therefore not to label every developmental stage as completed, but to identify current strengths, barriers, support needs, and appropriate continuity plans.

## **Materials and Methods**

### **Study Design**

This manuscript uses a descriptive single patient case report design to present nursing assessment, diagnoses, interventions, and short term outcomes guided by Mercer's Becoming a Mother framework. Reporting was organized with reference to the CARE principles for transparent clinical case reporting<sup>13,14</sup>. A case report was appropriate because the purpose was to explain the clinical reasoning and theoretical interpretation of one episode of care rather than to estimate an effect in a population. The report therefore presents the referral sequence, baseline postpartum assessment, theory mapping, nursing diagnoses, planned outcomes, interventions, immediate evaluation, and limits of follow up. No control group was used, and the observations are not

analyzed as inferential evidence. Clinical improvement is described only when the same indicator was documented before and after care.

### **Sample**

The case involved one primiparous postpartum patient assessed 6 to 7 hours after cesarean birth. The patient was selected purposively because she required maternity nursing care and agreed to participate. Singular terms are used throughout because no additional participants were enrolled.

### **Data Collection Technique**

Case information was obtained through interview, direct observation, physical assessment, and review of nursing records in the Melati Room of R. Syamsudin, S.H. Regional General Hospital, Sukabumi City, in May 2025. Only clinical details needed to understand the referral, early postpartum condition, nursing care, and outcomes were retained. Identifying information was removed.

### **Data Analysis Technique**

The case was analyzed descriptively through the five nursing processes of assessment, nursing diagnosis, planning, implementation, and evaluation. Findings were mapped separately to Mercer's temporal process and ecological systems. Outcomes were compared using the same observable indicators before and after intervention: infant position and attachment during breastfeeding, maternal verbal expressions of worry, observed tension or calmness, realistic expectations, interaction in infant care, and need for assistance. A validated anxiety scale and a complete standardized breastfeeding score were not administered, so no retrospective numerical score was assigned.

### **Ethical Consideration**

The submitted record identifies ethical approval from the Ethics Committee of the Sukabumi College of Health Sciences as No. 00045/KEP STIKES SUKABUMI/2026. Clinical data collection occurred in May 2025; therefore, the approval date and the year component of this identifier require confirmation against the original approval letter before submission. This report does not claim retrospective ethical approval. Written consent was obtained for participation and publication of the deidentified case, and unnecessary identifying information was removed.

### **Results**

The patient was a 24 year old primiparous woman, referred to here as Mrs. E, with a diagnosis of P1A0 after cesarean birth. She initially presented to Pelabuhan Ratu Regional General Hospital with abdominal pain, blood stained mucus discharge, and an oblique fetal lie. She was referred to the Obstetrics and Gynecology Department of R. Syamsudin, S.H. Regional General Hospital for operative management. The nursing case assessment was completed in the receiving hospital 6 to 7 hours after birth.

At assessment, the patient had eaten twice, had not defecated, had not slept since birth, and needed assistance from her husband with daily activities. She had no urinary complaint. Her general condition was good and consciousness was *compos mentis*. Blood pressure was 110/80 mmHg, pulse 77 beats per minute, respiratory rate 20 breaths per minute, and temperature 36.5°C.

Systemic examination found no acute abnormality in the respiratory, cardiovascular, digestive, nervous, urinary, integumentary, endocrine, or musculoskeletal systems. The breasts were symmetrical, the nipples prominent, the areolae clean and

hyperpigmented, and colostrum was present. The uterus was contracted with the fundus two finger breadths below the umbilicus. The operative wound was covered with sterile gauze. Lochia rubra had a characteristic odor and required approximately two underpad changes daily. The main physical problem was operative wound pain rated 6 of 10, with fatigue after loss of sleep.

Evidence of the prenatal commitment and preparation process was available from the patient's report of routine antenatal care, receipt of basic pregnancy and infant care information, and involvement of her husband. During the early postpartum assessment, observable Mercer constructs were limited to acquaintance with the infant, initial practice, attachment behaviors, and physical restoration. The patient sought information about breastfeeding, infant care, and wound care. She expressed joy and a desire to remain close to the infant, but pain limited independent care. Before intervention, infant position and attachment at the breast were incorrect, the patient doubted her technique, verbalized worry about caring for the infant, appeared tense, and required assistance from her husband. These observations were recorded after the patient had undergone referral and operative birth, events that could intensify fatigue and uncertainty during initial adaptation. At the same time, her willingness to attempt breastfeeding, change the infant's diaper with help, ask questions, and accept family participation indicated active engagement with the maternal role. The coexistence of engagement and difficulty was clinically relevant: anxiety and pain did not mean rejection of the infant, while affection and motivation did not mean that competence or independence had already been achieved. This distinction guided supportive intervention rather than premature judgment of role attainment.

The brief hospitalization did not permit observation of Mercer's later movement toward a new normal or integration of maternal identity. Seeking advice and beginning to organize feeding and rest were interpreted as early learning and practice, not as proof that later developmental stages had been reached. No longitudinal follow up data were available to assess whether maternal routines, confidence, and identity continued to develop after discharge.

The patient began to discuss how rest, breastfeeding, and household responsibilities might be shared with her husband. These statements demonstrated intention and early planning. They were not interpreted as completed integration of the maternal role because the assessment occurred within the first postpartum day and the patient continued to need physical and instructional assistance.

Within the microsystem, the patient infant interaction, operative pain, fatigue, breastfeeding difficulty, and direct support from her husband and mother in law were the principal influences. The infant was described as healthy and responsive. The husband assisted with maternal activities and infant care, while extended family members lived nearby.

Within the mesosystem, the relevant links were among the patient, family, hospital nursing team, village midwife, and integrated health service post. The patient needed continuing lactation and wound care guidance after discharge. Within the macrosystem, cultural restrictions on postpartum activity and diet could affect recovery and nutrition, while access to government health services could support continuity of care. These ecological levels describe contextual influence and were not treated as temporal stages of becoming a mother.

The nursing assessment supported three diagnoses: D.0029 Ineffective Breastfeeding

related to insufficient exposure to breastfeeding methods, D.0080 Anxiety related to a maturational crisis, and D.0122 Readiness for Enhanced Parental Role<sup>15</sup>.

For D.0029 Ineffective Breastfeeding, outcome L.03029 Breastfeeding Status targeted improved infant attachment and correct maternal positioning<sup>16</sup>. Intervention I.03130 Breastfeeding Process Assistance included observation, assisted positioning, and education about alignment and attachment<sup>17</sup>. For D.0080 Anxiety, outcome L.09093 Anxiety Level targeted reduced verbal worry, restlessness, and tension<sup>16</sup>. Intervention I.09314 Anxiety Reduction included assessment of triggers, attentive listening, factual information, and diversion activities<sup>17</sup>. For D.0122 Readiness for Enhanced Parental Role, outcome L.13120 Parental Role targeted attachment, positive parental behavior, realistic expectations, and participation in infant care<sup>16</sup>.

Intervention I.13495 Promotion of Parenting facilitated realistic expectations, acceptance of role transition, participation in infant care, and development of a support system involving the husband, family, and health professionals<sup>17</sup>.

On May 29, 2025, one documented inpatient nursing session was provided for each diagnosis; the duration of each session was not recorded. Before breastfeeding assistance, the infant's head and body alignment and attachment to the breast were incorrect, and the patient was uncertain about positioning. The nurse demonstrated alignment of the infant's head and body, placement of the face toward the breast and nose toward the nipple, close body contact, a wide open mouth, chin contact with the breast, greater visibility of the upper areola, and outward turning of the lower lip. After assistance, the patient demonstrated correct positioning and checked these attachment indicators with nursing help.

Ineffective breastfeeding was judged partially resolved because independent and sustained feeding was not yet demonstrated. Before anxiety reduction, the patient verbalized fear that she could not perform the maternal role well and appeared worried and tense. After attentive listening, factual information, and diversion guidance, she reported feeling calmer and appeared less tense; vital signs remained within normal limits. Anxiety was judged partially resolved because no validated scale or later reassessment was available. Before parenting promotion, the patient required help with infant care and expressed uncertainty. After intervention, she expressed happiness in learning infant care, stated realistic expectations for infant development, interacted with family and health workers, and reported greater readiness. Readiness for the parental role remained only partially achieved. No discharge or post discharge outcome assessment was documented.

## Discussion

This case illustrates the early postpartum portion of Mercer's Becoming a Mother process rather than completed maternal identity. At 6 to 7 hours after birth, the defensible observations were physical restoration, initial acquaintance with the infant, attachment behaviors, learning, and practice. Mercer's original work describes maternal identity as evolving through continuing experience across the first year<sup>1,2,3</sup>. The patient's need for assistance, wound pain, uncertainty, and early skill practice are therefore consistent with an initial transition, not normalization or full integration. Contemporary concept analysis likewise characterizes maternal role development as multidimensional and progressive<sup>5,18</sup>. The temporal and ecological elements of the theory answer different clinical questions. Temporal concepts describe how maternal competence

and identity develop, whereas ecological systems describe where influences arise. In this case, early practice occurred during the first postpartum day; the microsystem included the patient, infant, partner, close family, and immediate health condition; the mesosystem linked family members with hospital and community services; and the macrosystem included cultural expectations and access to public care. Treating these system levels as stages would imply a sequence that Mercer did not intend. Keeping them separate allowed pain, breastfeeding difficulty, family support, professional education, cultural diet restrictions, and community follow up to be interpreted as simultaneous influences on an evolving process<sup>3,4</sup>. The patient's positive statements after intervention represent early engagement and confidence building, not evidence that a final maternal identity had been reached. Mercer also emphasizes reciprocal interaction: maternal behavior affects the infant, while infant responses can reinforce or challenge maternal confidence. The infant in this report was described as healthy and responsive, which created an opportunity for early contact, but the available notes did not document infant cues, soothing responses, feeding transfer, or repeated interaction in enough detail to evaluate reciprocity. Satisfaction and gratification in the role were suggested by the patient's happiness and desire for closeness, yet these expressions occurred alongside anxiety and dependence on assistance. The framework accommodates this coexistence because becoming a mother is not a linear passage from difficulty to competence. Progress may vary across physical recovery, feeding skill, emotional comfort, and confidence, and each domain can change as new challenges emerge<sup>1,2</sup>.

The intervention outcomes were modest and should be interpreted at the level actually

measured. Correct positioning and attachment were demonstrated with nursing assistance, verbal worry decreased, observed tension lessened, and the patient articulated more realistic expectations. These indicators support short term learning and emotional reassurance but do not establish sustained breastfeeding effectiveness, a quantified reduction in anxiety, or long term maternal role adaptation. Training based on Mercer's theory has improved maternal self confidence in primiparous women in other settings<sup>19</sup>, but the present report involved one brief session and cannot estimate efficacy. The designation partially resolved is therefore more appropriate than resolved. For breastfeeding, the patient completed the demonstrated steps with assistance, but an independent feed, milk transfer, infant satiety, nipple comfort, and maintenance over repeated feeds were not documented. For anxiety, the patient's report of calmness and reduced visible tension provided immediate clinical evidence, but symptom severity, duration, and change on a validated scale were unknown. For parental role readiness, realistic expectations and willingness to participate were encouraging, yet she continued to depend on others for physical and technical support. These distinctions protect the report from converting a short observation into an unsupported claim of durable effectiveness.

Family and professional support were visible within the patient's microsystem and mesosystem. Her husband assisted with daily activities and infant care, while nurses, the village midwife, and the integrated health service post represented linked sources of guidance. Counseling and structured education have supported maternal role adaptation in trials involving women with preterm infants<sup>20,21</sup>. A systematic review also shows that interventions may facilitate maternal identity when they address knowledge,

confidence, interaction, and support<sup>22</sup>. These comparisons support the relevance of nursing assistance but do not prove that the same magnitude or duration of benefit occurred in this case. Partner involvement had both practical and emotional functions. Assistance with mobility and infant care reduced immediate physical demands, while presence during education created an opportunity for shared understanding and realistic division of responsibilities. Community professionals were relevant because the hospital observation was short and later maternal development would occur primarily at home. A clear handover to the village midwife or integrated health service post could support repeated breastfeeding observation, wound surveillance, nutrition counseling, anxiety screening, and reinforcement of infant care skills. The report did not document whether this handover occurred, so continuity remains a recommendation rather than an observed outcome.

Breastfeeding was assessed through observable positioning and attachment indicators. Standardized tools such as LATCH can improve reproducibility, although their psychometric performance depends on item selection, observer training, and timing<sup>23,24</sup>. Because no complete LATCH assessment was prospectively recorded, a numerical score was not reconstructed. This limitation is important after cesarean birth, which can be associated with delayed initiation and early breastfeeding difficulty<sup>25</sup>. Indonesian evidence also identifies maternal education, family support, early initiation, and access to counseling as determinants of breastfeeding practice<sup>10</sup>. Continued skin contact and skilled feeding support may assist early breastfeeding when clinically appropriate<sup>26</sup>. The indicators taught in this case were clinically concrete: alignment of the infant's head and body, orientation toward the breast, close body contact, a wide

mouth, chin contact, lip position, and visible areola. Reporting the same indicators before and after intervention improves traceability even without a total score. Nevertheless, future care should record who performed the observation, whether the mother required verbal prompting or physical assistance, the number of feeds observed, nipple comfort, audible swallowing, and infant response. Such details would distinguish demonstration of technique from effective and sustained milk transfer. They would also allow discharge planning to target the specific component that remained difficult. Repeated assessment is especially important because performance during one coached feed may not persist when the mother is fatigued, in pain, or feeding without a nurse present. A useful record would specify the baseline observation, education provided, degree of assistance, immediate response, and independent performance at a later feed. It should also document maternal comfort, concerns about milk supply, infant alertness, feeding frequency, urine and stool patterns, and any clinical reason for supplementation. These data were not available in the source record and are not inferred. Their absence limits the conclusion to improved demonstration with assistance. Even so, the documented correction of position and attachment identifies a practical nursing contribution and a clear target for continued support after discharge.

Post cesarean pain and fatigue limited independent infant care. An HTJ case report found that hand and foot massage accompanied reduction of pain during 48 hours of care, illustrating the value of explicit baseline, intervention duration, and post intervention measurement<sup>12</sup>. In the present case, pain was documented as 6 of 10 at baseline, but no comparable post intervention pain score was recorded; a change in pain therefore cannot be claimed. Anxiety reporting

was similarly limited to verbal worry and observed tension. Evidence linking accompaniment with maternal anxiety supports assessment of family context<sup>11</sup>, but a validated anxiety measure would have strengthened interpretation. Pain, sleep loss, anxiety, and breastfeeding difficulty may reinforce one another during early recovery. Pain can restrict comfortable positioning, fatigue can reduce attention to new information, and concern about infant care can increase muscular tension and perceived burden. A coordinated plan should therefore combine routine analgesia and wound care with positioning assistance, rest opportunities, calm communication, and involvement of a trusted support person. The original record did not provide analgesic timing, postoperative mobility milestones, or repeated pain assessment, so their contribution to the observed change cannot be separated from the nursing education and emotional support. This uncertainty should remain explicit in interpreting the case. Anxiety assessment should also distinguish a transient and understandable response to surgery and new responsibilities from clinically significant symptoms requiring further evaluation. In this case, worry centered on recovery and the ability to care for the infant. The patient could communicate, engage with teaching, accept reassurance, and report feeling calmer after support. These are relevant observations, but they do not provide a diagnostic anxiety score. Future documentation should record the content, frequency, intensity, and functional impact of worry; sleep disruption beyond routine infant care; physical symptoms; coping strategies; safety concerns; and whether distress persists. A validated measure administered at consistent time points would make change more reproducible, while clinical judgment would remain necessary to interpret

symptoms in the immediate postoperative context.

The principal strengths of this report are the detailed early postpartum assessment, explicit nursing diagnoses, linkage to Indonesian nursing standards, and separation of Mercer's developmental process from ecological context. Limitations include one patient, brief inpatient observation, absence of standardized breastfeeding and anxiety scores, unrecorded session duration, no post discharge follow up, and incomplete documentation needed to verify the ethics chronology. The case cannot establish causality or generalizability. Future reports should prospectively define outcome measures, record intervention dose, obtain discharge and community follow up, and trace changes in maternal confidence, competence, routines, and identity over several months. A prospective case protocol could schedule measurements at baseline, after each nursing session, at discharge, and during community follow up. Breastfeeding assessment could combine a validated observational tool with maternal comfort and infant feeding indicators. Anxiety could be measured with a validated postpartum appropriate instrument alongside clinical observation. Parental role readiness could be documented through independent care tasks, confidence ratings, response to infant cues, shared decision making, and use of support. Follow up at several weeks and months would allow later movement toward a new normal and maternal identity to be examined consistently with Mercer's timeframe. These additions would improve reproducibility while preserving the individualized value of a case report. For clinical practice, the case suggests a minimum discharge pathway rather than a conclusion of completed adaptation. The nurse should confirm safe mobility and wound care, observe at least one independent feed when possible,

identify a family member who can reinforce the same guidance, explain warning signs, and arrange contact with community services. The mother's own priorities and perspective should be documented directly, including which skills she considers difficult, what support she prefers, and what concerns remain. Patient perspective is a central element of transparent case reporting, but the source record contained only selected statements and no separate reflection at discharge. Documenting that perspective would strengthen person centered interpretation of the theory and prevent professional observations from being treated as a complete account of maternal experience. Ethical documentation should likewise be finalized before publication by confirming that approval and publication consent preceded the relevant activities.

## Conclusion

This case report shows that Mercer's Becoming a Mother framework can organize nursing assessment of physical restoration, early maternal infant acquaintance, initial caregiving practice, emotional response, and contextual support after cesarean birth. Following one documented session for each diagnosis, the patient demonstrated correct breastfeeding position and attachment with assistance, reported feeling calmer, appeared less tense, and expressed greater readiness to learn infant care. All nursing problems remained partially resolved, and sustained improvement was not established because standardized scores and post discharge follow up were unavailable. Family involvement and links with community health services were relevant contextual supports. Later movement toward a new normal and integrated maternal identity could not be concluded during the first postpartum day. These findings highlight the importance of continued nursing assessment and longitudinal

follow up to evaluate maternal adaptation beyond the immediate postpartum period.

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**Conflict of Interest Statement**

The author(s) declare no commercial, financial, or personal conflicts of interest related to this research. All authors approved the final manuscript and consented to its publication in *Healthy Tadulako Journal*.

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