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PART III

Chapter 10: First Parenthood: Crisis or Transition

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## 10.0 CHAPTER 10 FIRST PARENTHOOD: CRISIS OR TRANSITION?

### 10.1 Introduction

This chapter is focused on a series of theoretical, conceptual and substantive issues to do with first parenthood. One appropriate starting point is the extant literature on parenthood (see Chapter 2 and Appendix A). This literature may be sorted into two broad groups of studies, which are briefly summarised below. The first group [1] have been interpreted as indicating that first parenthood is a crisis. The second group [2] have been interpreted as indicating that first parenthood is not a crisis; some writers have therefore characterised first parenthood as a role transition and/or as the challenge of a demanding developmental task.

The first issue to be examined in the light of the findings from the present research is whether new parents in New Zealand [3] can usefully be described as experiencing 'crisis' at or shortly after the birth of their first child.

A brief review of the literature should bring into focus the background of research to date against which this first question can be considered.

### 10.2 Family Crisis In The Literature

There is an extensive empirical literature on various aspects of crisis and/or stress in families, dating back more than thirty years (see Aldous and Hill, 1967; Aldous and Dahl, 1974; Olson and Dahl, 1975). More particularly there have been a number of studies which investigate stress points in the family career (see Young, 1977: 28-32), leading one demographer to conclude that:

'broadly speaking one could consider that each event marking the transition from one stage of the life cycle to the next constituted a crisis' (Young, 1977: 28 emphasis added). ..

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[1] This group predominantly includes the earlier studies, which mostly had rather unrepresentative samples.

[2] This group predominantly includes the later studies, which mostly had random or more representative samples.

[3] See Swain (1978b: 41n) for a discussion of the extent to which the special/working universe (Sjoberg and Nett, 1968) used in the present research is a satisfactory basis for generalisations to New Zealand as a whole. There are grounds for avoiding further generalisation to the general universe of new parents beyond New Zealand (Swain, 1978b: 26; Houston, 1970: 22-27).

This matter is further considered below (see section 9.5). There has also been some attention to conceptualisation and model-building (see, for example, Hill, 1949; Burr, 1973: Chapter 10; Hansen and Johnson, 1979).

A review of this general literature would be a substantial task, and much of the literature on first parenthood (reviewed in Chapter 2 and Appendix 10) does not refer to the more general literature, or does so only lightly. In a relatively recent review of the more general literature, and especially its more theoretical items, Hansen and Johnson (1979: 598-9) concluded that conceptual clarification is an urgent current task, and that theoretically-grounded empirical research must for a while yet remain the object of researchers' 'yearnings'.

Thus for the above reasons this more general literature is not reviewed here (but see section 9.5 below), and attention is focused on the substantive body of literature reviewed elsewhere (Chapter 2 and Appendix 10). The procedure adopted here is first to consider the research which suggests that there is a substantial degree of crisis, and then to review the contrasting findings of little or no crisis. Within these broad divisions the research reports are reviewed in chronological order, with attention focused on the main findings as to crisis, the characteristics of the larger populations from which the sample findings are derived, and the researchers' conclusions as to the possible sources and correlates of any crisis which is found to occur. These are subsequently related to findings from the present research.

#### 10.2.1 Studies Suggesting Crisis

LeMasters (1957) reported that 83% of his sample of white, urban, middle class American couples with a first child under the age of five experienced 'extensive' or 'severe' crisis. He used an interactional conceptual framework which led him to expect that there would be crisis, and overall ratings of complete semi-structured interviews. The pregnancies were reported to be 'planned' or 'wanted', the sample members' personalities were judged to be 'average or better', and their marriages were reported to be 'good'. The sources of the crisis could not be located in these dimensions. LeMasters (1957) attributed the crisis to a 'romanticisation' of parenthood (compared with earlier generations' romanticisation of marriage), and inadequate formal preparation for parenthood.

Dyer (1963) conducted a broad replication of the study by LeMasters (1957), noting that such work was cognate with the more general crisis/stress research of Hill (1949) and others. He used similar criteria to LeMasters (1957) in the recruitment of his sample, but added provisions that they should be under the age of 35, that at least one should be college-educated, and that the first child should be under the age of two. The data were collected in 1959, not long after LeMasters' (1957) fieldwork, although not reported

until 1963. Separate questionnaires were administered to husbands and wives, involving a sixteen-item Likert-type scale, with a mean score calculated for each couple. The definition of crisis was similar to that of Hill (1949) and others: it is a disruption, incapacity or disorganisation of the family, beyond the level of routine problems, for which existing behaviours and processes are inappropriate.

Dyer (1963) equated his scores with the labels used by LeMasters (1957) in a manner which is not clear, but appears to be somewhat arbitrary. Dyer (1963) reported his results as similar to those of LeMasters (1957):

- a) 25% of his sample of thirtytwo couples experienced 'severe' crisis (scoring 49-64/64);
- b) 28% experienced 'extensive' crisis (33-48/64);
- c) 38% experienced 'moderate' crisis (17-32/64); and
- d) the remaining 9% experienced 'slight' crisis (1-16/64).

It is interesting to note that an orientation to 'crisis' as the conceptual framework (or perhaps less systematically the conceptual background) seems to lead to the labelling by Dyer (1963) of scores at the bottom of the scale (1-16/64) as 'slight crisis'. It was thus not possible for his respondents to achieve a 'no crisis' score according to his scheme for naming grouped data. A different orientation might well have resulted in a 'no crisis' label. The orientation is important in shaping the interpretation of results.

Wainwright (1964: 96-7), drawing on clinical experience and a very small number of cases, described how fatherhood could be a precipitant of mental illness, which supported the view of parenthood as crisis but added little that was useful to a more sociological approach. In a study conducted in Israel, Goshen-Gottstein (1966) found a group of 'traditional' women who seemed to experience more problems during and after their first pregnancy, compared with 'modern' and 'intermediate' groups. Her research illustrates the potential value of extensive background information in explaining findings, rather than providing any sort of normative data capable of comparison with the other studies reviewed here.

Meyerowitz and Feldman (1966) mention an earlier, unpublished, study which supported the findings of crisis by LeMasters (1957); and they report on data from a sample of 400 primiparae in which 'the first-child crisis' is found to be a combination of 'communication failures and experiential dis-synchronisations', the latter being inadequate synchronisation of experience, expectations and/or skills.

Beauchamp (1968: reported in Russell (1974)) and Hobbs and Cole (1976: 724) replicated the research designs of both LeMasters (1957) and Hobbs (1965), the latter being discussed in the next section below, and found that 'one-quarter' of

her sample of married college students with one or more pre-school children experienced 'extensive' or 'severe' crisis .

Research on marital satisfaction, and satisfaction with the family, over the life cycle (family career) has been somewhat contradictory, with earlier findings and interpretations (Rollins and Feldman, 1970) now being re-evaluated (Rollins and Cannon, 1974). However it does appear that satisfaction tends to show a shallow-W shape, with the low points generally falling into the 'pre-school' and 'teenage' family career categories. As has been pointed out (Rollins and Cannon, 1974: 280), however, family career category accounts for only 8% of the variance in marital satisfaction in this research. Nevertheless, this broad-scope research suggests that a relatively extensive degree of what is sometimes termed crisis is experienced in the years following the birth of the first child. Rollins and Cannon (1974) suggest that 'role strain' may explain the level of crisis experienced, and this concept (further developed) has also been incorporated in a model by Burr (1973: Chapter 6), and is used in the present thesis (Chapter 3).

Feldman (1971: 121) brings together published and unpublished data from his own research to conclude that in general the findings of crisis at first parenthood by LeMasters (1957) are substantiated. This seems to contradict the inference in Meyerowitz and Feldman (1966: 84) that 'communication failure and experiential dis-synchronisation' is a better description than 'crisis'.

Tooke (1974) studied a small sample of economically disadvantaged families and found significantly more difficulty was experienced than in the research (discussed below) by Hobbs (1965; 1968), which suggests a degree of crisis similar to that reported in LeMasters (1957) and Dyer (1963). The only other study of disadvantaged families (Geismar, 1973) contradicts this one (see below).

With some studies it is difficult to categorise the results as either substantial crisis or little crisis. Thus, Titus (1976) using an interesting non-reactive method (content analysis of family photographs) found evidence suggestive of high levels of role learning with ritual reinforcement of the role transition, but did not choose to summarise this as 'crisis'. Gilman and Knox (1976) report a level of crisis which they felt was intermediate between the higher levels (e.g. LeMasters, 1957; Dyer, 1963) and the lower levels (e.g. Hobbs, 1968; Russell, 1974).\*

LaRossa (1977) exemplifies the influence of theoretical orientation (cf. LeMasters, 1957, for a similar influence but a very different orientation) in his small-scale study, in which he concluded that:

'...marriage in general and marriage during first pregnancy in particular are best understood from a conflict perspective... (LaRossa, 1977: 29

emphasis added).

This conflict, however, is not necessarily the same phenomenon as is intended to be captured in the term 'crisis'. It is, rather, 'normal' (cf. Rossi, 1968 discussing the notion of 'normal crisis') and may be managed quite adequately. This study and argument may be allocated to either the 'crisis' or 'transition' groups according to the aspect of the work which is emphasised.

Thus the dozen or so studies which may plausibly be allocated to the 'crisis' category present a somewhat disparate and fragmented picture:

- a) the levels of crisis reported vary and are difficult to compare;
- b) the sampling varies sufficiently to make it difficult to identify any normative value of the findings;
- c) the discussions of possible sources and correlates of such crisis as is found are sparse and do not constitute a coherent account; and above all
- d) the influence of orientation and conceptual framework on the interpretation of data (shown to be an important consideration) is not extensively considered.

#### 10.2.2 Studies Not Suggesting Crisis

We now turn our attention to those studies which do not seem to indicate any particularly substantial degree of crisis. The first published study to call into question the existence of a crisis at first parenthood was conducted by Hobbs (1965), who used a random sample of 53 white urban American couples who had had their first child no more than 18 weeks prior to their interview, and a checklist measure, the content of which was based on the extant literature (Mudd, 1953; LeMasters, 1957; Mace, 1958). Hobbs (1965) reported that, typically, his sample of new parents reported being 'bothered' only 'somewhat' or 'not at all' by their new parental roles and responsibilities, although the new mothers tended to report higher levels of problems than their husbands.

A later replication and extension (Hobbs, 1968) tended to validate the measures used by Hobbs (1965), and indicated a modal pattern of 'slight' crisis for new fathers and 'moderate' crisis for new mothers, with 18.5% of the latter reporting 'extensive' or 'severe' crisis (cf. LeMasters, 1957; Beauchamp, 1968).

Uhlenberg (1970) studied a sample of university couples and found that virtually all experienced 'some' (rather than 'much') critical problems, and interpreted these results as supporting the findings of Hobbs (1965; 1968). In another

study of a non-representative sample, but on a larger scale, Geismar (1973) found that his sample of 555 young urban families in a markedly disadvantaged environment functioned fairly well through the transition to parenthood, although social handicaps tended to reduce the level of functioning somewhat. This study supports the view that first parenthood is not especially critical, even under disadvantageous conditions (cf. Tooke, 1974).

Russell (1974) studied the pleasures as well as the problems of parenthood (using a checklist similar in format to the Hobbs Checklist, which she also used) for a random urban sample. She eventually concluded (Hobbs and Cole, 1976: 724n) that her scores were virtually identical to those of Hobbs (1965; 1968). Her findings can be summarised as showing that the first year of parenthood is moderately stressful, but also includes plenty of rewards. Bogdanoff (1974, reported in Hobbs and Cole, 1976: 725), in the course of comparing the effects of preparation for childbirth and parent support groups, found levels of crisis were low, very similar to the findings by Hobbs (1965; 1968).

A 'decade replication' of Hobbs' studies (Hobbs and Cole, 1976), again using a random urban sample, found 68.4% of the couples experiencing 'slight' crisis (cf. Hobbs, 1965: 86.8%) with 22.3% 'moderate' (cf. 13.2%), and a slightly flatter distribution of scores in the later study. A middle class subsample reported less crisis than the whole sample, contradicting the general pattern for middle class samples to show higher levels of crisis than general random samples. The apparent long-term trend towards lower reported levels of crisis is also contradicted by these findings.

In a specific study of the transition to fatherhood, Wentz and Crockenberg (1976) concluded that the majority of fathers report only minimal to moderate difficulty (cf. Wainwright, 1964), although they express a need for more information. This is consistent with the general findings that fathers report lower levels of crisis than mothers whatever the latter level might be in different studies. Of the various studies by Hobbs, only one (Hobbs and Wimbish, 1977) shows crisis scores that could be interpreted as tending to support the crisis description of first parenthood. These relate to a sample of black couples.

Kirkpatrick (1978) conducted a study concerned mainly with accounting for variation in 'the adjustment to parenthood', but her somewhat larger (n = 428) random urban sample (based, however, on a 21.4% response rate) yielded crisis scores similar to those of Hobbs (1965; 1968). It is notable that the studies which suggest a low level of crisis tend to include a number of replications (very similar sampling and measurement instruments) which produce very similar results. Even where there are differences in method, the findings are reported to be similar, although in some instances this is a judgement by the researcher and is open to argument.

On balance, therefore, the literature reviewed in this section seems to suggest a generally low level of problems for new parents, and tends to be a more consistent body of literature than the 'crisis' studies.

### 10.3 Findings From The Present Research

The checklist of problems of parenthood developed by Hobbs (1965; 1968) and used by a number of other researchers (Beauchamp, 1968; Uhlenberg, 1970; Russell, 1974; Tooke, 1974; Bogdanoff, 1974; Hobbs and Cole, 1976; Kirkpatrick, 1978) was used in the present research. The wording was modified in some instances so as to be consistent with New Zealand usage [4]. The married women in the New Zealand sample [5] had a mean score of 8.7 compared with 9.1 for Hobbs' first study (Hobbs, 1965: 368) and 9.3 in his later replication (Hobbs, 1968: 415).

The median score was 8; the modal scores were 4, 7 and 11. The full distribution is shown in Table 10.1 below.

[Table 10.1 appears on the following page].

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[4] The details of the New Zealand version of the Hobbs Problems of Parenthood Checklist can be found in the fourth (final) questionnaire which is reproduced in Appendix E.

[5] This subsample has been selected so as to be comparable with the research by Hobbs (1965; 1968) which covered only married women.

Table 10.1 Hobbs Problems of Parenthood Checklist\*

Score	No	%	Score	No	%
0	7	3.1	13	3	1.3
1	6	2.7	14	12	5.4
2	13	5.8	15	4	1.8
3	11	4.9	16	8	3.6
4	19	8.5	17	3	1.3
5	16	7.2	18	3	1.3
6	12	5.4	19	2	0.9
7	19	8.5	20	3	1.3
8	12	5.4	21	3	1.3
9	18	8.1	22	0	0.0
10	16	7.2	23	1	0.4
11	19	8.5	24-29	0	0.0
12	10	4.5	30-46 #	3	1.3

Notes: \* Hobbs (1965: 368; 1968: 415)

# The scores in the 30-46 category comprised two at 30 and one at 31. The highest possible score is 46.

Only married or de facto married women are included (n = 223) for comparability with Hobbs (1968).

Mean score = 8.735; sd = 5.597; n=240

It thus appears that the findings from the present research are more consistent with the literature reviewed in the latter section above, studies not suggesting crisis. If this is accepted, it is not especially useful to go on to consider the nature, extent, sources, correlates and/or consequences of crisis, or to review possible ways of transforming the experience(s) of new parents into more positive ones by various interventions (e.g. LeMasters, 1957).

However the use of measures of crisis with a specified level identified as that level above which respondents will be designated as in crisis, validated only on the basis of the meaning attached by the researcher to items in the measurement instrument used, could be regarded as rather arbitrary. It is certainly the researcher's attribution of meaning rather than the respondents' attributions which are being considered.

Thus another approach would be to consider whether whatever happens at and around the birth of the first child is better (i.e. more usefully or more fruitfully) characterised as 'crisis' or 'role transition' or 'attainment of developmental task(s)' or whatever. This is a (somewhat) more theoretical approach.

The purposes of the researcher, or user, of the research are thus clearly relevant to the discussion. It may well be that for what might generally be described as social policy and practice purposes a 'crisis' characterisation (of some designated category or group within a sample or population)

may be useful. Those with higher 'crisis scores' on a particular measure (say the upper quartile or tenth decile) may - for social policy and/or practice purposes - be designated as the 'crisis group' at risk. Resources or interventions may then be oriented to this designated group, the nature of the resources or the design of the interventions having been shaped by knowledge of the overall profile of those so designated.

However, this is not to conclude that a 'crisis group' is other than a statistical construct by and for the purposes of the researcher or research user. The question it is now appropriate to consider, therefore, is whether those identified on the basis of crisis scores as constituting a 'crisis group' can reasonably be regarded as a 'real' [6] social group. If a qualitative research strategy had been used it might have been appropriate at one of the later phases of fieldwork to investigate this issue relatively directly with the respondents. However at this remove in time [7], and with the constraints of a pre-planned quantitative approach, the issue must be tackled somewhat differently (and perhaps a little more obliquely). A 'real' social group may be understood as:

- a) one so construed by its members;
- b) recognised by them at least as a distinct and meaningful category if not as a face-to-face 'primary' group;
- c) having meaning for its members independent of the researcher's construction of the group's meaning.

Considerations of social ecology suggest that such a 'real' group with similar 'crisis scores' will also show other similarities, distinct from the residual 'non-crisis group'. The present data can thus be examined for such patterns.

This will be done by partitioning the sample into 'crisis' and 'non-crisis' groups of respondents, and then by looking at [8] any patterns of statistically significant difference between the two groups so designated. If there are few differences, the more reasonable conclusion is that 'high' scores on a measure of 'crisis' identify a group of respondents meaningful only to the researcher (and perhaps those designing social policies and intervention practices). If there are many differences, and more so if those

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[6] The term 'real' has quotation marks around it to indicate that the term is used in the somewhat arbitrary sense in which it is contrasted with the 'construct' sense; it is not intended to review here the more philosophical debate about the nature of reality .

[7] The chronology of this project was set out earlier in section 5.4, Figure 5.1; the interval between fieldwork and the present writing is between seven and eight years.

differences can be organised into a plausible account of 'parenthood as crisis', then the possibility remains of the existence of a meaningful 'real' crisis group within the larger social category of 'new parents'. Should this turn out to be the case, the inherently contradictory concept of 'normal crisis' can also be abandoned.

There thus follows a review and comparison of the designated 'crisis' and 'non-crisis' categories of respondents in the present research on a variety of background social and demographic variables.

#### 10.4 Statistical Construct Or Real Group?

Those members of the sample whose scores fell above the upper quartile, i.e. scored above 12 (n = 46, 19.2% of the sample) will be called the 'crisis category' in the following discussion, although it should be noted that their scores are only relatively higher than the general pattern of the sample. As identified, this 'crisis category' are at the present point in the discussion most usefully understood as a statistical construct rather than as a proven discrete social grouping. An examination of other data may help to determine whether a category identified on the basis of 'crisis scores' can usefully and validly be regarded as a 'real' social group (i.e. existing independently of the researcher's construction of the category). This statistical construct of 'crisis category' will be compared below with the remainder of the sample, termed the 'non-crisis category' (to which, of course, the same remarks apply).

##### 10.4.1 Sociodemographic Variables

The sociodemographic variables considered are age, place of birth, number of children in family of origin, ethnicity, religious affiliation, marital status and duration of marriage. Certainly the first four of these attributes are background characteristics over which we have no influence; social and cultural forces ensure that we have only limited influence over the latter three. If the experience of first parenthood is shaped by these broader social forces, and the 'crisis' and 'non-crisis' categories have some 'real' meaning, then it might be expected that the two categories which have been differentiated on crisis scores would show differences on these variables.

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[8] While it is inappropriate to use statistical significance tests as a means of data-dredging (Selvin and Stuart, 1966), such tests may be useful in the examination of those patterns which appear to suggest that the crisis group are 'real' in the sense already outlined above, or that there may be 'significant' differences.

#### 10.4.1.1 Age

While the overall pattern with regard to age is not significant, it can be seen from Table 10.2 below that the crisis category is some four months younger than the non-crisis category. The average age of the crisis category was 21.9 compared with 22.2 for the non-crisis-category.

Table 10.2 Age Groups - Crisis and Non-Crisis Categories

Age group	Crisis		Non-Crisis	
	No	%	No	%
15-19	14	34.1	43	25.3
20-24	16	39.0	85	50.0
25-29	9	22.0	35	20.6
30-34	2	4.9	6	3.5
35-39	0	0.0	1	0.6
	41	100.0	170	100.0

Notes: Chi-square = 2.22; df = 4; p = 0.69; n = 212 [9]

#### 10.4.1.2 Place Of Birth

The grouped distributions on place of birth were very similar for the crisis category and the non-crisis-category (chi-square 3.73; df = 8; p = 0.88); and when these were further collated into urban/rural the differences were very small (chi-square 0.55; df = 2; p = 0.76). There were no noticeable differences at all.

#### 10.4.1.3 Number Of Children In Family Of Origin

There were only marginal differences between the crisis category and the non-crisis-category on number of children in family of origin (chi-square = 10.22; df = 2; p = 0.25) with the crisis category being somewhat fewer in number than expected (5 versus 8.5) with only one or two children in their family of origin, while the non-crisis-category had somewhat more (39 versus 35.5; n = 238; missing cases = 2) than expected.

[9] In sections 10.4.1.1 to 10.4.2.5 inclusive values of 'p' etc. are reported in precise detail (rather than using conventional levels); this makes quite clear the unequivocal lack of statistical significance in the great majority of instances tested.

#### 10.4.1.4 Ethnicity

The one sociodemographic variable for which there was a significant (chi-square = 9.52; df = 3; p = 0.02) difference between the crisis and non-crisis categories was ethnicity.

Table 10.3 Ethnicity: Crisis and Non-Crisis Categories

Ethnic Identification	Crisis		Non-Crisis	
	Number	%	Number	%
Pakeha	34	73.9	173	90.6
Maori	10	21.7	15	7.9
Indian/Chinese	1	2.2	2	1.0
Other	1	2.2	1	0.5
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	46	100.0	191	100.0

Notes: Chi-square = 9.52; df = 3; p = 0.02

#### 10.4.1.5 Religious Affiliation

Again there were no significant differences between the crisis and non-crisis categories in religious affiliation (chi-square = 4.21; df = 3; p = 0.24), although the Roman Catholics had somewhat fewer than expected in the crisis category (four versus 8.0; n=237). When the focus shifts to practicing church membership, however, exactly the same proportion of the crisis as of the non-crisis categories (29.1%) claimed to be practicing members of their church.

#### 10.4.1.6 Marriage

Virtually all of the crisis category were married or de facto married (96.4%), a somewhat higher proportion than for the non-crisis-category (90.5%), but again the difference was only marginal (chi-square = 4.21 df = 3; p = 0.24). Turning to duration of marriage, married respondents were grouped into 'Up to 1971' and single years 1972-1976 (the year of the research). Overall the crisis/non-crisis category differences were not significant (chi-square = 4.69; df = 5; p = 0.45). One year stands out in two respects: rather more respondents were married in 1975 than in the other single years (53 versus an average of 33.5 [10]); and there were more in the crisis category (15 versus 10.5 expected) and less in the non-crisis category (38 versus 42.5 expected) than expected.

The greater number of sample members in the 1975 marriage cohort presumably reflects the mean interval between marriage and first parenthood in New Zealand. The greater proportion of this cohort in the 'crisis' category might be explained by arguing that the 1975 cohort in the sample are those who married and immediately became pregnant; the earlier cohorts are those who deferred first pregnancy, and the 1976 cohort are disproportionately those who were already pregnant at marriage.

Thus the earlier cohorts are more likely to have accomplished the developmental tasks associated with the transition to marriage before tackling the tasks of parenthood. However the 1975 cohort are by definition (marriage in 1975; parenthood in 1976) tackling these tasks more or less simultaneously. The 1976 cohort might almost have reversed the order of developmental tasks - coping with conception might have precipitated marriage.

#### 10.4.2 Education And Occupation

The variables to be considered here are:

- a) duration of education, and educational qualifications (of respondents and of the husbands for the married/de facto married subset);
- b) occupation (both) and years in occupation (respondents); and
- c) plans regarding a post-natal return to paid employment (respondents).

For the majority of these variables the respondents have a degree of control or influence, and hence it is more likely that differences between the 'crisis' and 'non-crisis' categories would tend to reflect more purposive choices or actions on the parts of respondents (compared with the background variables previously considered).

##### 10.4.2.1 Duration Of Education And Qualifications

Two-thirds of the respondents (67.6%) had four (29.8%) or five (37.8%) years of secondary education. There were no significant differences between the crisis and non-crisis categories (chi-square = 6.26; df = 7; p = 0.51) on duration of secondary education. For educational and/or vocational training qualifications, however, the overall pattern showed significant difference between the two categories (see Table 10.4 below).

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[10] The numbers in each cohort in the sample are: 1972 = 38; 1973 = 35; 1974 = 30; 1975 = 53; 1976 = 31.

Table 10.4 Qualifications: Crisis and Non-Crisis Categories

Qualifications	Crisis		Non-Crisis		Total Sample	
	Number	%	Number	%	Number	%
None	18	39.1	48	25.0	66	27.7
S C (inc part)	8	17.4	35	18.2	43	18.1
U E and/or cf.	2	4.3	13	6.8	15	6.3
Vocational certs.	12	26.1	89	46.4	101	42.4
University etc.	5	10.9	4	2.1	5	3.8
Not known	1	0.4	3	1.2	4	1.7
	46	100.0	192	100.0	238	100.0

Comparing the crisis and non-crisis categories, it appears that the former had more than expected who were without formal qualifications or vocational qualifications, and more who had university-level qualifications [11]. This suggests that the crisis category may on this dimension be regarded as comprised of two subcategories of respondents:

- a) those with no qualifications (or none having occupational applicability); and
- b) those with tertiary qualifications.

It could be suggested that both situations might contribute to greater crisis at the time of first parenthood, but in rather different ways. There are suggestions in the literature (e.g. LeMasters, 1957) that highly-qualified women might experience more of a shock at the change from presumably satisfying paid employment to the mother role than those for whom employment is a job rather than a career. This might account for the highly-qualified subcategory within the crisis category. The subcategory of the crisis category who have no qualifications may be women for whom the mother role is the only 'career' they feel is available, and the undoubted challenges and costs of this role in the absence of occupational alternatives (in the light of their lack of any educational or vocational qualifications) might contribute to their crisis rating.

The possibility that the members allocated to any crisis category are not socially homogenous, that there are several possible subcategories within this category, is theoretically

[11] Crisis category: No formal qualifications: 18 versus 12.8 expected; vocational qualifications: 12 versus 19.5 expected; university-level qualifications: 5 versus 1.7 expected; n = 238.

quite acceptable. It does however undoubtedly complicate the research task.

#### 10.4.2.2 Occupations Of Respondents

There are no overall differences between those who were not in paid employment by 28 weeks of pregnancy (the first interview) and those who were still in such employment (chi-square = 0.50; df = 2; p = 0.78). There is no pattern of differences at all between crisis and non-crisis categories in terms of either types of occupations (chi-square = 5.46; df = 9; p = 0.79) or durations of employment in the present occupation (chi-square = 7.89; df = 9; p = 0.54). There are perhaps theoretical reasons for examining in particular the professional/managerial [12] and housework [13] occupational categories in the present results. The differences between expected and actual results are in the directions which would be expected [14] *i.e.* higher numbers than expected in the crisis category for both professional/managerial and housewife categories. The same sort of pattern of different reasons for the same outcome are likely to apply here, as for the unqualified and the tertiary qualified (above). Overall the differences are directional rather than significant, however.

#### 10.4.2.3 Plans Regarding Paid Employment

Virtually all of the sample (97.5%) had been in paid employment prior to pregnancy; almost one-third (30.0%) were still in paid employment at 28 weeks of pregnancy (the time of the first interview). There are no significant differences overall between the crisis and non-crisis categories for post-natal plans to resume (or continue) in paid employment (chi-square = 3.80; df = 4; p = 0.433).

#### 10.4.2.4 Husband And Marriage

There were no differences between the crisis and non-crisis categories for any of the variables which profile the husbands; there were, however, a number of marked differences for variables relating to the respondents'

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[12] See LeMasters (1957) etc.

[13] See Bernard (1973) for a review of the strong relationship between the housewife role and mental and physical ill-health etc.

[14] Crisis category: Professional/managerial 9 versus 7.5 expected; housework 4 versus 2.1 expected (crisis category size = 46).

Non-crisis category: Professional/managerial 30 versus 31.5 expected; housework 7 versus 8.9 expected.

descriptions of their marriage. There was a highly significant (chi-square = 25.76; df = 6; p = 0.0002) pattern on the precoded antenatal measure of marital happiness, with the crisis category showing markedly fewer than expected at the positive end of the measure (13 versus 24.2). The same pattern also showed up on the open-ended measure of the same dimension (chi-square = 58.79; df = 33; p = 0.0038).

A perhaps more concrete or specific measure also taken at the 28-week interview - marital problems experienced lately - showed similar results (chi-square = .9; df = 6; p = 0.0009) with the striking differences being on the 'No problems' and 'Major problems - not coping' items in the measure. Only one crisis category respondent (versus 8.4 expected) reported 'No problems'; for the non-crisis category more than expected (43 versus 35.6 expected) reported thus. The two categories were similar on intermediate items ('Some problems' and 'Major problems - but coping') but diverged again on 'Major problems - not coping', with the crisis category having more than expected (6 versus 2.1) and the non-crisis category fewer (5 versus 8.9).

Similar measures were taken at the final interview (at 8/26 weeks post-partum) and again the crisis category were significantly more likely to report major problems and less likely to report no problems (p = 0.0005), and significantly less happy in their marriages (p = 0.0001).

It is of course possible - even likely - at the post-partum interviews that there is a halo effect from the overall crisis measure to marriage ratings, or that problems perceived by respondents as centred on the marriage are being reflected in some crisis items (enough to put those respondents into the crisis category). The consistent pattern from antenatal to post partum measures however suggests that for those whose marriage is experienced as encountering problems and/or unhappiness, first parenthood is more likely to be experienced as a problem or crisis. This is different from at least some of the 'crisis' literature (e.g. LeMasters, 1957).

The linkage(s) between marriage and first parenthood can be understood in several ways. In New Zealand there is a close temporal association between the two, with the statistically normative pattern being conception - marriage - parenthood (Swain, 1983). Conceptually, both may be understood as role transitions involving similar sorts of developmental tasks.

An open-ended question on the baby's effect on the marriage showed similar patterns for crisis and non-crisis categories (chi-square = 56.32; df = 48; p = 0.19). One might speculate that the total sample of new parents more or less agree on the nature of the new baby's effect(s) on the marriage, but differ in what they make of it (i.e. their construction of or attribution of meaning to new parenthood).

However, a more specific question oriented to marriage/parenthood issues - who gets up to the baby when s/he cries at night - showed some very different patterns (chi-square = 11.20; df = 5; p = 0.0476). The crisis category had more than expected (28 versus 20.5) in the 'Mostly or always the wife/mother', and the non-crisis category fewer (81 versus 88.5).

It might be inferred that it is not so much what happens (e.g. the baby crying at night) as how it is handled (e.g. who gets up to the baby) and/or especially what the participants make of it (i.e. their crisis score) that is most relevant. This view is more cognate with the 'developmental task' perspective than the 'crisis' one. It is, however, hardly conclusive.

#### 10.4.3 Conclusions: Construct Or Group?

It would appear on the basis of the data reviewed that it is on balance more plausible to treat the 'crisis category' as a construct of the researcher's rather than as a 'real' group of the participants' construction, occupying a social ecological niche in New Zealand society.

#### 10.5 Putting Crisis In Family Career Context

Rollins and Feldman (1970) and Rollins and Cannon (1974) (see section 2.3.1) have shown, from a review of twelve studies plus their own data, that marital satisfaction declines during childbearing and childrearing, especially for women, while satisfaction with parenthood reaches a low point when all of the children have left home (see also Young, 1977: 30).

Rapoport and Rapoport (1975) discuss stress situations which occur at the four main 'stages' (phases) of the individual 'life cycle' (positional career) - adolescence, young adulthood, 'establishment' and retirement - and the need for 'resourcefulness' (which may connote resources, extent and variety of information, etc.) in coping with the many difficulties encountered. Their approach implies a concept of 'normal crisis', the inherent contradictions of which rather reduce its utility to the researcher.

Wilensky (1962) is one of the very few writers to consider the male pattern - of 'morale' and 'involvement' - over the family career, describing a high peak for the young single male, dropping sharply during the period of 'active fatherhood' [15], rising to a high level which persists in the later years, eventually falling sharply in old age.

Yule (1969) has argued that crisis points or periods are:

- a) the birth of the first child;

- b) the entry into school of the last (youngest) child;
- c) the ending of schooling for the last (youngest) child;  
and
- d) the departure of the last child from the home.

Harris (1969: 151) regarded the second of the above points (the entry into school of the last (youngest) child) and a further point:

- e) the transition to economic independence of the first child to do so (and hence changes in the distribution of family power)

as the times during the family career of 'sharpest' change (i.e. 'crisis'?).

A number of researchers and writers have focused on later transitions and categories of the family career. Bell and Buerkle (1962) and Bell (1967) have emphasised the transitions at the 'launching' of adolescent or young adult children as involving ambivalence and conflict, while Waller (1951) argued that the launching of a young adult was equally as stressful as the incorporation into the family of a new child.

Bossard and Boll (1955) saw the independence and/or launching of the children as stressful for their mother, while typically a few years later the necessity to come to terms with unrealised occupational goals was stressful for the father. Deutscher (1962; 1964) also identified the 'post-parental phase' of the family career as difficult because in demographic terms it is quite new and thus 'role models' or norms do not exist for those now entering this new phase.

In view of the findings from the present research and the above discussion of 'crisis' in the context of the whole family career, two conclusions may be advanced. The first is that Young (1977: 28) reasonably concludes that the net effect of a variety of specific studies at particular family career transitions is to give the overall impression that all such transitions are to be regarded as marked by 'crisis'. Taking the longer view, such 'crisis' may be better understood as the usual or 'normal' accommodations and/or adjustments to be made at all role transitions, rather than as the inherently contradictory 'normal crisis'.

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[15] This is 'active' in a relative rather than an absolute sense; typically it is the mother who engages in the child care activities. 'Fatherhood' has a different, less extensive, less salient role content than 'motherhood'. The number and ages of the children, however, are used to define family career categories for all family members, including the husband-father.

The second conclusion which follows is that this rather reduces the value or usefulness of the concept of 'crisis', which can hardly be applied to the unexpected, unpredictable, unusual and/or highly disruptive exceptional event [16] if it routinely occurs a number of times to most families.

It is thus appropriate to proceed to consider tasks of conceptual clarification (as urged by Hansen and Johnson, 1979: 598-9). One such task - answering the question as to whether the 'crisis category' in the present research is a statistical construct or a 'real' social group - has already been considered. A more extensive task - conceptual clarification, explication, interrelation and interdefinition of a 'role transition' conceptual framework to be used in place of the 'crisis' framework - is tackled in the next section.

## 10.6 A Role Transition Framework

Given that the 'crisis' conceptualisation is inappropriate, it may be that a (somewhat) more conceptually elaborate scheme can be used to order and present [17] the large number of variables having potential relevance to the study of new parents. The model of role transition presented by Burr (1973: Chapter 6) provides a list of variables, and some propositions linking them to ease (or otherwise) of role transition, for this section. Further components were added to the model of developmental change in families already described (see sections 3.2.5.1 to 3.2.5.19 for the full set). Some of these concepts from the model (Chapter 3) are used in sections 10.6.1 to 10.6.7 following, to order and facilitate the discussion of the data from the present study on first parenthood as crisis or transition.

### 10.6.1 Anticipatory Socialisation

Thus, the first variable to be considered is anticipatory socialisation. Burr (1973: 124-127) suggests that 'the amount of anticipatory socialisation influences the ease of transition into roles' and that this is a 'positive, monotonic [18], curvilinear [19] relationship in which the influence [of the variable] decreases as the independent

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[16] See Hill (1949) for a similar description in terms of disruption, incapacity or disorganisation beyond the level of routine problems and for which existing behaviours, resources and processes are inappropriate.

[17] This phrasing lends a heuristic orientation to the use of the role transition framework; this could be further developed analytically by formulating hypotheses based on the framework and seeking to test these with empirical data on (for example) new parents in the classic hypothesis-testing strategy.

variable [anticipatory socialisation] increases (op. cit. 125-126).

In empirical terms, the suggestion is that the more anticipatory socialisation to which prospective new parents are exposed, the less they will experience crisis, but that the greatest difference is between none and some, rather than some and more.

The actual term 'anticipatory socialisation' was first used by Merton (1968: 316ff) but essentially the same concept was described as 'emotionally intimate contact which allows identification with persons functioning in the [new] role' and 'imaginal or incipient rehearsal' many years earlier (Cottrell, 1942). It has been defined as

'the process of learning the norms of a role before being in a social situation where it is appropriate to actually behave in that role' (Burr, 1973: 125).

The concept of anticipatory socialisation has been used in research in other substantive domains, such as the transition to the post-parental phase of the family career, where it was not empirically measured but was used as a possible explanation of the ease of role transition which did emerge from the data (Deutscher, 1962: 523). Data on anticipatory socialisation are presented here.

LeMasters (1957: 354) argued that the members of his sample 'were not trained for parenthood, ... practically nothing in school, or out of school, got them ready to be fathers and mothers' although he assumed that the minority (17%) who did not experience crisis were 'somehow ... better prepared for

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[18] The term 'monotonic' describes the shape of the relationship when graphed, more particularly that in which the direction of the relationship does not change over the complete range of both variables; this is relatively less demanding than the requirement of linearity (which also requires that the amount of influence in the relationship does not change either). See Burr (1978: 14).

[19] The term 'curvilinear' describes the shape of the relationship when graphed, more particularly that in which in (a) the low range of the independent variable (e.g. anticipatory socialisation in this instance) a given amount of variation in that independent variable is associated with a marked amount of variation in the dependent variable (i.e. ease of role transition, or more specifically low Hobbs Checklist (Hobbs, 1965; 1968) crisis score), while in (b) the higher range of the independent variable (i.e. anticipatory socialisation in this instance) a given amount of variation in that independent variable is associated with much less variation in the dependent variable. See Burr (1973: 12).

parenthood than was the crisis group' (op. cit. 355).

Dyer (1963: 200) found that husband's or wife's attendance at preparation for marriage courses in high school (35% of the wives and 12% of the husbands) was significantly ( $p < 0.05$ ) associated with experiencing only 'slight' or 'moderate' crisis, which suggests the working of anticipatory socialisation.

It is implicit in the reports by Hobbs (1965: 371; 1968) that indicators of formal anticipatory socialisation are not associated with reduced crisis.

Russell (1974) reported that men's preparation for parenthood (in various ways) was significantly related to their pleasures of parenthood scores, but not women's; neither was related to crisis scores.

There are thus some grounds for including variables relevant to anticipatory socialisation in the present research.

The variables in the present research relevant to anticipatory socialisation are:

- a) size of family of origin (larger numbers of siblings suggest more chance of experiencing some aspects of the parent role);
- b) adult siblings already have children (similar suggestion);
- c) previous experience of the care of babies and/or children;
- d) which antenatal classes (if any) attended (because the Parents Centre classes, especially, are deliberately designed to socialise prospective parents into their new role while sharing with the Campbell-Johnstone classes the primary focus on the management of labour and delivery);
- e) actual/intended attendance at such classes (it has been suggested by Burr (1973: 125-126) that the important difference may be between not experiencing and experiencing at least some formal anticipatory socialisation);
- f) evaluation of formal preparation (anticipatory socialisation which is positively evaluated is likely ceteris paribus to be more effective in promoting ease of role transition, or reducing crisis);
- g) detailed aspects of participation in formal anticipatory socialisation, such as ease of asking questions, the value of small groups rather than formal lessons (see Willacy, 1976), and difficulties of getting to know people in large classes (because not only do opportunities for anticipatory socialisation have to be

provided, they have to be taken up);

- h) detailed aspects of class content and coverage, such as breastfeeding and the new husband's role (there may be different priorities for coverage and/or information), and satisfaction or dissatisfaction with the relative importance attached to various topics such as labour, and sexual relations (which may reflect areas of stress or anxiety); and
- i) other aspects of anticipatory socialisation which are less formal, such as various aspects of parentcraft which may have been experienced prior to the birth of one's baby.

For matters covered in (a) to (c) inclusive the findings are quite clear. For size of family of origin the results were not significantly different overall for the crisis and non-crisis categories, although the former tended to come from slightly larger families (which would not be the expected direction of difference if people - especially women - from larger families have experienced more anticipatory socialisation for parenthood). For all other variables relevant to aspects (a) to (c) inclusive the crisis and non-crisis categories were virtually identical.

For matters covered in (d) the choice of antenatal class was virtually identical for crisis and non-crisis categories. In view of the more general preparation for parenthood of Parents Centre classes, the belief of both Parents Centres committees and Campbell-Johnstone Antenatal Clinic staff that their respective courses attract different sorts of people, and the role of Campbell-Johnstone Antenatal Clinic staff in guiding prospective parents into the course which is felt to be more appropriate for them, this similarity is perhaps somewhat surprising!

Turning to (e), the crisis category attended slightly fewer classes (mean = 6.45) than the non-crisis category (mean = 6.68) but the modal number of classes was eight for both the crisis category (47.7%) and the non-crisis category (50.0%). The difference between the overall patterns of the two categories approached significance ( $p = 0.06$ ), with the crisis category noticeably more to be found in the six out of eight category for attendance (10 versus 4.8 expected) with the non-crisis category correspondingly less (15 versus 20.2). This may perhaps reflect the fact that two out of the eight Campbell-Johnstone classes were held in the evening, for husbands as well, and it may be that the marital problems and unhappiness which significantly differentiate the crisis and non-crisis categories meant that the former were more likely to miss these sessions.

With regard to the matters in (f) and (g), the overall evaluation of classes showed no significant differences at all. However there were significant differences between the crisis and non-crisis categories on some specific items, which might be taken to suggest that while choice of class

and attendance were very similar for the crisis and non-crisis categories, the use or value of the experience might have been reduced for the crisis category. Thus, fewer than expected of the crisis category (27 versus 31.2 expected) found it easy to ask questions at class while more found it difficult (4 versus 1.7) or impossible (2 versus 0.6), a pattern of difference which approached significance ( $p = 0.06$ ).

Similarly, more of the crisis category than expected strongly agreed that large classes make it difficult to get to know and talk to other class members (22 versus 17.2) - although the overall pattern was directional rather than significant ( $p = 0.19$ ). This was reinforced by the strong agreement of those in the crisis category that small group discussions are preferable to formal classes (13 versus 8.6) - although the overall pattern was directional rather than significant ( $p = 0.16$ ).

While these detailed data are not conclusive, there are some indications of respects in which those who were later to report relatively more crisis at the transition to parenthood differed in their evaluations of the antenatal classes compared with the sample as a whole. In general:

- a) they found questions harder to ask and felt that classes did not entirely meet their needs;
- b) they regarded small group discussions as better than lectures;
- c) they found it difficult to get to know people in large classes; and
- d) they tended to find the timing of classes inconvenient.

These differences are directional rather than significant in some cases, and the criticisms are generally expressed by minorities even in the case of respondents in the crisis category, but they suggest overall somewhat less value in the antenatal classes (as formal anticipatory socialisation) for the crisis category than for the sample as a whole.

With regard to matters noted in (h) (antenatal class content and coverage) distributions were very similar for the crisis and non-crisis categories [20] and there were no significant patterns of difference whatsoever. Taking these results

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[20] It should be noted that these questions were asked at the interviews conducted at 36 weeks of pregnancy, and despite the indications received at exploratory interviews with Antenatal Clinic staff, it turned out that quite substantial numbers of respondents were nowhere near completion of their classes at this interview, and thus there are quite high levels of missing data which mean these particular results should be interpreted with caution.

together, and noting the caveat that any differences were directional rather than significant, it might be suggested that on substantive issues:

- a) members of the crisis category identified sexual relations as more salient (both in treatment and importance);
- b) they felt that the reasons for breastfeeding were not treated adequately, but that the practical information on how to breastfeed was not so important, i.e. they seemed to want to know why, rather than how;
- c) they also tended to feel that treatment of the new father's role was unsatisfactory; and
- d) they felt that the information on the progress of labour was overemphasised.

These findings may tentatively be summarised as suggesting that those who were later to be collated into the crisis category were more concerned with relationships (within classes and with their spouses) while those in the non-crisis category were more concerned with the specifics of childbirth and breastfeeding. This matter of relationships may be the area which, overall, can most plausibly be associated with 'crisis' (cf. Fielden, 1978). It may thus be regarded as requiring further conceptual explication, and empirical investigation.

Finally, for the informal anticipatory socialisation matters covered in (i) above, some two dozen such items of experience were listed, and the level of experience recorded. All but two items showed no significant difference between the crisis and non-crisis categories, although there was perhaps a directional tendency for the former to report slightly more in the 'Never' and 'Occasionally' response categories. For only one item was the difference between the two categories significant: 'Soothe a crying baby'. The crisis category had more 'Never' responses (15 versus 8.4 expected) and fewer in the 'Occasionally' (11 versus 16.5) and 'Frequently' (20 versus 21.1) responses ( $p = 0.01$ ).

While one item out of 23 might well show up as a statistically different pattern by chance - which is why significance tests should not be used for data-dredging - it does remain that soothing (or failing to soothe) a crying baby is probably one of the experiences of first parenthood which is most likely to engender a sense of crisis (Kirkland, 1984).

Overall therefore, anticipatory socialisation - formal and informal - shows little in the way of meaningful and statistically significant patterns of difference between the crisis and non-crisis categorisations of respondents, although there are some indications of topics for which further conceptual explication and empirical research would be appropriate.

## 10.6.2 Role Clarity

Role clarity has been defined (Cottrell, 1942: 618) as the presence of 'explicit definitions of the reciprocal behaviour expected', and Burr (1973: 127) associates a low level of role clarity with 'ambiguous or vague definitions'. He could find no research on role clarity (Burr, 1973: 128). LeMasters (1957: 353) may be suggesting a low level of role clarity when he quotes one respondent as saying 'We knew where babies came from, but we didn't know what they were like'.

A possible source of lack of clarity (and perhaps role conflict too), and a linkage with anticipatory socialisation, is to be found in the observation by Benedict (1939) that young people in Western societies are often the victims of 'discontinuity in cultural conditioning' (i.e. they have to 'unlearn' what they have previously learned before they can learn what has recently become appropriate). The developmental task (see section 2.2.2.2.13) thus often has two components: the unlearning and the learning. Where these are imperfectly accomplished, role clarity may well be reduced.

Burr (1973: 127-128) has suggested that 'the amount of role clarity influences the ease of making transitions into [new] ... roles' and that 'this is a positive, monotonic, curvilinear relationship in which the amount of influence decreases as the independent variables increases' [21]

In terms of the present research, the suggestion is that

- a) where prospective new parents have highly ambiguous or ill-defined notions of their forthcoming parental roles, they are likely to experience a high degree of crisis, so that relatively slight improvements will reduce crisis; but
- b) that further reductions in ambiguity etc. will have markedly less effect (the quadratic component).

Dyer reported that the women in his sample reported fourth most frequently

'feelings of inadequacy and uncertainty of ... the mother role (58%)' (1963: 198, emphasis added),

which seems suggestive of lack of role clarity. There are no findings in respect of role clarity reported by Hobbs (1965; 1968) or Russell (1974).

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[21] This is a 'second-order' or 'quadratic' relationship, such that the amount of influence of the independent variable (role clarity in this example) is greater in the lower ranges of the dependent variable (ease of role transition) than in the higher ranges. See Burr (1973: 14).

Two areas of findings in the present research may be identified as relevant to role clarity: expectations of changes with parenthood (Swain, 1978a: 33), and the allocation of parental tasks between spouses (op. cit. 37). Were there any differences between the crisis and non-crisis categories in terms of their expectations of the new parental roles, as evidenced by expected changes? The open-ended responses on expected changes by crisis score, measured at 28 weeks of pregnancy, showed a complete absence of significant differences ( $p = 0.9974$ ) overall. Few of the categories of responses were offered by more than one in twenty of the sample, and only one by more than one in ten.

When the open-ended responses (up to four per respondent) were coded and grouped into categories it became clear that two-thirds of the respondents (68.5%) identified 'limitations on personal time' as a major expected change with parenthood, with a quarter (23.8%) identifying 'changes in domestic routines' and a third expecting 'little change' (23.0%) or 'no change' (13.7%) [22]. There were, however, no significant differences in patterns for the crisis and non-crisis categories.

The same question asked at 36 weeks of pregnancy (after exposure to antenatal classes) indicated no significant differences overall ( $p = 0.9453$ ). The most frequent responses by the crisis category were 'less freedom' (14.5%) and 'adjustments to routine' (12.7%), but similar proportions of the non-crisis category gave these. There were no other responses given by more than one in ten of crisis or non-crisis categories, except 'be more organised' from 10.9% of the latter.

A further asking of the same question at the immediately post-partum interview yielded even less conclusive results. The largest single response classification within both the crisis and non-crisis categories were 'unable to offer an answer' (crisis category: 25.5%) or felt that 'no changes of any importance' were to be expected (12.7%). For those changes which received more than a very few mentions there were no great differences between the crisis and non-crisis categories.

While the degree of role clarity experienced by the complete sample is still a matter for various interpretations (Swain, 1978a: 37) it appears that these data do not indicate significant differences between the crisis and non-crisis categories.

One other set of data may throw some light on the role clarity issue, and these deal with parental task allocation. An indication that most, if not all, the parental tasks of early childhood were regarded by the sample as exclusively or

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[22] Percentages may sum to more than 100% due to multiple responses.

largely the mother's has been interpreted (Swain, ibid.) as suggesting a relatively high degree of role clarity. The question here is thus whether the crisis and non-crisis categories differ from the total sample in the extent to which most or all parental tasks are allocated to the mother's virtually exclusive responsibility, remembering that for the sample as a whole the pattern was for a few items to be predominantly shared (e.g. cuddling the baby) while for the majority of items it was predominantly 'largely' or 'exclusively' the mother's role [23].

For one task (out of twentytwo) there was a significant difference between the crisis and non-crisis categories, with the former more likely than expected both to share equally and to allocate responsibility to the mother; for three other tasks the differences approached significance. Over the whole 22 items, however, there is no firm evidence of differences in role clarity. While it would be a mistake to over-emphasise these results, there is at least a basis for speculation that for the sample as a whole there was (at least for the mother role) a fair degree of role clarity, while for the crisis category there may have been the same degree of clarity, but the role definitions were somewhat different, tending to emphasise more the mother's exclusive 'mothering' role, and attaching less importance to nurturant behaviour on the part of the father.

While the data are not conclusive, it would appear that variation in role clarity is not a powerful explanatory variable for degree of crisis experienced, although the low overall level of crisis may in part be attributed to a fairly high degree of clarity about the mother role at least.

### 10.6.3 Role Conflict

Role conflict has been defined in a variety of ways. Burr (1973: 129) refers to 'the presence of incompatible expectations for a social role', while Cottrell (1942) defined role conflict in terms of its likely sources such as inconsistency between verbal and behavioural expressions of expectations, or contact with other subcultures in which role expectations are different from the actor's subculture.

Burr (1973: 131) distinguishes between 'role conflict', where there are different and mutually exclusive or inconsistent expectations of the same role, and 'role incompatibility', where there are expectations for two or

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[23] It should be remembered that these are role allocations when both parents are present; the mothers' predominance would of course be enhanced if the question were refocused on the total period of child care responsibility, given the predominance of the traditional male breadwinner/female caretaker pattern in this sample, and New Zealand society generally.

more roles which are different and mutually exclusive or inconsistent. The lack of an agreed framework for role concepts in sociology is illustrated by the use of the term 'role conflict' by Gross Mason and McEachern (1957). They include a number of distinct categories (e.g. perceived and unperceived role conflicts), and also include what Burr (ibid.) terms 'role incompatibility'.

The concept of role conflict has proven useful in a variety of substantive studies, as exemplified by the research of Campbell and Pettigrew (1959) on southern United States clergy. These men were described as experiencing role conflict as a consequence of the contradiction between their Christian ideals (which the clergy-as-ministers were expected to exemplify) and the segregation and discrimination practiced in their parish (which the clergy-as-resident might share). Role conflict is also described in the research by Gross Mason and McEachern (1957) on school superintendents.

Burr (1973: 129) adds the concept of 'role strain' originally proposed by Goode (1960) to the basic idea that role conflict is inversely related to role clarity and to ease of role transition. Role strain is defined as

'the stress generated within a person when he [sic] either cannot comply or has difficulty complying with the expectations of a role or set of roles' (Burr, 1973: 129).

In discussing role strain, other concepts which may be useful are role compartmentalisation and 'amount of role activity that is prescribed'. Goode (1960) suggests that playing roles in different physical locations or social situations (i.e. role compartmentalisation) may reduce role strain. It is not too difficult to imagine role compartmentalisation in practice, although it is also possible that the maintenance of role compartmentalisation could contribute to strain of some sort. Goode (1960) also suggests that the total amount of prescribed role activity may be positively related to role strain; the suggestion here (Burr, 1973: 132) is of the 'camel's back' variety: up to a moderately high level increases in total role activity probably have little effect, but over a threshold relatively small increments might have a marked influence!

Use of the concept of role strain as a second-order variable enables Burr (1973: 133 [Figure 6.5]) to relate a number of variables to ease of role transition indirectly via their common contribution to role strain [24]. He suggests that:

- a) the relationship between role conflict and role strain is positive;

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[24] Role conflict is also related to ease of role transition via its inverse relationship to role clarity and thence to ease of role transition (ibid.).

- b) the relationship between role strain and ease of role transition is inverse;
- c) the effects are probably 'relatively influential';
- d) they 'seem to be monotonic'; and
- e) maybe 'role strain has more influence toward its upper end' (Burr, 1973: 130).

He concludes (*ibid.*) that the observed relationship between role conflict and ease of role transition may thus be the outcome of more complex but not easily accessible processes. This makes empirical investigation more difficult, and he concludes by raising the possibility that further investigation will show that these relationships are considerably less influential than might now be expected!

With this background in mind, we can now examine the empirical evidence which may relate to role conflict. The variables to be examined deal with conflicting 'advice'. While a third of the sample as a whole (30.3%) were 'somewhat' upset by 'suggestions or advice from in-laws', and one in ten (11.3%) were 'very much' upset, significantly higher ( $p = 0.0008$ ) proportions of the crisis category were 'somewhat' (45.5%) or 'very much' (21.8%) upset. Very similar proportions of the crisis category (65.2%) and of the non-crisis category (63.7%) reported some post-partum depression or 'new baby blues', but only one new mother (in the crisis category) linked this to conflicting advice about her new role. The evidence for role conflict in these data, such as it is, is thus not strong.

#### 10.6.4 Role Incompatibility

The conceptual background to this variable has been examined above. It should be evident that it is conceptually and empirically undeveloped:

'On an intuitive basis it is suggested that this is probably a positive, monotonic relationship, but there is no basis for asserting any other characteristics of this relationship. No data have been found that empirically test it' (Burr, 1973: 131).

The variables which are examined for evidence of role incompatibility inversely affecting ease of transition into the parental role are those which relate the parent role to employment, marital and other roles.

One area in which there might be incompatibilities between the parental (and especially the maternal) role and other roles relates to involvement in organisations and activities outside the home, excluding paid employment. There was a clear trend for the new mothers in the present research to reduce their outside involvements after the baby was born

(see also Harvey, 1978). For the whole sample, there was a reduction from a mean of 1.9 to 1.4 outside involvements, with an increase in those with no such interests from one-third (30.9%) antenatally to almost half (48.9%) post-partum.

For the crisis category, the reduction was from a mean of 1.7 to 1.4 and for the non-crisis category it was from 1.9 to 1.2. Those who experienced little or no crisis were those who initially had a higher level of outside interests but after the baby was born had a lower level of interests, compared with the crisis category. Post-partum, the crisis category had one-quarter (25.5%) with three or more outside interests, compared with a smaller proportion (19.8%) of the non-crisis category.

If the parental role and extramural roles are by definition somewhat incompatible, these data may be interpreted as indicating a higher degree of role incompatibility (as indicated by the greater number of post-partum outside interests) on the part of the crisis category.

These data thus provide a basis for speculation that there are incompatibilities between the maternal and other roles, and that where such incompatibilities were resolved by a marked reduction in outside activities little crisis was experienced, while continuing with a relatively high level of other, arguably incompatible, roles contributes to crisis. This is a useful starting-point for further empirical investigation.

The marital role might also have demands which compete with the parental (and especially maternal) role. The post partum reported levels of marital problems were greater than ante-natal levels for the whole sample, although only one in five (19.4%) reported major problems, and most of these felt that they were coping with them. The proportion of the whole sample with no reported problems fell from 35.3% to 19.8% (crisis category 2.3%, non-crisis category 24.0%).

There were increases in both minor and major reported marital problems. For minor problems the increases were from 54.2% ante-natally for the whole sample to 61.7% for the whole sample (crisis category 67.4% and non-crisis category 60.3%). For major problems the proportions for the whole sample rose from 10.5% ante-natally to 18.5% post partum (crisis category 30.3% and non-crisis category 15.6%). Overall, the differences on marital problems between the crisis and non-crisis categories were highly significant ( $p = 0.0005$ ).

It is plausible to attribute some at least of these increases to incompatibilities between parental and marital roles. The crisis category were somewhat less happy in their marriages than the non-crisis category. Thus:

- a) while two-thirds (63.1%) of the non-crisis category said their marriages were 'very happy' less than half that proportion (29.5%) of the crisis category did so;

- b) the proportions for 'happy as most' were higher for the crisis category (31.8%) than the non-crisis category (24.0%);
- c) more of the crisis category were 'quite happy' (31.8%) than of the non-crisis category (12.3%); and
- d) more of the crisis category were 'not very happy' or 'unhappy' (6.9%) than of the non-crisis category (0.6%).

Overall, the differences on happiness between the crisis and non-crisis categories [25] were highly significant ( $p = 0.0001$ ). Role incompatibility is thus plausible as at least in part an explanation of these differences.

Specific questions were asked about arguments between spouses on particular topics ('family finances', 'recreation', 'demonstrating affection', 'choice of friends', 'sex', 'what is right and proper', 'general outlook on life' and 'relations with in-laws'). The findings were that:

- a) between one-fifth (20.5%, on 'what is right and proper') and almost half (46.4%, on 'demonstating affection') of these couples 'always agreed';
- b) around half (from 39.7%, for 'demonstrating affection', to 58.0%, for 'general outlook on life') 'usually agreed'; and
- c) only fairly small proportions 'sometimes disagreed' (from 12.1%, for 'demonstrating affection', to 26.3%, for 'what is right and proper').

These specific data are, overall, consistent with the earlier marital happiness and problems data. There were some topics on which there were more marked differences between the crisis and non-crisis categories, in each case in the direction of lower levels of agreement among the crisis category couples .

This difference was most significant for 'relations with in-laws' ( $p = 0.0038$ ), but was also significant for money matters' ( $p = 0.0109$ ) and approached significance for 'sexual interaction' ( $p = 0.0563$ ). It seems quite plausible to interpret these differences in terms of role incompatibilities, but it may also be appropriate simply to regard these measures as specifying the areas of difficulty the crisis category were experiencing in their marriages (relative to the non-crisis category).

When asked antenatally an open-ended question about the effects of the new baby on the marriage over three-quarters of the non-crisis category (78.6%) identified a positive

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[25] This was immediately after being asked about marital happiness and marital problems.

effect in their first response, while a smaller proportion of the crisis category (69.1%) did so. In their second response, the non-crisis category were more likely to pass (43.2% gave no second response, compared with 34.5% of the crisis category), while the crisis category were more likely to refer to curtailed activities (20.0%, compared with 11.7% of the non-crisis group). These latter data suggest a degree of role incompatibility, and perhaps forced choices in favour of the maternal role.

One of the items in the Hobbs Checklist relates to 'having to change plans made before the baby's birth'. While for most of the non-crisis category (92.1%) this was not a problem at all, the proportion was smaller for the crisis category (71.1%). There was a greater proportion of the crisis category who were somewhat (22.2%) or very much (6.7%) bothered by this, compared with the non-crisis category (7.4% and 0.5%). Overall, the differences were highly significant ( $p = 0.0001$ ). Similarly, significantly ( $p < 0.0001$ ) more of the crisis category were bothered somewhat or very much by reduced contacts with other adults (53.6% compared with 17.7% of the non-crisis category). It should be noted as a caution of course that there are likely to be differences between the crisis category and the non-crisis category on all Hobbs items, since the crisis category were defined by their total Hobbs Checklist scores; the point here is, however, that on these items the crisis category differed most significantly from the non-crisis category.

Each of the sets of data reported in this section are not conclusive by themselves, but an overall pattern of evidence for role incompatibility especially marked for the crisis category is important. While for the sample as a whole role incompatibility is not marked, it does appear to be relevant for those (few in number) who experienced the highest Hobbs Problems of Parenthood Checklist scores.

#### 10.6.5 Duration Of Role

Burr (1973: 137) suggests that the amount of time to be spent in a role probably influences ease of transition, i.e. the extent of crisis experienced. It is suggested that short role durations mitigate the frustration of goal attainment. This has been elaborated (Swain, 1978b: 38-9) to include the perception of the role as finite, as well as its short duration, tending to reduce the level of crisis experienced.

The role duration can be conceptualised in two ways: the actual or experienced duration, which can be known only when the role has been relinquished, and the expected or planned duration, which can be estimated from planned family size, planned birth intervals, and expected ages at which the children will leave home. In terms of crisis measured at the transition to parenthood, clearly the latter will be the relevant matters.

There are data from the research for planning (or lack thereof) of the pregnancy, and for planned or desired family size. These data were collected at 28 weeks of pregnancy and again at 8/26 weeks post-partum. Only a third (34.3%) of the total sample planned their pregnancy (including its timing), with quite similar proportions for the crisis (30.4%) and non-crisis (35.3%) categories. For the further third (32.6%) who intended in general to start a family, but did not plan the timing the differences between the crisis (26.1%) and non-crisis (34.2%) categories were somewhat more marked.

An attitude or position of unenthusiastic acceptance of an unplanned and presumably more or less unintended pregnancy (18.2% overall) was higher in the crisis (26.1%) than non-crisis (16.3%) categories; and the pattern for the pregnancy as an 'accident', unwanted, the result of contraceptive failure (14.8% overall) was similar with the crisis category (17.4%) higher than the non-crisis category (14.2%). Overall the pattern of differences was directional rather than significant.

On antenatal planned/intended/desired family size, the sample as a whole reported a mean planned family size of 2.65, with a lower mean for the crisis category (2.55) than for the non-crisis category (2.68), a difference which is not statistically significant but which may cautiously be interpreted as suggesting that those who were later to report crisis had somewhat lower levels of planned family size at the antenatal stage. This is not however consistent with the idea that a short duration of the role reduces crisis.

The modal size was two (54.1% overall - crisis category 63.4% and non-crisis category 51.9%). While overall a quarter (24.3%) chose three children, the crisis category were markedly lower (14.6%) than the non-crisis category (26.5%).

The mean desired family size overall post-partum was 2.59 (crisis category 2.49 and non-crisis category 2.62) with the former somewhat more represented in the smaller sizes than the latter. The overall pattern was not, however, significant. The modal family size post-partum was still two.

Other data directly relevant to this sample are not available; however, the childbearing span in New Zealand has fallen to just over four years, with the average age of first marriage at about 22 years (Swain, 1978a: 69). If it is assumed that children leave home between the ages of 17 and 22 (based on the legal school-leaving age of 15, age at starting university or other tertiary training at 17+, age of marriage at about 22, and so on), then some overall New Zealand estimates of the likely duration of the active parenthood role can be made. In round figures, with the first child born at age 22, and one/two more children born over the next four or five years (childbearing completed by age 26 or 27), and with the youngest child leaving home at about age 20 (with the mother aged about 47), the duration of the active role of parenthood, the period when there are

'children' in the family, is approximately twentyfive years.

However, if it is assumed that the mother is likely to resume paid employment when the youngest child is established in school (which is a reasonable assumption, based on the intentions recorded in the present research, and other New Zealand research, e.g. Society for Research on Women in New Zealand (Inc.), 1975; Society for Research on Women in New Zealand (Inc.) and Swain, 1979), then the active phase can be divided into two parts, with the most active one occupying perhaps the first half of the above 25 years of parenthood.

This suggests that a plausible future pattern for the present sample as a whole is for the birth of their first child to mark the beginning of between ten and fifteen years of active, demanding parenthood, to be followed by a somewhat less active phase, when the parental role may become less central, and finally a post-parental phase (Swain, 1978b: 29) when the children have left home and the nature of the role changes.

Whether this may be regarded as a short duration role or a long duration role (and hence as having different effects on crisis) rather depends on the comparisons made. Both marital and employment roles (at least for families' major breadwinners) are expected to be longer than the active parental role. Statistically, the marital role might last about half a century (or at least, the participants might have that expectation at its inception). This is if its termination is by the death of one partner; it is rather shorter if termination is by marital breakdown. The breadwinner role would be similar, perhaps somewhat shorter with New Zealand's currently generous superannuation provisions. The active phase of the parenthood role may thus be expected to be regarded as of relatively short duration.

The data on and analysis of role duration and crisis are thus inconclusive; it would be reasonable to regard the relationship as continuing to be worth taking seriously, and subjecting to further examination.

The elaboration of this idea to include the degree to which the role is seen as finite (even if rather long in duration) may be explored a little more. At the antenatal interviews the non-crisis category had a low level of 'don't know' responses to the question on planned family size (4.2%) compared with the crisis category (10.9%). Post-partum the 'don't know' categories had reversed their relative positions: for the non-crisis category they had increased (to 11.3%) while for the crisis category they had decreased (to 7.3%). While it would be possible to construct plausible accounts of these rather small movements, perhaps the more reasonable conclusion is that the evidence here is also inconclusive.

#### 10.6.6 Substitute Gratification

Cottrell (1942: 619) initially suggested that substitute gratification could mitigate deprivation or frustration of desired goals, and this has been found empirically in research on adjustment to the postparental role (Deutscher, 1969). As with the previous variable, substitute gratification is conceptualised as mitigating the crisis-provoking effects of goal attainment being frustrated by the new parental roles. Substitute gratifications might, for example, include pleasure at successful breastfeeding in a social climate which is not supportive of the activity. Indicators of substitute gratification used here are selective rather than comprehensive, since the range of possible gratifications is great.

Perhaps one potential substitute gratification is a 'good', well-managed labour and delivery with which the woman feels she has coped well. There were some clear differences between the crisis and non-crisis categories in perceptions of labour and delivery immediately post-partum. One-third (33.3%) of the non-crisis category felt that it had been 'easy or good', while noticeably fewer of the crisis category (17.6%) gave this opinion [26]. For 'short and sharp' there was a similar kind of difference, although the crisis category was smaller (5.9) than the non-crisis category (16.1%).

For other evaluations the two categories were perhaps a little more similar (and overall the differences were not statistically significant). Somewhat larger proportions of the two categories rated their labour 'O.K. or alright' (crisis 35.3% and non-crisis 21.5%); 'long and/or tiring' (crisis 23.5% and non-crisis 16.1%); 'short and sharp' (crisis 16.1% and non-crisis 5.9%); and 'very painful' (crisis 17.6% and non-crisis 12.9%), but overall the pattern was not significant.

If the 'easy or good' and 'O.K. or alright' responses, and the 'long and/or tiring', 'short and sharp' and 'very painful' responses, are aggregated and summarised as positive and negative respectively, we find that there is only a slight difference between the crisis and non-crisis categories. The crisis category was somewhat less likely to be positive (52.9%) than the non-crisis category (54.8%), but the differences are more in the aspects of positive or negative emphasised than in these more encompassing summaries.

Turning to a rating of how the sample members felt they coped with labour and delivery - which is perhaps more likely to be a source of gratification if they felt that they had coped well - crisis scores against ratings shows no significant

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[26] Whole sample: 26.4%; all percentages based on those with vaginal delivery, excluding caesarian sections.

pattern of differences. However, crisis and non-crisis categories of respondents on a five-point rating scale show few meaningful patterns. One-third (33.7%) of the non-crisis category rated themselves as having coped very well, but slightly more (35.3%) of the crisis category did so. The mean score on this five-point scale for the non-crisis category was 4.1 while for the crisis category it was 3.9, which is indicative, but the overall pattern is not significant.

A further measure related how respondents felt they coped to how they expected or hoped they would cope. One quarter (27.6%) of the total sample felt they coped far better than they expected, with almost no difference between the crisis (26.7%) and non-crisis (27.8%) categories. Overall another quarter (28.8%) of the total sample felt they coped far better than they expected, more so in the crisis category (33.3%) than the non-crisis category (22.2%). A further quarter overall (22.9%) felt they coped about as they expected they would, more so the non-crisis category (24.4%) than the crisis category (13.3%).

Proportions in the 'worse' and 'much worse' responses were similar, and overall the pattern was not significant.

Turning to infant feeding, while few overall did not breastfeed at all (6.8%), the proportion was greater in the crisis (13.3%) than non-crisis (5.2%) categories. For those who breastfed for at least a few weeks the proportions were similar, and overall the pattern of differences was not significant.

Turning to a rating of the pleasures of infant feeding, the crisis category seem to have enjoyed infant feeding rather less than the non-crisis category. Thus, two-thirds of the non-crisis category (62.4%) reported that they 'thoroughly enjoy' infant feeding (whether breastfeeding or bottlefeeding), while less than half (47.4%) of the crisis category did so. A slightly greater proportion of the crisis category (36.8%) reported that they 'enjoy' feeding, compared with the non-crisis category (33.7%). Thus while only a few of the non-crisis category 'do not enjoy' feeding (4.0%), the proportion of the crisis category who actually do not enjoy feeding is somewhat greater (15.8%). The pattern is not, however, significant. It is associated with a directional tendency for the crisis category to report that they do not find their baby easy to feed.

Turning to the pleasures of parenthood (Russell, 1974), the total sample of new mothers almost uniformly reported that they 'very much enjoyed' playing with their baby (93.3%), taking pride in their baby's developmental milestones (90.8%) and enjoying their baby's company (90.8%). There were no significant differences between the crisis and non-crisis categories on these or indeed any of the other items in the Russell (1974) Pleasures of Parenthood Checklist. In most cases there was a directional tendency for the crisis category to be somewhat less enthusiastic about their new

role. About one-third to half of the sample 'very much enjoyed' a greater appreciation of the maternal grandparents (34.5%) and having more to share with the baby's father (55.1%), while a third (34.5%) felt similarly about being closer to other relatives.

Differences between the crisis and non-crisis categories most closely approached statistical significance on 'being less bored' ( $p = 0.1491$ ), with however more of the crisis category (74.0%) being 'somewhat' or 'very much less bored' than of the non-crisis group (65.8%), which is difficult to interpret! A similar level of near-significance was attained with 'appreciation of [the new mother's] family' ( $p = 0.182$ ), but again a greater proportion of the crisis category (82.6%) than of the non-crisis category (70.7%) reported that they 'somewhat' or 'very much' 'appreciated their parents more'. The item for 'feeling closer to one's husband' also falls into this grouping, with a directional pattern ( $p = 0.1101$ ) of more of the crisis category very much or somewhat closer to their husbands post-partum (93.2%) than the non-crisis category (89.5%). Any attempt at interpretation of these results runs into the problem that feeling closer to the husband and feeling closer to the respondent's family of origin seem to be contradictory; what they have in common is perhaps a tendency to look for closeness other than with the baby?

As one of the first pieces of information a new mother receives is the sex of her baby, it is interesting to note that there was a difference between crisis and non-crisis categories in the sex of their baby. Six out of ten (58.1%) of the crisis category had a boy, while less than half (48.3%) of the non-crisis category had a boy. The actual distribution of babies by sex over the whole sample was equal. Both the crisis and non-crisis categories had the same score (3.4) on a 5-point scale measuring the extent to which they did or did not want a baby of the sex they received, but the overall pattern was approaching significance ( $p = 0.0603$ ) in differences of distribution.

Thus, somewhat more of the non-crisis category (57.1%) than of the crisis category (41.5%) 'didn't mind' what sex their baby was; the crisis category had more who definitely wanted a baby of that sex (45.5% compared with 33.3% of the non-crisis category) and more who definitely did not want a baby of that sex (18.2% compared with 10.9%). The relationship of these data to the concept of substitute gratification is not entirely straightforward and indeed not entirely clear, but it is plausible to argue that the crisis category attached more importance to an attribute of their baby which, if perhaps now becoming predictable while still in utero, is still difficult (Etzioni, 19 ) to control, and hence the degree of gratification to be derived from their baby is perhaps inhibited.

### 10.6.7 Transition Procedures

Again it was originally suggested by Cottrell (1942: 619) that ease of role transition

'varies directly with the degree of importance attached to and the definiteness of the transitional procedures used .. in designating [a] change in role'.

Burr (1973: 139) suggests that this is a positive relationship, but the focus is neither conceptually developed nor is there empirical evidence available.

During the period in which the sample members were having their babies there were no home births, or births in other institutions, in the Campbell-Johnstone Obstetric Unit catchment area. For all of these new mothers, as has been argued elsewhere (Swain, 1978b: 39), any transition procedures are probably located in the hospital experience. So far as the new fathers are concerned, there are no data at all (although Ritchie and Ritchie, 1970, suggest that, as part-time parents, fathers in New Zealand are not much involved in the whole process of pregnancy and parturition). Perhaps, as has already been argued ((Swain, 1978b: 40), the near universal hospitalisation of birth in a state medical system makes this factor of transition procedures nearly uniform for new mothers in New Zealand.

### 10.7 Revision Of Burr's Model Of Role Transition

The review of empirical evidence now completed has been organised in terms of the model, and its conceptual components, put forward by Burr (1973: Chapter 6). The model is, however, available for revision, and changes suggested elsewhere in this thesis could be incorporated. The variables which are possible candidates for incorporation in Burr's model have come to notice in part as a consequence of conducting this research, and there are few of the extant data reported here which can be applied to these suggested new variables. They are:

- a) continuing socialisation (positively related to ease of role transition);
- b) role congruency (inversely related to role conflict);
- c) adequacy of sanctions (inversely related to role incompatibility);
- d) role consensus (positively related to role clarity);
- e) adequacy of role definers (positively related to role consensus);

- f) role performance ability (positively related to ease of role transitions);
- g) adequacy of role complex (positively related to ease of role transitions); and
- h) tolerance of norm/role behaviour discrepancies (inversely related to role strain).

#### 10.8 Summary

Earlier items in the extant literature indicate that first parenthood is best understood as 'a crisis'. More recent and methodologically more sound studies suggest that new parents experience relatively low levels of crisis at and immediately after the birth of their first child. The present research is generally consistent with these latter findings, although a category can be constructed (from crisis scores) who relative to the remainder of the sample experience somewhat more problems and less satisfactions in their new role.

In terms of social characteristics, while there are no striking differences between the crisis and non-crisis categories, the former are somewhat more likely to be married or de facto married, of longer marital duration, younger, Maori, formally Protestant, early school leavers and without educational qualifications. Some of these characteristics might be associated with social disadvantage more generally (e.g. young, unqualified, Maori, early leavers), but others might not (e.g. longer-married, Protestant). Moreover, one major American study (Geismar, 1973) shows that even substantial social disadvantage is not associated with crisis at first parenthood, as might have been expected.

The data were examined in this chapter on the basis of a conceptual framework (Burr, 1973: Chapter 6) which was compiled in order to explain ease or otherwise of role transitions such as the transition to parenthood.

For anticipatory socialisation, the crisis category were found to differ somewhat from the non-crisis category on some aspects of formal socialisation (e.g. antenatal classes) but there were no differences for informal anticipatory socialisation.

For role clarity the data were not conclusive, but a plausible view would be that there was a fair degree of clarity about the mother role at least. One piece of data showed that the crisis category were significantly more likely to report upset at role conflict, but did not link role conflict to evidence of crisis such as post-partum depression. However, it would appear that role conflict warrants further investigation.

The data for role incompatibility suggest that this is perhaps one of the major causes of difficulty in role transition, with some evidence that the non-crisis category adjusted more quickly and/or effectively to role incompatibilities, especially between maternal and marital roles, and between family and community roles. Nevertheless, there was some evidence of role incompatibility widely across the sample, suggesting that adjustment was incomplete at the time of interviews (8 or 26 weeks post-partum).

For role duration the situation is not unlike role conflict: the variable seems to have some relevance, and should continue to be considered and examined, but the present data are inconclusive although suggestive of relative positive influence on ease of role transition. For substitute gratification there was generally directional but non-significant indications of a positive influence in various areas. It would thus appear that

- a) even those Waikato primigravidae with higher crisis scores did not report widespread or severe crisis at the transition to parenthood (although those who experienced relatively more problems were influenced especially by role incompatibility and perhaps role conflict, and perhaps by role duration and substitute gratifications); and
- b) the differences between the crisis and non-crisis categories (constructs) were not such as to lend weight to the notion that these are - in the sense already discussed - 'real' groups in the community.

To what extent do these findings extend our knowledge of first parenthood? Further weight is added to the general findings of the more recent research, that for the great majority of new parents their experience of the transition cannot usefully be characterised as a 'crisis', and indeed appears to be most aptly summarised as demanding but rewarding. Some of the substantive experiences or characteristics which have been identified in some studies as contributing to ease of transition, such as exposure to education for marriage and especially parenthood, have here been shown to be poor discriminators between crisis and non-crisis categories. No new substantive variables have been added to the list of candidates for crisis amelioration.

What has perhaps been achieved is an initial review of the conceptual propositions suggested by Burr (1973: Chapter 6), showing that these are useful for the purpose of ordering a large mass of data, and that some of them (role incompatibility, role conflict, role duration and substitute gratifications are the most obvious) seem likely to repay more extensive attention in further research. Such further research could be either in this substantive area of first parenthood or in other empirical domains of inquiry, where the abstract concepts listed above could be applied in different empirical terms.

PART IV

Chapter 11: Conclusions

## 11.0 CHAPTER 11: CONCLUSIONS

### 11.1 Parenthood As Crisis

This thesis was initially envisaged as a study of 'parenthood as crisis' or 'the transition to parenthood'. The extant literature (see Chapter 2, Table 2.1) mostly indicated that the transition to parenthood [1] was experienced as a crisis, and included speculation as to its causes and consequences.

The researcher's initial intention in the present study was to collect and analyse a large dataset, replicating the measurement of 'crisis', with a view to identifying:

- a) the causes or 'predictors' of crisis;
- b) its immediate (perinatal) and short-term (up to six months) consequences; and
- c) the variables associated with low and with high levels of crisis (i.e. an indication of means whereby crisis might be reduced by social action).

To this end a relatively large-scale prospective longitudinal survey of a 'normal' cohort of new parents was undertaken. A series of structured interviews using mostly pre-coded questions was conducted, yielding a relatively large

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[1] While most of the material on this topic implies that the general universe (Sjoberg and Nett, 1968) is something like 'contemporary urban industrial societies', almost all of the research constituting 'the literature' has been conducted in one society, the United States of America. Moreover, the special or working universes chosen in that society do not seem to be self-evident normal or typical cases (ibid.). What little research there has been in other societies such as Israel (Goshen-Gottstein, 1966), Australia (Rechtner, 1981; Pritchard, 1982; see also Richards, 1978) and New Zealand (Fielden, 1978; Wright, 1978; Pybus et alia, 1978; Harvey, 1980) tends to contradict what has been the predominant thrust of the American research. It is argued that the special or working universe in the present research (Hamilton, New Zealand) is more or less a normal or typical case with respect to the general universe of New Zealand. It may be that New Zealand is not a normal or typical case with respect to the general universe of English-speaking societies. New Zealand may be rather more like the Scandanavian societies, especially the smaller ones like Finland. However, as a major emphasis of the present study is the construction of a generally applicable conceptual framework of developmental change in families, the dataset on which it is tested (with a view to its improvement) does not need to be derived from a normal or typical case. The whole of this discussion underlines the importance of researchers making more explicit and considered reference to these sorts of methodological issues.

quantitative dataset. The intention was to analyse this dataset by multivariate means with a view especially to establishing predictors of crisis.

However this normal New Zealand cohort of new parents did not experience 'crisis' as operationalised in the Hobbs Checklist, the standard measure used, taking into account the scores reported in the literature and the actual wording of the specific items and responses which gave rise to those scores.

There do not appear to be any major methodological shortcomings in this research which might call into question these empirical findings. There was a reasonable response rate (65.8%; 241 respondents). The special or working universe (Sjoberg and Nett, 1968) from which the respondents were drawn was carefully chosen (Chapter 5), and defined so as to exclude any disproportionate representation of subgroups [2] who might be more or less likely to report crisis.

Standard measures were used, such as the Hobbs (1965; 1968) and Russell (1974) Checklists, and the Maternal Attitude to Pregnancy Indicator (Blau Welkowitz and Cohen, 1964). The questionnaires were quite extensively pre-tested, and interviewers were carefully trained and supervised in the field. Within the intrinsic limitations of such large-scale quantitative empirical research [3], the methodology was satisfactory.

The empirical findings are unequivocal. The Hobbs Checklist score, calculated on a basis comparable with the extant literature, was 8.735 [4], which does not indicate 'crisis'.

It was thus not possible to investigate the causes (or rather predictors) and consequences of crisis, or determine which variables appear to ameliorate or protect against crisis.

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[2] For example, those experiencing poor health and referred (from outside its usual catchment area) to Campbell-Johnstone Obstetric Unit because of its association with the region's base hospital, the Waikato Hospital, were excluded. Only those who were routinely booked-in to Campbell-Johnstone were included in the cohort.

[3] This refers to the fact that all research strategies have their advantages and their disadvantages. When a particular strategy is chosen its advantages and disadvantages come as a package. It is not possible to remedy such intrinsic limitations.

[4] See Chapter 10 for a fuller account of these results; see also Chapter 2 and Appendix A for a fuller account of the scores reported in the literature.

This finding is consistent with the more recent literature on the topic [5]. While discussions of the emerging contradictions in the literature have tended to be in terms of substantive variables or methodological matters, it is suggested here that the presence or otherwise of 'crisis' is a matter of the researcher's interpretation, and that such interpretation is strongly influenced by his/her theoretical orientation and conceptual framework.

## 11.2 A Framework For Research On Family Change

Given the above empirical findings, two further conclusions are important. The first is to emphasise the likelihood that the conceptual frameworks used by the earlier researchers made their interpretation of results as 'crisis' more likely. This is a specific instance of the general influence of theoretical orientation and conceptual framework on selection of topic, formulation of research questions, collection of data and - finally - interpretation of results.

The second conclusion - based on the work represented especially in Chapters 3, 4 and 9 - is that it is possible to devise a conceptual framework for handling developmental change in families which does not inevitably tend to emphasise one outcome. The conceptual framework constructed as part of this research allows for a variety of processes, such as homeostasis, morphogenesis and/or conflict. This is demonstrated using a large dataset in Chapters 6-8 inclusive.

The desirability of constructing an explicit, useful, systematic, empirically-explored conceptual framework for the study of family change was thus indicated initially by the empirical results. In constructing such a framework, it became clear that the effort should be made to avoid or minimise the bias implicit in at least some of the existing conceptual frameworks. Broderick (1971) has argued that the developmental conceptual framework can encompass all of the others. The effort to incorporate such concepts as homeostasis, morphogenesis and conflict (conceptualised as non-pathological) in the present conceptual framework for developmental change in families was a test of Broderick's (ibid.) argument. The construction of such a conceptual framework, then, became a major focus of this thesis.

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[5] The Australian and New Zealand research [1] uniformly shows a lack of crisis. It is not clear whether (a) the transition to parenthood is less critical in these societies; (b) the transition to parenthood has become less critical in contemporary urban industrial societies (including Australia and New Zealand) in the 1970s and 1980s; (c) the theoretical orientations and conceptual frameworks of family researchers in the 1970s and 1980s are such that crisis is neither sought nor found; (d) some other explanation is appropriate; or (e) several of these explanations apply.

A variety of theoretical ideas were thus brought together, and integrated with additional original ideas, in order to construct a first draft of a conceptual framework for handling developmental change in families.

From Roy H Rodgers (1973) the definition of the major dimensions of analysis as structure, interaction, transactions and norms was obtained, as well as a number of insights into the overall strategy for researching and theorising.

From Joan Aldous (1978) came both the centring of the conceptual framework on movements between successive family career categories, and ways of incorporating a number of important concepts focussed on these movements (such as 'developmental task' and 'morphogenesis').

From Wesley R Burr (1973) were obtained the definitions and suggested interrelationships of more than a dozen concepts associated with role transition, which were adapted and extended. Some of the clearest and most widely used family career category definitions/boundaries (i.e. between one category and the next) can be specified in terms of role transitions (e.g. the transitions to and from parenthood). Burr (ibid.) contributed to the present conceptual framework one of the more systematically constructed segments. This deals with ease or otherwise of role transitions, and introduces a number of useful variables.

The second major focus of the present thesis is thus the bringing together of the above ideas, their adaptation, the addition of some further concepts/variables, and their more detailed interrelationship into a framework.

By working with such a framework, which explicitly incorporates several different orientations, approaches or ideas, there is hopefully less likelihood of particular and implicit assumptions or concepts subtly shaping the interpretation of data. This is especially important where data are particularly open to more than one such interpretation.

A basic assumption made explicit in this study is that 'the facts' do not speak for themselves. All data are open to several interpretations. However, there are likely to be some topics, and some forms of data, which are especially liable to selective interpretation according to the theoretical orientation, implicit assumptions, and concepts used to capture the data.

Thus, for example, the suggested framework incorporates three features which are typically present only singly - perhaps implicitly - in the theoretical and conceptual backgrounds to most empirical studies of new/first parents:

a) homeostasis or equilibrium;

- b) morphogenesis or deliberate change; and
- c) conflict, struggle or tension.

With (probably considerable) further work it may prove possible, using a framework such as this, to bring together empirical findings generated in terms of a variety of diverse theoretical and conceptual backgrounds.

The four major dimensions suggested by Rodgers (1973), taken together with the focus on transitions from one family career category to the next, have been shown to be most useful in ordering the presentation of a very large and diverse dataset ([6] see Chapters 6-8). In some instances topics have been shown to have been neglected in terms of empirical investigation. In other instances proxy variables have been sought, or indices comprising several variables could be constructed. In still other instances a relatively large number of variables have been brought into focus on one component of the framework, which has thereby been elaborated (e.g. socialisation).

### 11.3 Reporting Conceptualisation And Research

Almost five hundred references were covered in the literature review, covering both the relevant theoretical literature and the substantive literature on pregnancy and parenthood. It is evident, however, that even on substantive issues the literature is inconclusive. It is not based on anything approaching an explicit, comprehensive or systematic conceptual framework designed to accommodate change, the one unavoidable feature of families.

The outline of the field of family sociology and the introduction of the developmental conceptual framework in the first portion of Chapter 2 show that change has been central to the explication of concepts and to the empirical inquiries in this field. The developmental conceptual framework, more than most other conceptual frameworks in family sociology or indeed sociology proper, leads the researcher into a consideration of social change. This is an intrinsic and (for family researchers and probably for family members) unavoidable feature of families. This framework, then, is the background for both the empirical research and the construction of the conceptual framework for handling developmental change in families.

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[6] This dataset was originally collected for use in a multivariate data-dredging strategy (see Chapter 5). It was, however, useful to analyse this dataset as a first empirical use of the conceptual framework for handling developmental change in families, since the dataset was centred on a major developmental change - the transition to parenthood.

Chapter 2 is also a review of the substantive New Zealand and overseas literature on pregnancy and parenthood. It is shown that:

- a) research on and discussion of 'the family' in New Zealand lacks both adequate empirical data and explicit theoretical orientations or conceptual frameworks - much as the field was earlier overseas;
- b) the more particular New Zealand and overseas literature on pregnancy and parenthood (outlined in Chapter 2 and covered more extensively in Appendix A) is contradictory, shows only limited replication, lacks cumulation, manifests some avoidable methodological limitations and is largely atheoretical;
- c) specific attributes and longer-term consequences of the social and psychological dimensions of pregnancy, parturition and the puerperium are presumed and sought rather than regarded as problematical and researched; and
- d) parenthood is not researched or discussed to any great extent in terms of its sociological character, i.e. in contrast to the individual developmental focus of most childrearing studies (see especially Appendix A for a full review);
- e) the dichotomy of 'crisis' or 'transition' is treated as if it is objectively real rather than at least in part a consequence of the researcher's theoretical orientation and conceptual framework (see especially Appendix A for a full review).

Thus in Chapter 3 a relatively abstract conceptual framework for designing research and organising data on developmental change in families is presented. This framework was not constructed (indeed, the need for it was not apparent to the researcher) until the data collection phase of the present research had been completed and the data analysis was imminent.

At this point the evident lack of crisis (as measured) in this New Zealand sample of new parents made the data analysis initially envisaged [7] irrelevant. Fortuitously, this precipitated a more extensive examination of the conceptual and/or theoretical considerations which underlay the whole approach of the literature [8] to that date. From this review the conceptual framework was developed. In Chapter 3 it is presented in relatively abstract terms in order to facilitate its use in the widest possible variety of substantive domains of inquiry.

The wider applicability of this conceptual framework is based on its formulation in abstract terms in Chapter 3. Its specific applicability to new/first parenthood is demonstrated in Chapter 4. Here the framework is illustrated

using concrete examples all of which are drawn from the domain of new/first parenthood and closely cognate areas.

The conceptual framework is next used in the ordering and analysis of a rather extensive dataset in Chapters 6-8 [9]. Here the dataset is explored and presented within an essentially longitudinal framework. This uses the concept of social process time previously described as important. At the same time, the data are also organised in terms of the four major dimensions of the model (structure, interaction, transactions and norms).

In Chapter 9 the focus is shifted back [10] to the conceptual framework or model, with a more 'cross-sectional' review. The underlying aim is to consider the areas where either the dataset is inadequate for evaluation of the framework (which leads to the usual call for further research), or the model is in need of further refinement (which is consistent with the 'improvement stance' endorsed earlier).

Chapter 10 is closer to 'the literature' in addressing the more substantive issues generally raised but infrequently answered in that literature (Chapter 2 and Appendix A). Also and more particularly it addresses an important question not previously answered (or, apparently, even considered). Can those respondents with the highest 'crisis' scores sensibly be regarded as a 'real' social group, or is such a 'crisis group' rather a construct originating in the mind of the researcher and operationalised by means of the researcher's data processing? The conclusion on this point is the latter:

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[7] The data analysis strategy which was originally contemplated involved a multivariate search (e.g. using Multiple Classification Analysis and Automatic Interaction Detector software available overseas at that time in the OSIRIS package (see Sonquist and Morgan (1964); University of Michigan, 1970). 'Crisis' would have been used as the dependent variable, and an extensive range of predictor variables would have been analysed. The lack of crisis evident in this New Zealand sample of new parents was a major reason for a reappraisal of strategy for the research.

[8] There were some exceptions; this refers to the predominant tenor and content of the literature.

[9] Chapter 5 covers the major methodological and research design features of this study.

[10] There are likely to be several ways in which these chapters could usefully have been arranged. Any arrangement is necessarily somewhat arbitrary, depending on the writer's purpose(s) in presenting the material. With the present format cross-referencing to relevant sections and chapters has been used to foster a sense of the various connections and linkages between specific matters necessarily presented in a linear sequence.

they are a construct rather than a 'real' social grouping.

Chapter 5 presents the methodology and research design. While dealt with as a separate chapter, methodological issues must also be considered in other chapters as appropriate (e.g. Chapter 2) as such issues impinge on the evaluation of 'the literature'.

#### 11.4 Themes Broader And More Various

Several themes of wider significance are thus illuminated by this research. The broadest of these centre on the importance of:

- a) an explicit theoretical orientation and conceptual framework;
- b) one which encompasses different assumptions and dimensions; and
- c) the greatest practicable methodological rigour, including attention to the limits of appropriate generalisation.

While all sociological research has its limitations, some are hopefully not inevitable.

The present project addresses (however incompletely) the possibility of working within an explicit theoretical orientation with both a large dataset based on original empirical research and a conceptual framework designed to facilitate the investigation of a wide variety of specific substantive topic areas. The more recent empirical research in this topic area of new/first parenthood (including, it is argued, the present work) illustrates the possibility of confronting and to a satisfactory extent overcoming methodological difficulties. The integration of theorising (conceptualisation, construction of conceptual frameworks) with such empirical research is equally important.

At the most specific substantive level it has been shown that new/first parenthood in New Zealand was "not a 'crisis' for a representative cohort of new parents. The detailed data (Chapters 6-9) show that it was an important, salient and in some respects demanding transition, but it is not usefully regarded as a crisis, let alone a 'normal crisis'.

It has also been shown that there are clearly limitations to the use of quantitative research methods and strategies in the understanding of social processes (as opposed to distributions, incidences, statistical relationships between variables and so forth). Associated with these methodological matters is the more theoretical and perhaps even epistemological matter of the influences which shape the selection of research topics, the formulation of specific inquiries, the collection of data (and hence the non-collection of other data), and the interpretation of those data. It has, finally, been argued that theoretical

orientation and conceptual framework have been such shaping influences. They need not be so, or at least need not be so limited in their influence. A variety of perspectives can be incorporated within one conceptual framework, as demonstrated by the framework described in Chapter 3.

Cognate with this theme is another concerned with what might be termed the isolation of family sociology from the 'mainstream' [11] discipline. Family sociologists have mostly developed the field's major topic areas and issues (and such theoretical content as it has) rather largely outside the focus of general or 'mainstream' sociology. Practitioners of the latter have been concerned with such substantive topics as stratification, bureaucracy, religion and economic action, ideology and the like. These aspects of society do not generate great interest among most family sociologists - which is complemented by the general lack of interest, among 'mainstream' sociologists, in substantive family sociology topics. 'Mainstream' sociologists have also focused on several major theoretical schools but only one or two of these have been reflected in family sociology (e.g structural-functional theory has, while Marxian theory by and large has not).

At the same time both quasi-theoretical ideas and substantive material have been imported into family sociology from other areas, most noticeably from applied, social action-oriented professional or quasi-professional fields such as social work or community development. Unfortunately, most such professionals appear to be rather unimpressed with the utility of family sociology in their professional practice [12]. At the same time, the casework or social action source of much of the empirical content of family sociology has perhaps rather undermined any claim to the provision of normative data. This characterisation of the insularity of family sociology and its consequences should not be overstated; nor should it be overlooked.

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[11] It is accepted that this is a debateable term to use as a collective description of the areas of substantive and theoretical interest most frequently and extensively handled by sociologists and reported in the literature. No other term immediately suggests itself as more appropriate, however.

[12] More recent work, such as the construction of the circumplex model of family cohesion and adaptability (Olson and Craddock, 1980), may resolve some of these problems. The development of measures such as FACES (ibid) which have both clinical and empirical utility offers the possibility of integrating findings generated in the currently rather different areas of social research and clinical or social action practice.

And yet there are aspects of family sociology which confront what must be major issues for the wider discipline, especially the question of change. Change is inherent in much of the substantive focus of family sociology. Reproduction and maturation cannot be overlooked, and are inherently dynamic. The construction of conceptual frameworks, theories and research designs to study and explain change, while vital for family sociology, are scarcely less important for the wider discipline.

This thesis is, from the substantive point of view, concerned with one of the major sources of family change: the birth of the first child. The conceptual frameworks and research designs needed to pursue research into this topic have the potential to contribute to the study of social change in families and in particular areas of the wider society.

A more narrowly-focused theme is necessarily a critique of the extant literature on parenthood as crisis or transition. There are few areas in family sociology in which conceptualisation and findings are cumulative [13] and the literature on new parents is rather contradictory, inadequate and unreliable. While it has eventuated that the present research has made necessary attention to these broader issues, it has also been appropriate to consider more specifically-focussed questions. These have arisen as a consequence of the limitations of some of the research already reported in the literature. For example, a significant proportion of the literature suggests that there is a crisis at the transition to parenthood, while some of the more rigorous studies do not support this view. The present research has added to these studies; it has dealt with further questions arising from this parenthood literature; and it has refocussed attention on more theoretical issues.

#### 11.5 In Conclusion

At the substantive level, it is clear that the transition to parenthood was not a crisis for a representative sample of Hamilton primiparae. This finding is broadly consistent with the more recent items in the literature, especially those based on more representative samples. The transition to parenthood does represent, however, an important change to most conjugal families. The consensus among family sociologists in recognising this family career category boundary and role transition as important is substantiated. There are relatively major changes, perhaps approaching the

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[13] Examples to illustrate such cumulation can perhaps be found in the literature on mate selection (see Winch, 1971: Chapter 10) or perhaps conjugal power (see Wolfe, 1959; also Winch, 1971: 98), but there are few other clear examples. See Burr *et alia* (1979a) for recent systematic efforts to improve this situation by providing a basis for cumulation.

status of discontinuities, between the antenatal and post-partum periods. It is still tempting to speculate that first parenthood, rather than entry into employment, or tertiary education, or departure from the family of orientation, or marriage, is the decisive change for most young people.

At a more general level, it has been demonstrated that methodological improvements in family research are both possible and eminently desirable. The prospective, longitudinal research design does have practical difficulties which some other designs avoid, but those costs can often be justifiable in terms of the benefits of such a design.

Whether the use of an elaborate conceptual framework designed to apply to a variety of substantive topics has yet been justified is more open to debate. That debate cannot be concluded unless and until further use is made of this - or other - frameworks in different substantive areas, and the results are to hand. It is argued here that the framework used to organise the investigation of a large dataset on the transition to parenthood proved helpful in making some sort of sense out of a complex and multidimensional phenomenon. The conceptual framework was found useful in organising and making sense of the experience(s) of 241 new parents, and while difficulties were encountered and exposed, for example in the treatment of the normative dimension, a foundation on which to build improvements was laid.

#### 11.6 Future Opportunities

The identification of the necessity or desirability of further research is almost a ritual in reporting social research results. In an area of sociology already replete with empirical studies it perhaps invites scrutiny. What sort(s) of further research? On what theoretical, conceptual, methodological, substantive, bases?

The conceptual framework (or 'model') presented in this thesis is most usefully regarded as a first draft (remembering the stance of improvement). As some of the writers drawn upon in this thesis (Rodgers, 1973; Aldous, 1978) have more or less directly argued, conceptual explication, elaboration, interrelation and interdefinition are needed. The construction of theoretical models which make explicit the process by which we see what we look for, and we look for what we know (Goethe; quoted by Mason, 1978) is also necessary. It seems appropriate that any future attention to conceptual frameworks for research design and dataset organisation (such as the present one) should involve scrutiny, elaboration or simplification as may be, and further use. It may also be that their deficiencies could encourage the formulation of different conceptual frameworks. The process has only begun with attempts such as the present work, but it is clear that researchers in the family area need to make the attempt to work with both conceptualisation and data collection and analysis if understanding of the

field is to progress.

There are several respects in which the present conceptual framework clearly requires further attention. These have been indicated as appropriate in Chapters 3, 4 and 9. For the purposes of the model 'unexplicated processes' are assumed to mediate between the early manifestations of mismatch and the various alternative coping behaviours (section 3.6). These early manifestations are identified as tension, conflict and pressure to change. The coping behaviours are identified as avoidance, emotional expression, coercion and morphogenesis.

These components of the module were not explicated (in section 3.6) or illustrated (in section 4.5) because there are no indications in the literature (see Chapter 2 and Appendix A) of the processes by which the symptoms of above-threshold mismatch lead to the various kinds of coping behaviours. Further work in terms of exploration, conceptualisation, explication and illustration - and then investigation is required. This could begin with the prima facie plausible linkages (see sections 3.6.1 and 3.6.2).

It has already been pointed out (see section 9.5) that the concepts of 'checking for fit', 'fit', 'lack of fit', 'reversion' and 'dissonance reduction' - and perhaps even 'morphogenesis' - require further conceptual explication and/or inter-relation, operationalisation and empirical investigation. Further, the whole area of norms is more honoured in general discussion than in specific empirical investigation (see section 8.1). It has been argued (see section 9.6) that the specific variable, 'amount of normative change' could be a useful starting point for this.

Other concepts or variables in the 'role transition and mismatch' module of the conceptual framework (see section 3.7) which could usefully be explicated etc. include 'role performance ability', 'goal attainment', 'value of goals', 'role strain' (which is a rather more abstract concept than most of those presented), 'role congruence', 'role compartmentalisation' and 'tolerance' of norm/behaviour discrepancies' (see section 9.6).

It may be that the recent literature in the area of counselling, some forms of therapy (e.g. family therapy) and even social work may provide a basis for conceptual explication and elaboration of the processes by which above-threshold mismatch leads via tension, conflict and pressure to change to various kinds of coping behaviour, such as emotional expression, avoidance, coercion and/or morphogenesis.

More particularly, morphogenesis - which is especially cognate with the developmental conceptual framework - could be related to the variety and volume of information available to family members, and to the effectiveness of their patterns and methods of communication. These two dimensions of

information and communication are central to much of the more structured or formal socialisation which is available in New Zealand (e.g. through antenatal classes, parent education provisions and the education service of Marriage Guidance Councils). Thus conceptual explication and empirical investigation of these two dimensions could contribute to the understanding of changes such as the transition to parenthood.

The circumplex model and the FACES measure (Olson and Craddock, 1980) could well be linked here. The dimensions of Adaptability and Cohesion (*ibid.*) are prima facie relevant to transitions between family career categories.

The somewhat abstract concept of 'role strain' also needs to be further explicated and interrelated (see section 3.7.12) with other concepts in its area of the model (see section 3.7 and Figure 3.9). Similarly, there are some potentially useful elaborations relating to 'role congruence' (see section 3.7.14) which offer scope for further attention.

More particularly, an inverse relationship has been suggested between 'role conflict' and 'role incompatibility' (see section 3.7.15). This could readily and usefully be investigated without further prior conceptual attention being required.

There are also a number of substantively-defined issues which have emerged from the present research and could repay further investigation. Ethnicity was one sociodemographic variable for which there was a significant difference between the crisis and non-crisis categories of respondents, with a far higher proportion of the former being Maori (see section 10.4.1.4). Further investigation of this finding could usefully be focused on whether it is ethnicity per se which is associated with crisis, or whether there are intervening variables.

The relationship between duration of marriage (measured at the time of the first birth) and crisis is also worth further investigation (see section 10.4.1.6). It appears that for this New Zealand cohort allocation to the crisis category was associated with the co-occurrence of two transitions - marriage (de facto or de jure) and parenthood. If either transition preceded the other by sufficient (social process) time, allocation to the crisis category was unlikely.

Cognate data relating to duration of the maternal role and allocation to the crisis category (see section 10.6.5) were found to be inconclusive. This relationship is a worthwhile topic for further conceptual attention (e.g. to the idea of duration perceived as finite being the relevant consideration) and research.

Another similarly-shaped relationship is that between both educational qualifications and occupation (which are likely to be correlated, of course) and allocation to the crisis category (see sections 10.4.2.1 and 10.4.2.2). Those with no

qualifications and those with tertiary qualifications were both more likely to be allocated to the crisis category. Similarly, those whose occupation was housewife and those whose occupation was professional or managerial were both more likely to be allocated to the crisis category. Differences in all cases were more directional than significant.

A further similar pattern was found in respect of marital happiness and marital problems (likely to be inversely correlated) and allocation to the crisis category (which might encompass lower levels of marital happiness, and higher levels of marital problems). That these variables might be correlated in various ways does not detract from their conceptual distinctiveness. The crisis and non-crisis categories were similar in distributions on intermediate levels of both marital happiness and marital problems, but diverged in the anticipated directions on the high and low levels (which were 'no problems' and 'major problems - not coping' for the latter). Some of these differences were highly significant. Possible explanations have been discussed (see section 10.4.2.4), and this topic area would probably repay further research.

The topic of relationships is again highlighted by the data on anticipatory socialisation (see section 10.6.1). It is suggested that those who were allocated to the crisis category were more concerned with relationship issues, while the others were more concerned with pragmatic matters.

Data on the cognate dimension of 'closeness' - whether to baby, husband (if applicable) or other kinsfolk - showed some seeming contradictions (see section 10.6.6). The topic thus requires both further conceptual explication and empirical investigation.

Conceptual explication of 'role incompatibility' has already been identified above as a priority. The data on extramural activities of the respondents (see section 10.6.4) suggest that - at least in the short-term - a reduction in such activities was associated with allocation to the non-crisis category. This substantive area could usefully be researched in association with further explication of the concept.

Finally in this consideration of substantive areas for further work, 'transition procedures' (see section 10.6.7) constitute a topic which is neither conceptually developed nor empirically explored, at least by sociologists. Perhaps there is scope for locating and using some 'seminal concepts' (Aldous, 1970) from the work of anthropologists in the area of such procedures and processes.

The coverage planned for the present research was ambitious, perhaps too extensive. Over several years the research strategy was modified. It may well be that what is required is attention to more limited aspects of the whole encompassed by the present model. Some areas were specifically noted as unexplicated, or problematical. Others were not so noted but

might be shown to be so. Specific research could focus on thresholds, or coercion, or communication, or any of many other areas covered by the present model. Perhaps understanding of the field progresses most when there is movement between large-scale and small-scale, between attention to conceptual frameworks and to the the empirical world?

It is also clear that any particular methodology will be limited. This was not so clear to the present researcher at the initiation of the present research. The only qualitative research design in the literature on new parenthood (LaRossa, 1977) also used a theoretical orientation (accepting conflict as normal) which was unusual in the particular area. Thus it is difficult to attribute all of the value of that study to its methodology. However it would appear that the interview-based survey is only of limited utility, and that the linking of sociological and anthropological (or survey and qualitative) perspectives (Sieber, 1973) may be required. There are aspects of the transition to parenthood which may be quite amenable to survey techniques, such as the measurement of 'sociodemographic' variables or attitudes. Other areas (such as the coping mechanisms, avoidance, coercion, emotional expression and morphogenesis) may best be captured through more qualitative techniques. These could include semi-structured interviews, participant and non-participant observation, life histories, expert and key informants and the like. Thus a conceptual framework such as the one presented here might usefully lead to greater diversity in the research methods used to operationalise it.

One area of potential methodological improvement lies in the organisation of long-term [14] prospective longitudinal studies in which interval or higher-order data are gathered and analysed using stochastic procedures (see section 5.2.3 and 5.3.2).

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[14] The shortest 'long-term' period it would be appropriate to cover is not entirely clear, but there is some evidence that six months post-partum is sub-optimum. In Chapter 9 there is (for example) discussion of whether a final interview (in the present research) at 26 weeks post-partum allowed sufficient time for the emergence of lack of role congruence. As far as the husband-father counter-position goes, the available data suggest a high degree of congruence. There was only a low reported level of disagreement over a variety of domestic and interpersonal areas. These did not constitute an exhaustive list, and hence there might be other areas where there was less congruence. And of course the final interviews were conducted at 8/26 weeks post-partum, which might be early days for the emergence of lack of role congruence (although in some sense it might be latent).

However, complementary approaches are also vital, and have been relatively neglected to date. The 'qualitative' methodologies do have their own particular problems, but the research by LaRossa (1977; see also LaRossa and LaRossa, 1981) shows that such approaches can be especially valuable in exploring and illuminating social processes (see section 9.5). In the case of the above studies (*ibid.*) the theoretical orientation used was also unusual - a conflict approach - and this also is likely to have contributed to the particular insight to be gained from that research. The qualitative, almost anthropological, research by Gilling (1985) in Australia, and the earlier non-reactive methodology of Titus (1976) are also instructive in the value of more qualitative methods and approaches.

There are quite a number of more substantive topics which have been shown to be empirically problematic, and are thus particularly available for further research. One of these provides linkages with an important topic for family sociology and policy analysis: women's paid employment, conjugal power and the transition to parenthood (see section 6.3.6). Another, much debated in New Zealand, relates to the efficacy of antenatal classes and, by extension, similar provisions for anticipatory socialisation (see section 7.4 and *cf.* Gunn, 1983).

The whole topic of norms requires both theoretical and empirical attention. It is necessary both to explicate the concepts being used (at least, in textbooks if not in research: see section 8.1) and to investigate more extensively appropriate substantive areas (see sections 8.2 to 8.6 for a very partial list).

The post-parental revolution (Swain, 1978a; see Chapter 9) is in some ways the conceptual complement of the transition to parenthood. Burr (1973: Chapter 6) includes 'ease of transition out of roles' with 'ease of transition into roles' in his work on role transition, although the latter has received more empirical attention overall in family sociology. Complementary studies of the transition to the post-parental phase of the family career could be extremely valuable, both for putting any 'crisis' at the transition to parenthood in family career perspective and in providing further insight into crucial variables and processes in the transition to parenthood.

One of the uses of a generally-applicable conceptual framework for handling developmental change in families is that it facilitates such comparisons. One module of that framework, on 'change, match and mismatch' (see section 3.5) was found to be somewhat inconsistent with the available data (see section 9.4). This suggests the need for more extensive revision of the module to enhance its utility. Specifically, the issues of conflict, coercion and compromise seem potentially most promising. Substantively, focus could be on the intercontingency of the wife-mother's fertility and occupational careers.

There are a number of specific areas for further empirical investigation identified in Chapter 9 (see especially section 9.4) which would be central to a conventional call for further research.

Chapter 10 is devoted entirely to revisions required in the conceptual framework used in the present work. It thus constitutes a checklist for further work. In particular, there are eight new or revised concepts which have been developed in the course of this project (see section 10.7). These, it is suggested, are candidates for incorporation in a revision of Wesley R Burr's (1973: Chapter 6) model of ease or otherwise of role transitions. This model, as revised, has been incorporated in the conceptual framework presented in the present work (Chapter 3).

There is plenty of scope for further work both of a theoretical and of an empirical nature in this general domain of inquiry.

### 11.7 Epilogue

Perhaps we should not apologise for the benefits of hindsight. A research project carried through entirely as planned, and especially one of necessarily long duration, is very likely to be one which exemplifies at least two limitations:

- a) indifference to serendipity; and
- b) oversight of the social researcher's active role [15] in 'making sense' of 'the data'.

This thesis does not represent the outcome originally expected when the project was planned. It could now be described as both more ambitious and more flawed.

It is more ambitious because a relatively straightforward (albeit technically complex) multivariate analysis of quantitative data has been replaced by the more difficult task of constructing and testing a conceptual framework for the presentation of data (and, in other circumstances, the design of research) on a wide variety of developmental changes to families.

It is more flawed because the 'stance of improvement' (Rodgers, 1973: Chapter 1) has been adopted, and hence the limitations of this first approximation to the 'ultimate' conceptual framework have been deliberately sought and brought to light. In all of this it represents, however inadequately, an effort by the researcher to engage in a sort

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[15] See Merton (1948) on the four active roles of empirical research itself (initiation, reformulation, deflection and clarification).

of dialogue or interaction with the topic of new/first parenthood within the field of family sociology. In this dialogue the researcher is also liable to change! It is perhaps only with hindsight that these changes can fully be appreciated. They were surely - and perhaps fortunately - not foreseen when the project was begun.

## PART V

### References

### Appendices

Appendix A: The Literature on Pregnancy and Parenthood

Appendix B: Questionnaire 1 (28 Weeks of Pregnancy)

Appendix C: Questionnaire 2 (36 Weeks of Pregnancy)

Appendix D: Questionnaire 3 (2-7 Days Post-Partum)

Appendix E: Questionnaire 4 (8/26 Weeks Post-Partum)

## REFERENCES

The following references have been selected and formatted from the VISOR database FAMSOC (C) David A Swain 1983, 1985. Where more than one item has the same author and year of publication, the order of listing corresponds to the suffixes 'a', 'b' etc. used in the text. Sorting of items has been according to the ASCII hierarchy using a specified author-sort field where provided in the database record, or otherwise (the default) the surname and initials.

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## 1.0 APPENDIX A: THE PREGNANCY AND PARENTHOOD LITERATURE

### 1.1 Introduction

Summaries of the overseas literature on pregnancy and parenthood are included in Chapter 2 (see sections 2.3.2 and 2.3.3), together with the conclusions drawn from the literature review. In this appendix the literature is reviewed in greater detail, to substantiate the conclusions presented in Chapter 2. This appendix may also be treated as a resource to elaborate and/or substantiate the more synoptic references to items from 'the literature' in other chapters.

### 1.2 Empirical Studies Of Pregnancy And Parturition

There are several reasons why it is not possible, in a review of the literature on psychological and social aspects of pregnancy and parturition for the purposes of the present work, to avoid being highly selective:

- a) the available literature is extensive;
- b) it is to be found in a number of distinct academic and professional areas; and
- c) it is largely unorganised - it has not been brought together in texts, decade reviews etc.

Pregnancy corresponds rather well to the 'anticipatory phase' (Rossi, 1968) of the maternal - and perhaps even paternal - role. Labour and delivery mark the beginning of what Rossi (ibid.) has termed the 'honeymoon phase', and are the point at which the family structure changes (see section 3.2.2) in the process of developmental change in family systems. For these reasons some attention should be paid to the available literature.

That pregnancy and parturition have dimensions other than the physiological has long been recognised, even by those with a narrowly-focused professional interest in these states and events. Half a century ago Hall and Mohr (1933) studied 66 primiparae and reported a wide variety of fears, anxieties and problems, as well as considerable ignorance of pregnancy and childbirth. They pointed out that their findings had obvious potential implications for later childrearing. Many of the findings in the later literature have been tentative or contradictory, while improvements in methodology are still needed. There are few replications and only limited cross-references to other studies. The sociology of birth has only reached the perinatal stage.

Zemlick and Watson (1953) studied 15 white married primigravidae without 'gross' physical or psychological problems. They collected antenatal data on both emotional and physical 'symptoms', while their parturition data included duration of labour and 'adjustment' in labour and delivery. Post-partum data included anthropological

observation of mother-baby interaction. Instrumentation included selected TAT items [1] the McFarland-Seitz Psychosomatic Inventory [2] and the ZAR Pregnancy Attitude Scale [3]. Their results were less than definitive, perhaps in part because of the large number of measures used and the lack of a clear and systematic theoretical orientation. Labour duration, a frequent measure of 'ease' of parturition, was unrelated to any other measure. Antenatal emotional adjustment was related to delivery adjustment. Antenatal physical symptoms were unrelated to any other measure. There were low intercorrelations of all post-partum measures. Antenatal emotional adjustment (related to delivery adjustment) was unrelated to post-partum observed behaviour. Antenatal physical symptoms were related to post-partum observed maternal behaviour.

Zuckerman *et alia* (1963: 328) contradict these results from Zemlick and Watson (1953), and other comparable results from Davids DeVault and Talmadge (1961), Zuckerman *et alia* (1963) reported two studies of psychological correlates of somatic complaints in pregnancy and difficulty in childbirth. Their first sample was of 52 primiparae, mostly black, lower status, young and poorly educated. Their instruments were mostly from the general literature with one or two devised for this research; there were also structured interviews. They found significant ( $p < 0.05$ ) correlations between the Manifest Anxiety Scale [4] and the PARI Marital Conflict scale [5] on the one hand, and the Somatic Complaint Inquiry [6]. However, they did not carry this finding through to an explanation of the processes which might link these

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[1] See Murray (1943). The Thematic Apperception Test has been used or discussed in the following studies of pregnancy and/or parturition: Davids DeVault and Talmadge (1961), Goshen-Gottstein (1966) and Breen (1975) as well as in several studies cited in McDonald (1968), and in Zemlick and Watson (1953) which is the basis of this paragraph.

[2] The McFarland-Seitz Psychosomatic Inventory appears to have been used only in Zemlick and Watson (1953).

[3] The ZAR Pregnancy Attitude Scale appears to have been used only in Zemlick and Watson (1953), although there is some reference to it, and to an unpublished paper describing it, in McDonald (1968).

[4] See Taylor (1953). The Manifest Anxiety Scale has been used or discussed in the following studies of pregnancy and/or parturition: Davids DeVault and Talmadge (1961), Brown (1964) and several studies cited in McDonald (1968: 227-8) as well as in Zuckerman *et alia* (1963) which is the basis of this paragraph.

[5] See Schaefer and Bell (1958). Zuckerman *et alia* (1963) use the 'Marital conflict', 'Rejection of the homemaking role' and 'Irritability [with children]' items from the PARI.

variables. Their second, similar, sample also included data on labour duration and analgesic use: they found labour duration unrelated to other data, but anxiety (measured by Zuckerman Affect Adjective Checklist) [7] significantly higher for those women with higher analgesic use.

Coppen (1958) concentrated on psychosomatic aspects of the HOP syndrome [8], and in a comparison of 50 primiparae with HOP against 50 matched controls found that the former reported higher emotional disturbance at menarche, premenstrual tension, sexual problems, 'disturbed' attitude to pregnancy, psychiatric symptoms during pregnancy, neuroticism score (Maudsley Personality Inventory) [9], 'masculine physique' according to 'anthropometric measures', family upsets, heartburn and day-long vomiting! Setting aside the grounds for criticism arising from the pre-feminist lack of consciousness evident in the discussion, one wonders whether the HOP group would have fared any better if studied when they were not pregnant? The research by Coppen (1958) illustrates the problem of failure to consider alternative explanations (which it may be argued is more likely to arise when theoretical orientation and conceptual framework are not made explicit) and to rely on two or three control variables to support the ceteris paribus assumption.

It is probably psychiatrists who have constructed the most elaborate accounts of processes linking findings (often based on small numbers of unusual cases) about pregnancy and parturition. Bibring (1959: 116, emphasis added) illustrates this well:

'Pregnancy, like puberty or menopause, is a period of crisis involving profound psychological as well as somatic changes. These crises represent important developmental steps and have in common a series of characteristic phenomena ... [It] is proposed to accept in the same way [as in adolescence] that there is a disturbance, peculiar to ... pregnancy, arising from the facts of pregnancy themselves, be they emotional, physiological or social. Stress is inherent in all

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[6] The Somatic Complaint Inquiry appears to have been used only in Zuckerman et alia (1963).

[7] See Zuckerman (1960). The Zuckerman Affect Adjective Checklist appears to have been used only in Zuckerman et alia (1963).

[8] The HOP syndrome refers to hypertension (blood pressure over 140/90 at 24 weeks), oedema and proteinuria, and was previously termed pre-eclamptic toxæmia, or simply toxæmia.

[9] See Eysenck (1956). The Maudsley Personality Inventory has been used or discussed in Coppen (1958), Brown (1964), Pitt (1968) and one study cited in McDonald (1968).

areas'.

The analysis by Bibring (1959) has in common with family sociology theorists some key concepts, albeit without explicit reference and using different terms; she proposes that pregnancy requires new 'tasks of adjustment' (i.e. developmental tasks), with the possible emergence of old (i.e. previous family career category) conflicts and inadequate solutions (i.e. failure to accomplish previous developmental tasks).

Bibring (1959) asserts that there is a broader social explanation of enhanced stress and inability to cope among families in transition to parenthood. She cites a supposed breakdown of an earlier pattern of extended families and closeknit communities, and argues that this leads to increased reliance on the nuclear family and especially the spouse. These are said to be unable to provide adequate support, hence the sense of crisis. She quotes the functionalist stream within sociology in support of this view, which is not generally accepted now (Sussman, 1959; Sussman and Burchinal, 1962; Laslett, 1965) of the breakdown of the extended family and its consequences. This argument illustrates one of the real difficulties researchers face when they find it necessary to draw upon different disciplines, but are unable to attain equivalent expertise in them. Notwithstanding the dubious sociological grounds of her argument, Bibring (1959) does make a useful point in challenging the assumption that only neurotic women are adversely affected by pregnancy. Following Erikson (1950), she argues that pregnancy is a crisis but also a turning point or developmental opportunity affecting everybody involved (cf. LeMasters, 1957).

Hooke and Marks (1962) studied the MMPI [10] characteristics of pregnancy and provided the same contrast with earlier and 'gloomier' research as in the transition to parenthood research (see section 2.3.2). Their 24 primiparae, studied at eight months of pregnancy as part of a longitudinal study (Benedek, 1970), and compared with a normative group, gave no evidence even of mild subjective discomfort, anxiety or depression, and had a low incidence of any psychopathology. For them, pregnancy was a period of good psychological adjustment and emotional health.

Mead and Newton (1965) have placed conception, pregnancy, labour and the puerperium [11] in cross-cultural perspective. They show how the assumption that these events and processes

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[10] See Welsh and Dahlstrom (1956). The Minnesota Multiphasic Personality Inventory, or components of it, have been used or discussed in Cramond (1954: Lie Score only), Brown (1964: Lie Score only), Zuckerman et alia (1963: Masculinity-Feminity Scale only) and four studies cited in McDonald (1968: 226-7) as well as Hooke and Marks (1962) which is the basis of this paragraph.

have any particular characteristics varies cross-culturally. The fundamental finding in this review was that in all human cultures those dealing with pregnancy and parturition begin with the basic physiological cues and construct a biosocial process which they regard as appropriate [12]. The assumption of and search for characteristics of some sort of norm from which pathologies deviate may not always take into account the universal existence of cultural patterning of conception, pregnancy, parturition and the puerperium.

Brown (1964) reviewed the literature on anxiety in pregnancy, and found scattered findings that related various diagnostic criteria (HOP [8], hyperemesis gravidarum [13] duration of labour) to various psychological variables ('stress' measured by interview, Manifest Anxiety [4], Maudsley Personality Inventory (Neuroticism Scale) [9], TAT [1], Sentence Completion and/or MMPI [10] scores, etc.). These data were collected throughout pregnancy and in the early post-partum period. There were no consistent detailed patterns, although researchers agreed or assumed that there was some sort of relationship between 'the course of pregnancy' and 'psychological factors'.

A sample of 148 white, married primigravidae attending an antenatal clinic and over 30 weeks pregnant were given a structured interview and a series of psychological measures (Manifest Anxiety Scale [4], Maudsley Neuroticism scale [9], MMPI Lie Scale) [10]. Brown (1964) found significant interrelationships among the psychological variables, but these had no significant relationship to the course of pregnancy. Other research reviewed by Brown (1964) had been retrospective with all the problems (e.g. retrospective rationalisation) of that method: this was a prospective study and the relationships found among the psychological variables were 'essentially contemporary' (i.e. they varied more or less simultaneously).

Cohen (1966) studied 750 pregnant women recruited via obstetricians and 'mental hygiene clinics'. Unfortunately, given the objective of the collection of normative data, it is quite likely that these data will be atypical or non-normative, in that women under obstetrician care may be wealthier and/or of poorer prognosis, and emotional or other problems are likely to be a predisposing factor in attendance at such clinics. The sample members were studied intensively, with weekly interviews from about 3-4 months antenatally to 3 months post-partum, with 'psychological

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[11] The puerperium is the immediate post-natal period.

[12] They describe some cultures where the basic cues are dealt with in ways even more insensitive than the obstetric care of urban industrial societies (Haire, 1972).

[13] Hyperemesis gravidarum is vomiting associated with pregnancy, typically in the morning during the early months.

examinations' at 6 months of pregnancy and 3 months post-partum. Husbands were also interviewed, which is unusual both in this and indeed the more general family sociology research literature.

She found that multiparae [14] had more pregnancy-related problems than primiparae. This seems to contradict an assumption of the crisis literature, in which the crisis is assumed (for reasons deriving from the sometimes implicit theoretical orientation of the researcher) to occur at the initial transition to parenthood. Brant (1972) indicates that clinical experience suggests that multigravidae can also experience problems and require somewhat different attention. Cohen (1966) distinguished five groups among the sample. The first group were mentally healthy according to the instruments and definitions used, and had no problems with their pregnancies. This group usually reported mostly harmonious childhoods, happy marriages, loving secure relationships with their mothers (but not necessarily their fathers), and were found to be 'mature', competent and free of 'conflicts about femininity' [15]. Whether in paid employment or not they were 'satisfactorily adjusted' to their situation. Cohen (1966) does not indicate the size of this group, but an inference may be made that it was of intermediate size. This group might well be comparable to those studied by Hooke and Marks (1962).

The members of the second group, a small one, were similar to this first group except that they were experiencing problems (typically, but not exclusively, physical) with their pregnancies. Given the small size of this group, its members may not have much influence on the characteristics of larger random samples in the research on the transition to parenthood, but might be more salient in non-random samples, depending on the nature of the sample's recruitment.

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[14] Parity refers to the number of live births to a woman: primiparae have not had a previous live birth, while multiparae have had one or more. Gravidity refers to the number of pregnancies a woman has had: primigravidae have not had a previous pregnancy, while multigravidae have had one or more. A woman may have a different parity and gravidity where she has experienced one or more pregnancies which have not resulted in a live outcome (i.e. she may be in the small multigravidic nulliparae group).

[15] One may perceive here the sort of implicit assumptions about the 'normal' female position of wife-mother to which feminist sociologists have more recently been drawing attention. As has been shown (see Bernard, 1973; Calvert, 1976; 1982; see also Novitz, 1978), the 'traditional' or 'conventional' (i.e. patriarchal) female wife-mother role is not necessarily 'normal' or 'healthy'.

The remaining three groups she distinguished were all found to have 'obvious neurotic difficulties' (remembering the sampling frame used, the size of these groups does not provide normative data). In the first of these groups, these difficulties did not worsen during pregnancy, which seemingly contradicts the assertion by Bibring (1959: 116) that pregnancy is by definition a time of crisis and stress for all women involved in it. The data in Cohen (1966) for this group suggest that serious trauma in childhood may predispose towards neurotic difficulties in adulthood and/or pregnancy, but that a 'good marriage' may provide some protection from stress and prevent deterioration.

A fourth group, unexpectedly and quite clearly contradicting Bibring (1959: 116), were found to have obvious neurotic difficulties which were alleviated during pregnancy. They reported both past and present trauma and/or problems, but pregnancy and the prospect of motherhood were intensely satisfying and dominant, and other aspects of their situation tended to fade in importance over time.

The last and largest group were those who were found to have obvious neurotic difficulties which worsened during pregnancy. These women were described as 'unhappy' and 'frustrated', came from conflictual childhood homes and had marital problems. They were described as having sharp 'identity problems', with the husband's problems being highly relevant to their difficulties. Given that pregnancy may be seen as involving inherent dependency needs, the women's modes of asking for behaviour to meet their needs (or failing to do so), and the men's modes of meeting their wives' needs (or failing to do so), were found to be crucial. This points to the importance of coping mechanisms, and may suggest ways in which the various possible coping behaviours in the developmental model of family system change (see section 3.2.4.3) are selected.

Grimm and Venet (1966) reviewed the literature on emotional and attitudinal variables and their relationship to the course and outcome of pregnancy. They agreed that psychological factors are expected by researchers to show an association with the maternity cycle, and that early psychological data similarly are expected to predict the course and outcome of pregnancy. However, the literature is contradictory. Five studies indicated that certain specific personal characteristics can be related to later symptoms of pregnancy and 'adjustment' to pregnancy, while another three studies related emotional variables to adjustment in labour. In contrast, six references indicated no relationship between psychological variables and the duration of labour or its complications, and a further four indicated some relationships only. Four studies indicated that antenatal personality measures are associated with post-partum 'adjustment' and attitudes to the infant, while seven references related the antenatal psychological state of the mother to the neonate's behaviour.

The methodological inadequacies of many of the studies cited in the literature review have been indicated. There are rarely adequate baseline data. Relationships between psychological and physiological variables are assumed and sought, and when they do not appear, the findings rather than the assumption are questioned. Alternative models of cause and effect are rarely explicated, although correlations do not tell us about the direction or directness of causal relationships. There are no large, prospective random sample studies drawn from normal obstetric populations, with extensive coverage of social and medical data, and long-term follow-up, all within an explicit theoretical orientation and conceptualisation. These would at least provide normative (statistical) data, and a comprehensive basis for systematic theorising. Of the many extant studies only a few (Stewart and Scott, 1953; Scott and Thomson, 1956; Grimm, 1961; McDonald *et alia*, 1963) meet at least some of the criteria. Grimm and Venet (1966) themselves conducted research which met some of these criteria. They developed a variety of measures of emotional and attitudinal variables, and tested their relationships to later repeat measures, plus maternal behaviour, physiological variables and the neonate's condition. While their methodology represented an improvement on much previous research, there were some aspects such as sampling which still did not entirely meet the authors' own stated standards.

The results of the above study (Grimm and Venet, 1966) were unclear. Some degree of relationship was found, broadly, between emotional/attitudinal factors in early pregnancy and reactions to the neonate later. No relationships were found between emotional and attitudinal factors and either the mother's or the neonate's physical condition. Despite their brave beginnings, Grimm and Venet (1966) conclude in terms quite similar to those of earlier researchers they themselves have criticised (an outcome the present writer perhaps is not in turn in a position to criticise unduly)! Thus, they point out that improved measurement of variables could show more relationships, which might be helpful (or might, in the absence of a theoretical framework, compound confusion). Parity, age and/or prior experiences could be confounding relationships among the variables measured, and thus a focus on primigravidae could clarify relationships. Finally, gross pathology is rare, and in the normal situation emotional factors could have little effect, hence an even larger sample could be required in order to study infrequent but revealing phenomena. However, large samples are not without problems, such as the tendency to equate statistical with substantive significance!

In a later review Grimm (1967) summarises and discusses six psychosocial factors which could influence women's attitudes and reactions to childbearing. Favourable previous attitudes to and experience of femininity and motherhood in the form of other 'female functions' (e.g. menstruation) correlate with favourable attitudes to pregnancy but coefficients of only around 0.3 to 0.4 are reported so other variables are likely to be involved. In turn, attitudes to pregnancy correlate

positively with emotional adjustment at labour and delivery, but not with the more objective duration of labour or complications of labour.

The expressed level of desire for the pregnancy under study is not often measured, but when it is, it is found to be significantly related to social class (positive), parity (negative), neurosis (negative), satisfaction with the husband (positive) and satisfaction with life in general (positive). The level of desire for this pregnancy is not related to labour and delivery variables (i.e. these may be regarded as of more or less independent origin). However, Grimm's review (1967) shows that there are significant associations in the literature with post-partum enthusiasm for the baby, relative lack of depression and greater warmth towards the baby.

Even if psychosomatic explanations are valid for most adverse physiological symptoms of pregnancy, some at least may have no psychogenic components (and this is supported by the cross-cultural findings in this area in Mead and Newton, 1965). It does appear that psychological health in early pregnancy is associated with good emotional adjustment during pregnancy, labour and the puerperium, but the correlations found are low to medium, and reversals of expected direction are not uncommon. The research results on personality and somatic symptoms are contradictory, as even the results of the methodologically better studies conflict on the psychological correlates of nausea/vomiting. Personality adjustment is not related to duration of labour or complications. Most psychosomatic studies are retrospective and thus cause and effect cannot be established, or even reliably inferred.

Parity is an obvious possible influence on attitudes and reactions to childbearing. Much of the psychosocial and sociological research is on primiparae, based on the assumption that the transition to parenthood at the birth of the first child is more threatening and disruptive than any further changes when there are later additions to the family. It is established (Clayton, 1972: 146) that first labour is very likely to be the longest, and may well be the most difficult (especially for physiological reasons, although length and difficulty vary between women). It has been assumed that the psychological process is analogous to the physiological process. It might well be argued that the opposite appears to be true.

Grimm and Venet (1966) found that multiparae had shorter labour durations but less desire for the pregnancy. They had the same somatic symptoms, more or less the same levels of emotional adjustment and post-partum depression, and similar patterns of post-partum adjustment. Cohen (1966) found that primiparae had better emotional adjustment than multiparae. Grimm (1967) reports other studies which confirm this pattern. It may thus be that for multiparae stress derives from such sources as:

- a) the assumption that they need less support (and hence they receive less help);
- b) the additional caretaking requirements of the present small children;
- c) a view of the mother role based on the experience of care and responsibility for young children; and so on.

These findings suggest that primiparae and multiparae should be studied separately in 'parenthood as crisis' studies, for their experience (including that which might be termed or interpreted as 'crisis') may differ in character and incidence.

The fifth area with which Grimm (1967) deals is that of the interpersonal field of significant others, the people who matter, for pregnant and parturient women. Adaptation to childbearing, they suggest, is a function of both interpersonal and intrapsychic phenomena. The significant others may, for example, include the woman's mother, husband or medical attendant. A good relationship with her mother (but not necessarily her father) is associated with good adjustment to childbearing. The relationship with the father of the baby is an important influence on adaptation to childbearing, and may be patterned on the woman's relationship to her mother. Cohen (1966) reported that marital adjustment was a key variable. Congruence of the woman's perception of her pregnancy role (as either healthy or sick) with her medical attendant's view was associated with shorter (under seven hours) labour. This suggests the power (to influence somatic processes) of the shared (social) construction of her pregnancy.

Finally, there are the broader social factors. Grimm (1967) found education, income and other social class variables to be positively associated with adaptation to childbearing. Gordon and Gordon (1957; 1959) found the cumulation of social stress factors (e.g. religious intermarriage, marital age differences, geographical mobility, lack of social supports) to be associated with post-partum personality disturbance.

Grimm (1967 : 148) concludes that:

'[How] well a woman adapts to her developmental task of childbearing is determined by a complex set of interacting elements - intrapsychic, interpersonal, social - from her past and present'.

There are a number of independent strands to each of these elements. Thus Grimm and Venet (1966) found seven largely independent attitudinal dimensions (only four significant intercorrelations out of a possible 21). Subsets of these attitudinal dimensions were found to be related to specific elements of later adaptation. These sorts of findings suggest that some of the contradictions in the literature may be resolved by the disaggregation of data.

Jarrah-Zadeh et alia (1969) with a mixed parity (56% primiparae), white, high status sample of 86 and a control group of 21 found that multiparae experienced significantly more antenatal and post-partum depression, were more labile post-partum and exhibited greater 'cognitive fogginess' post-partum compared with primiparae. This is not inconsistent with the comments on parity made by Grimm (1967) above.

Hanford (1968) attempted to link psychosocial and physiological aspects of pregnancy in terms of biochemistry. A model of psychosocial processes was set up, with the first trimester seen as a conflict of positive and negative factors, with cognitive dissonance (Festinger, 1957) operating in the second and early third trimesters to reduce conflict. It was suggested, based on a number of references, that in the late third trimester anxiety is reactivated. Further, where the conflict is severe, it was suggested, cognitive dissonance is inadequate, with psychological and somatic consequences.

Hanford (1968) presents an extensive review of data on corticosteroids, chorionic gonadotrophin, histamine and similar substances. The changing presence and balance of these substances in the pregnant woman's body is related to the psychological model. Hanford (1968) finds that there is a basis for his model, with specific findings that:

- a) the steroid/histamine balance controls spontaneous abortion, eclampsia (HOP syndrome - see [8] above) and hydatidiform mole (all somatic conditions); and
- b) it is a factor in duration of labour (which has somatic, psychological and social/cultural dimensions), completion of labour and perhaps intrauterine conditions and foetal health.

Given current research in biochemistry it is possible that the articulation of somatic and psychosocial processes will be facilitated by further similar research, but at present there are few clear psychological or social consequences of biochemical factors.

The somewhat more recent state of the literature is reviewed by McDonald (1968) who covers both single-topic and multiple-complication studies. The 92 references cover pseudocyesis [16] hyperemesis gravidarum, habitual (three consecutive) abortion, prolonged (more than 24 hours) labour, prematurity (birth weight under 2500 grammes) and the HOP syndrome [8]. Instruments used have been both general ones (e.g. Manifest Anxiety Scale [4], Rorschach [17], TAT [1], MMPI [10] etc.) and more specific ones (e.g. PARI [5],

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[16] Pseudocyesis is 'phantom pregnancy', when there are one or more apparent clinical indications but the woman is not in fact pregnant.

Pregnancy Research Questionnaire [18], Health In Pregnancy Questionnaire [19], MAPI (Blau Welkowitz and Cohen, 1964) and ZAR Pregnancy Attitude Scale [3] etc.).

The latter, more specific, measures were found to have enabled researchers to differentiate significantly between groups with 'normal' and 'complicated' parturition. While the content of these latter measures (PARI, PRQ, HIPQ, MAPI and ZARPAS) is specific to pregnancy there is clearly conceptual overlap with more general measures, and McDonald (1968) suggests that at either an explicit or implicit level these are all measures of anxiety. McDonald (1968) recognised the frequently mentioned methodological inadequacies of many studies, such as:

- a) use of selected cases;
- b) clinical population observations;
- c) small samples;
- d) lack of controls;
- e) retrospective data collection;
- f) inadequate provision of methodological details (e.g. of sampling methods);
- g) arbitrary timing of fieldwork.

However, he found general support in the literature for a positive relationship between psychological and physiological functioning in pregnancy, with consistent psychological differences between 'normal' and 'complicated' pregnancies. He suggested that the common denominators in the results are greater anxiety in complicated pregnancies, and less use of 'repression' (including avoidance) defences (cf. Chapter 3, Figure 5). McDonald (1968) realises that common denominators and correlations do not a causal relationship make, and confines his findings to a discussion of possible psychosomatic mechanisms.

In the pursuit of more detailed specification of psychosomatic mechanisms, Wolkind (1974) measured neuroticism by using somatic items from the Malaise Inventory [20] of the Cornell Medical Index and obtained pregnancy information

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[17] See Krech and Crutchfield (1958: 637). The Rorschach projective test ('ink-blot test') has been used or discussed in four studies cited in McDonald (1968: 224-6).

[18] See Clifford (1962), in which the Pregnancy Research Questionnaire is introduced and used.

[19] See Grimm and Venet (1966). The Health in Pregnancy Questionnaire is also used/discussed in Wolkind (1974).

using the Health In Pregnancy Questionnaire [19] (HIP) developed by Grimm and Venet (1966). Of the HIP items used, one group (typically those somatic items likely a priori to have physiological/anatomical aetiology) were found equally in 'neurotic' and 'non-neurotic' women, while a second group of five items was found in both but more in the 'neurotic' respondents, and a third group of six items was found in the 'neurotic' group but in less than 20% of the 'non-neurotic' group. A finding of two or more of these latter items was almost exclusive to the 'neurotic' group. The suggestion here is that somatic items, the 'minor symptoms of pregnancy', can be differentiated according to the likelihood of physiological or psychological aetiology, and that the latter are associated with low levels of adjustment to labour and the puerperium.

Graham (1977:81, 96-97) makes the important point that while recent years have seen both large-scale surveys and psychological investigations which seem to be exhaustive, in fact they are limited:

- a) firstly to either demographic predictions or psychoanalyses which have been shown to have their limitations (respectively, Cicourel, 1964; Grimm, 1967); and
- b) secondly by the basic assumption that in pregnancy and parturition women may be differentiated according to adjustment, anxiety, ill-health, post-partum maternal behaviour etc.

A further methodological criticism not often advanced in this field is that the use of quantitative methods with narrow focii prevent the flexible negotiation between researcher and respondents of the meanings and categories appropriate to the data, (cf. LaRossa, 1977).

Graham (1977: 83) points out that there is little concern in the literature for seeing conception and pregnancy as a

'unifying process in which women of differing social backgrounds and psychic constitutions are drawn together in a shared physiological experience'.

Research by Graham (1977) on a heterogeneous random sample of women (n=50, stratified into 25 primiparae and 25 multiparae) showed that there are important similarities in attitudes to conception and pregnancy which transcend differences.

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[20] See Rutter et alia (1970). The Malaise Inventory is also used/ discussed in Wolkind (1974) and in one study cited in McDonald (1968).

With regard to conception, 54% reported that the pregnancy was planned [21] but the validity of the distinction between planned and unplanned pregnancies was eroded by other qualitative data from semi-structured questions on the salience of motherhood. Thus, whereas a pregnancy in question may not have been planned it nevertheless took place within a context of personal significance for 'having a family', *i.e.* it was the specific timing that was unplanned. The process of impregnation was seen as unproblematic, straightforward, compared with the prevention of conception, except when a 'planned' (*i.e.* desired and appropriately-timed) pregnancy did not eventuate, in which case impregnation assumed the deliberate characteristics of contraception. Most important, this research (Graham, 1977) supports the suggestion put forward by Hass (1974) that the planned/ unplanned or even intended/unintended dichotomy is inadequate to handle respondents' frequent ambivalence about pregnancy and parenthood. The unanimity of partners on these issues and the long-term stability of intentions and priorities, are as yet assumptions, still to be established by empirical research. Changes over time, and conflicts (*cf.* LaRossa, 1977), could thus usefully be included in theoretical frameworks for transition research.

These three areas of similarity across a heterogeneous sample of pregnant women expose at least two research problems: distortions due to use of the planned/unplanned dichotomy, and the effect of responses about pregnancies being 'planned' swamping, or preventing the expression of, negative feelings.

Turning to pregnancy, the timing of Graham's (1977) interviews in relation to her respondents' pregnancy durations made it likely that experience would contaminate expectations data. Graham (1977) however finds the pattern of expectations presented by her respondents to be convincing. It is one in which the image of pregnancy is of minor discomforts and major compensations. This may be contrasted with the reality, tapped by a qualitative approach to the research, which revealed concern with 'secret complaints of an embarrassing nature' (90%), and medical complications (50%). This heterogeneous sample of women shared four concerns about the 'dynamics of pregnancy'; all of the women expressed at least two of these, while over 70% expressed all four:

- a) the first was concerned with the nature and management of the woman's body: uncertainties about beauty/ugliness, health/pathology, and sexuality;
- b) the second was concerned with the nature of the baby in utero: over 90% feared abnormalities due to lack of previous health care, genetic history, reproductive

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[21] There is an extensive demographic literature on this and related topics, but it is not intended to cover it in this review.

history and so on, while medical intervention, for example to prevent miscarriage, often enhanced fears (e.g. such miscarriages were seen as 'nature's way' of eliminating defects);

- c) the third area was the management of time: it passed slowly [22], these women found themselves increasingly future-oriented, and anxious to reach 'landmarks' in their biosocial progress; and
- d) finally, there were fears about labour and delivery, with differences of degree rather than differences of kind between primigravidae and multigravidae.

Graham (1977) draws a parallel between the reported characteristics of antenatal clinic staff (especially towards multiparae and single women) who were not 'tuned in' to worries and fended off tentative initiatives, and the assumption by social scientists studying pregnancy and parturition that they know what questions to ask, thus overlooking the attitudes and experience of the women themselves.

Stewart and Erickson (1977) review the sociology of pregnancy and parturition. The literature in this topic area is divided into fairly arbitrary areas:

- a) the transition to pregnancy;
- b) pregnancy;
- c) labour and delivery;
- d) the immediate post-partum period (week 1);
- e) post-partum weeks 2-6;
- f) post-partum weeks 7-52.

They quote two unpublished bibliographies which indicate that social science research on pregnancy has had five main themes:

- a) social problems (e.g. juvenile ex-nuptial pregnancy);
- b) socio-medical (e.g. antenatal care);
- c) personal 'adjustment' to pregnancy (e.g. psychiatric studies);
- d) social planning (e.g. fertility/fecundity studies); and

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[22] The concepts of chronological and social process time seem relevant to the understanding of this reported experience (see section 2.2.2.1).

e) cross-cultural research (e.g. ethnographies).

Sociologists' interests in this topic area have centred, they argue, on demography and deviance, with role analysis as their main analytical tool (see sections 2.2.2.2.1 to 2.2.2.2.13 and 3.7.1 to 3.7.19 inclusive). This approach has been used to specify and compare role entrance, role expectations, role relationships and role exit. How a woman comes to be pregnant (the social, rather than the biological, process), and hence some social and psychological consequences, are thought to vary according to whether conception is:

- a) deliberate (i.e. planned, chosen, wanted etc.);
- b) accidental (i.e. unplanned, unwanted prior to conception, perhaps covertly wanted etc.); or
- c) the result of coercion (which is not limited to rape).

There are cultural pressures (e.g. laws and public opinion making termination difficult) which make it likely that women will move through the pregnant role to the parturient and maternal roles. There is also the long-run physiological inevitability of conception, given fecundity and unprotected sexual intercourse.

The almost inevitable occurrence for women of entry to the pregnant role has been reduced by social structural and ideological changes which enhance choice (e.g. opportunities for paid employment, the women's movement), and by the wider availability of more effective contraception. The legitimacy attributed by participants and others to entrance into the pregnant role varies, they argue, according to marital status, timing of pregnancy with respect to marriage and age, and probably other variables such as economic characteristics. However, as Graham (1977) has pointed out, if too much is made of these differentiating factors the common experiences of pregnant and parturient women are overlooked.

Sociologists are now more familiar with the social construction of reality, including family realities (Berger and Luckman, 1971), but such realities may be overshadowed by the biological component of the pregnancy role. However, pregnancy and parturition are biosocial processes and the physiological processes/sequences are always and everywhere (Mead and Newton, 1965) interpreted and translated into social patterns, and these are empirically problematic. The acquisition of the pregnancy identity, Stewart and Erickson (1977) argue, is a key process (cf. the acquisition of the sickness identity in medical sociology research). Miller (1974) finds that this process of acquisition varies by degree of 'planning' of the pregnancy, and it could be that other variables are relevant. This process of acquisition of the 'pregnancy identity' or role may be clarified by the application of the idea of role-making (Olesen and Whittaker, 1967), in which the pregnant actor takes some active

initiatives as well as responding to the definitions of her role made by significant others. The model of fertility decision-making outlined by Hass (1974) offers a first step towards theorising about this process of pregnancy role entrance.

Stewart and Erickson (1977) suggest that role expectations in respect of pregnancy in western societies have some unusual or unique features. As Hass (1974) has also emphasised, pregnancy is a biosocial process, with a relatively short duration, overt physiological features, and the overwhelming probability of leading in turn to consequent roles (parturition, motherhood). In any one society (or subculture) there is relatively little opportunity for alternative paths, although great scope for variation in labelling of the infant, its location in the kinship structure and other such aspects (Young, 1977). The relatively short duration, Stewart and Erickson (1977) suggest, implies limited opportunities for learning the role, or correction of role-playing errors, and hence there is a likelihood of ambiguity, inconsistency, lack of clarity and disharmony. The overt characteristics bear similarities to sickness (and are handled by the same institutions that handle sickness) and yet there is also a cultural definition of pregnancy as natural, a peak experience for women, and this inconsistency can also give rise to lack of role clarity. The high probability of serial assumption of defined roles makes anticipatory socialisation highly appropriate, but (in whatever form) this is not by any means widely or uniformly available.

According to Stewart and Erickson (1977), the quite common pattern of cohort movement through role transitions (e.g. educational institutions, paid employment, even marriage) is less prevalent with the pregnancy role. This is because the timing is uncoordinated and the role duration is short so that small differences in timing lead to isolation from others and hence a pregnancy subculture is unlikely, although other researchers (Hubert, 1974) have not made this assumption and have - interestingly - found evidence to the contrary.

Role exit (i.e. labour and delivery) is largely biologically programmed in timing, although the option of termination of the pregnancy has been available (but variable both through time and across socioeconomic strata). Rosen and Martindale (1976) in research on 'problem pregnancies' found that mode of role entry (e.g. contraceptive 'failure') and type of role expectations (e.g. non-acceptance of the more traditional female role) were associated with mode of role exit (e.g. termination of the pregnancy). While this particular pattern is not surprising, it illustrates the heuristic value of these role concepts.

The bulk of the empirical research on labour and delivery has been either ethnographic accounts of childbirth in both urban industrial societies (Kitzinger, 1967; Oakley, 1979a; 1979b; 1980; Cartwright, 1979) or non-western cultures

(Mead and Newton, 1965; Hart *et alia*, 1965), or more polemical reviews (Haire, 1972; Walton, 1976). Some aspects of labour and delivery are included in studies spanning pregnancy and the puerperium, typically duration of labour. In most of these studies little relationship is found between most antenatal variables and most aspects of labour and delivery. There has been some attention to post-partum consequences of obstetric intervention (Haire, 1972) and a debate over the medical, social and psychological grounds of obstetric intervention in childbirth (including the psychology of obstetricians).

Stewart and Erickson (1977) point out that descriptions, remembered experiences and evaluations of labour and delivery vary greatly (Oakley, 1979a, titles her chapter on labour and delivery 'The agony and the ecstasy'). Role entry usually coincides with institutionalisation in most western societies, and a comparison may be made with the description by Goffman (1971) of the hospitalisation of the mentally ill, where frequently the patient co-operates in his/her capture in the pre-patient stage and then comes to feel angry and humiliated. Such factors as ignorance, anxiety, fear, power differentials, impression-management and coercion reinforce the sickness syndrome, ensuring that the participant is truly in horizontal orbit (Taylor, 1970). As the people concerned are all women their prior socialisation in obedience, deference, guilt and shame may be found to facilitate role entry according to the criteria and requirements of the professionals involved.

Role expectations can be summarised in terms of objectification (the health professional has a special use of language [23] to reinforce this process), compliance and so forth. Thus, role relationships are congruent with these expectations, being highly asymmetrical, differentiated along a power dimension, and characterised by one-way communication and action. Role exit is involuntary, unavoidable, fraught and not really under the control of the central participant. All in all, according to Stewart and Erickson (1977), the role characteristics of labour and delivery are unusual and a priori likely to generate role strain (but see Young, 1977, for a different perspective).

### 1.3 Empirical Studies Of Parenthood

Early references, based on social casework, refer extensively to the possibly disruptive or destructive effects of parenthood (or childrearing, or children) on marital relationships. Illustrative examples of such references

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[23] Examples of this language would be 'The pph in Room 3 ...' or 'The septic perineum over there ...'; cf. the special use of personal pronouns etc. such as 'we', 'us' and 'our', as in (nurse speaking to 'patient') 'It's time for us to have our shower'.

would include Mudd (1953), who reported how children almost wrecked her marriage, and Mace (1958), who drew on his experience in marriage counselling to ask whether a baby can break up a marriage, and answered that it can, or at least it can seem to do so, but need not [24] The first publication based on social research (albeit with a number of theoretical and methodological imperfections) was the widely-reprinted research report by LeMasters (1957), who first used the phrase 'parenthood as crisis'. Based on a symbolic interaction conceptual framework [25] which predisposed the researcher to find 'crisis' (i.e. define what he found as 'crisis') this research (LeMasters, 1957) on white urban middle-class couples with pre-school children showed that 83% of the 46 couples agreed with the researcher's assessment that they had experienced 'extensive' or 'severe' crisis. Given that their pregnancies were 'planned' or 'desired', that their marriages were 'good' and their personalities were rated 'average or better' [26], LeMasters (1957) attributed the crisis he described as experienced by most of them to 'romanticisation' of parenthood and little preparation for it.

Dyer (1963) reported a general replication of LeMasters (1957), with a somewhat improved methodology, the results of which Dyer (1963) interpreted as being consistent with the earlier findings by LeMasters (1957). However two years later Hobbs (1965) published the first of what was to be a series of studies which contradicted LeMasters (1957) and Dyer (1963). The first of these (Hobbs, 1965) was based on a random sample of white urban couples who had recently experienced their first birth, and used a checklist derived by Hobbs from both the earlier research by LeMasters (1957) and the more popular reports by Mudd (1953) and Mace (1958). In this study Hobbs (1965) found that both new mothers and new fathers typically reported being 'bothered' either 'not at all' or only 'somewhat' by various problems of parenthood suggested by Hobbs, with the new mothers scoring

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[24] With the benefit of hindsight, this synopsis of the views expressed by Mace (1958) may be seen as summarising a great deal of the later material on the transition to parenthood, and representing a very reasonable conclusion to be drawn from that material!

[25] The research by LeMasters (1957) was conducted several years before the first publication (Hill, Katz and Simpson, 1957) to set out some of the conceptual frameworks 'discovered' in family sociology research. However, the symbolic interaction approach was relatively well understood in sociology more generally, and it is clear that this was the conceptual framework used by LeMasters (1957).

[26] These brief global ratings by the researcher may be criticised both in terms of the dichotomies they imply and in terms of their susceptibility to perhaps unconscious bias on the part of the researcher.

significantly higher (i.e. more problems) than their husbands.

The differences between the earlier research (LeMasters, 1957; Dyer, 1963) and the later research (beginning with Hobbs, 1965) appeared at the time to be most appropriately attributable to methodological differences (e.g. between the global assessment of an interview and the use of a checklist, and/or between convenient or purposive sampling and random sampling). However in later reviews (see Jacoby, 1969) the differences were attributed to other variables such as social class. From the perspective of the present work more influence would be attributed to general (pervasive) theoretical orientation, perhaps in association with the tenor of those earlier more popular reports (e.g. Mudd, 1953; Mace, 1958), and conceptualisation.

The bulk of the substantive literature is based on research in the United States of America. However the next study to appear, by Goshen-Gottstein (1966), was concerned with the cultural influences on attitudes to marriage and first pregnancy of three subsamples of Israeli women whose childhood had been spent in, respectively, the Near East, western Europe or Israel itself. Briefly, she found that the members of her sample could be characterised on a traditional-modern continuum, with an intermediate group. If anything it was the traditional group who experienced more problems in becoming mothers than either the intermediate or modern groups. This traditional group were:

- a) accepting of their place in a patriarchal family;
- b) passive and believing in luck rather than planning;
- c) had negative expectations of their husbands;
- d) lacked conjugal communication;
- e) were home-centred; and
- f) regarded their children as the raison d'être of their life.

Goshen-Gottstein (1966: 120) concluded that:

'understanding of the psychological make-up [through TAT - see [10] below - and intelligence tests] and attitudes of the expectant mother may be increased if it is based on extensive information concerning her marriage background and immediate environment'.

The significance of this comment by Goshen-Gottstein is in its implicit criticism of much of the literature on the transition to parenthood. It is largely focused on the immediate transition, and lacks both wider background coverage and temporal extent (see Chapter 4).

Meyerowitz and Feldman (1966) report data from a large-scale 'short-term longitudinal' study covering the late pregnancy and early post-partum experiences of 400 primiparae. The study was prompted by an earlier unpublished study (see Feldman, 1961) which supported the findings from LeMasters (1957) and Dyer (1963). Meyerowitz and Feldman (1966: 84) reported a changing pattern of

'communication failures and experiential dis-synchronizations called "the first-child crisis"'.

A decade after LeMasters' (1957) research the first serious effort to set his and others' findings of crisis in a broader and somewhat more theoretical framework was published. In effect Meyerowitz and Feldman (1966: 84) are suggesting that first parenthood is a point in the family career at which there are likely to be communication failures, associated with discrepancies in the perceptions of the situation between the spouses (cf. Bernard, 1973, on 'his' and 'her' marriage), and a lack of synchronisation between expectations and experience, or skills and experience (both between the new parents, and within their own personal histories to date). This situation may succinctly, but not especially helpfully, be termed 'a crisis' according to Meyerowitz and Feldman (1966).

One of the disappointing features of family sociology (and other subdisciplines of sociology no doubt) is the lack of cumulation of research and theoretical writing. Thus the basic point made by Meyerowitz and Feldman (1966) - that 'crisis' was an unhelpful concept, and that what was interpreted as crisis could, more usefully, be understood in more general theoretical terms - was not taken up by later researchers.

In the earliest of half-a-dozen unpublished studies, all conducted for higher degrees (and thus somewhat small scale) Beauchamp (1968; reported in Russell, 1974 and in Hobbs and Cole, 1976: 724) conducted a comparison of the semi-structured interview used by LeMasters (1957) with the checklist used by Hobbs (1965) and obtained almost identical results for the two methods, with three-quarters of both groups reporting 'no' crisis or 'moderate' crisis and the remainder equally divided between 'extensive' and 'severe' crisis.

The sample in this study (Beauchamp, 1968) were married college students with one or more pre-school children. While methodological limitations are understandable in small-scale research for higher degrees, nevertheless it must be considered whether the limited nature of the sample in such research may not undermine any wider utility of the results. Unfortunately, this is not always fully considered in evaluation and subsequent citation of such small-scale research.

In the same year Hobbs (1968) reported a replication and extension of his earlier (Hobbs, 1965) study. This also compared the interview (LeMasters, 1957) and checklist (Hobbs, 1965) methods, as well as comparing the checklist results from the present and earlier studies. The checklists produced virtually identical results, with comparable samples, in both studies (Hobbs, 1965; 1968). The interview method produced similar results to the checklists, with a modal position of 'slight' crisis for new fathers and 'moderate' crisis for new mothers, with 18.5% of the latter reporting 'extensive' or 'severe' crisis. The research by Hobbs (1965; 1968) used random samples of white urban couples.

With this replication and extension it becomes clearer that something is being consistently measured; the (theoretical) question of what it is that is being measured remains, and indeed becomes more important.

Using a sample of university student couples and a modified checklist (in another higher degree study) Uhlenberg (1970; reported in Hobbs and Cole, 1976) found that 98% of the husbands and 93% of the wives experienced [27] 'some' critical problems in the transition to parenthood, which findings were interpreted as essentially supporting Hobbs (1965; 1968).

The data reported by Meyerowitz and Feldman (1966) above on the transition to parenthood were part of a larger study of marital satisfaction over the life cycle (Rollins and Feldman, 1970). The latter, and its later re-evaluation (Rollins and Cannon, 1974), can be used to place the results reported in the substantive literature on the transition to parenthood in the family career context. Rollins and Feldman (1970: 20-22) summarised twelve studies published between 1929 and 1968 [28] as strongly suggesting that marital satisfaction is lowest in later stages of the family life cycle. Only one of these studies showed satisfaction lowest at the childbearing stage of an eight-stage [29] pattern (Duvall, 1967: 9 for the stages; Burgess and Cottrell, 1939, for the - dated - findings), and that study only

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[27] It would perhaps be more exact if the secondary sources for this unpublished research used phrasing such as 'were interpreted as reporting 'some' critical problems ...'. It must be emphasised that the general point made by Meyerowitz and Feldman (1966) above is an important one, applicable to much of the literature in this topic.

[28] As with the parenthood research, the long timespan raises the possibility of macrosocial, ideological (Novitz, 1978) and/or institutional changes influencing the general trend of the results through time. While institutional and other macrosocial change was excluded from the present research under the ceteris paribus rubric, their possible influence should be remembered.

covered the first three stages [29]. Although the findings from other studies are not entirely consistent, it appears that the stages from 'later schoolage' through 'teenage children' and 'launching' are lowest in marital satisfaction (Rollins and Feldman, 1970: 21).

This is not simply a quibble about findings, but raises an important methodological point. The original research (LeMasters, 1957) was primarily concerned with testing some theoretical ideas from the symbolic interaction conceptual framework. These were that adding a new member to a social system in equilibrium would destabilise it and cause a 'crisis'. New parenthood was chosen as the empirical test. The results were interpreted as consistent with the theoretical prediction. However, there was no comparison of these results with the various studies of marital satisfaction and satisfaction with various stages of the family life cycle (family career). This may have been because the focus of interest was on the symbolic interaction conceptual framework rather than on the substantive topic of satisfaction at a transition point in the family career per se. These family career/life cycle studies are summarised in Rollins and Feldman (1970: 21) and Rollins and Cannon (1974). These data offer some sort of benchmark for the purpose of establishing whether the degree of 'crisis' observed may reasonably be described as high from the changed perspective of interest primarily in new/first parenthood (compared with LeMasters' (1957) primary interest in finding a substantive area - he happened to choose new/first parenthood - in which to test theoretical ideas).

It is thus inappropriate to take the substantive results from LeMasters (1957) and others without explicitly considering their theoretical and conceptual foundations, and hence not discuss the ways in which the theoretical orientation may shape the findings. Thus a consequence of the lack of theoretical sophistication in the discipline is that findings (such as 'parenthood as crisis') acquire an unqualified momentum. Different later results are seen as empirical contradictions (and perhaps as more methodologically sound) rather than as derived from different theoretical orientations and/or conceptual frameworks.

The later re-evaluation based on more extensive coverage of the family career (Rollins and Cannon, 1974; see also Kirkpatrick, 1978), with methodological improvements, suggests a shallow W-shaped curve for satisfaction by categories of the family career, with the categories characterised as 'pre-school' and 'teenage children' lowest in satisfaction, especially for marital satisfaction. Satisfaction for those in the second category, just after the

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[29] It should be remembered that sets of family career categories (life cycle stages) are arbitrary; the eight stages here are only one of a number of ways of dividing up the family career.

transition to parenthood, is lower than for those in the first category (i.e. newly married), but later categories show still lower levels. However, as Rollins and Cannon (1974: 280) point out, the variation from one category to another, while clear, is not great, and only 8% of the variation in marital satisfaction for example is attributable to family career category. These findings make it necessary to treat the parenthood as crisis research with some caution. Rollins and Cannon (1974) also suggest a theory of role strain (see Burr, 1973: 129-133 for a discussion of this concept in relation to role transition) to account for their findings, making this one of the few items in the literature which has an explicit theoretical content.

This use of the concept of 'role strain' (see section 3.2.5.12 below) illustrates the choice of explanation rather than prediction as the researcher's goal (see section 1.4.4 above), the same choice as has been made in the present research.

A study by Geismar (1973) discussed below illustrates the use of variables such as social class and ethnicity to predict 'the level of family functioning', although as the discussion below is intended to illustrate, theoretical explanation (e.g. of the origins of behaviour and attributes) may not be avoidable even in statistical prediction studies.

Feldman (1971: 121) brings together published and unpublished data from his own research to conclude that:

'In general, the finding by LeMasters [1957] that parenthood is a crisis seems to be substantiated'.

This contrasts with the earlier inference in Meyerowitz and Feldman (1966: 84) that the polysyllabic phrase 'communication failures and experiential dis-synchronizations' is a more useful account of what these studies have been measuring than the term 'crisis'! The reasons for the change of view are not clear.

Geismar (1973) reported a substantial social psychological study of young families in transition, focused on the measurement of family functioning among the under-privileged. He concluded that young, urban, American families [30] were functioning 'fairly well', though social handicaps reduced the level of functioning (but not critically) both before and after the transition to parenthood.

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[30] This conclusion holds for young, urban American families only to the extent that Newark, New Jersey is a suitable special or working universe (Sjoberg and Nett, 1968). Geismar (1973) does point out that his findings may be specific to that special or working universe (Newark, New Jersey) and not necessarily generalisable. This methodological caution is not noticeably widespread in the substantive literature on the transition to parenthood.

Social class and ethnicity were found to be significant variables for predicting [31] the resources (broadly defined) with which couples began the transition to parenthood. The origins of both behaviour and attitudes were attributed to social characteristics rather than subculture. There was clear evidence of intergenerational continuity in family functioning (which subsumes the cycle of deprivation). Where present, intergenerational family stability plus extensive kin ties were found to protect against otherwise disturbing events such as ex-nuptial conception and birth, economic deprivation and deterioration of the urban environment. This research is thus consistent with the view that first parenthood is not usually a crisis, even under disadvantageous conditions.

Russell (1974) introduced the dimension of the pleasures of parenthood into studies of new/first parents, an important correction to the previous (and as it turned out, continuing) focus on problems, 'crisis' and similar negative aspects. Her study also used the Hobbs checklist (Hobbs, 1965; 1968), on a random sample of urban couples, and obtained scores 'virtually identical' to Hobbs, although differences in reporting initially obscured this (see Hobbs and Cole, 1976: 724n). Russell (1974) found that the first year of parenthood could only be described as moderately stressful, and included plenty of rewards.

In the same year Tooke (1974) and Bogdanoff (1974) completed studies for higher degrees which explored various aspects of the topic. Tooke studied 50 couples in a Montana state economic development programme and found (Tooke, 1974, reported in Hobbs and Cole, 1976: 725) that:

'the [subjects] ... reported significantly more difficulty with the first child than did subjects in Hobbs' studies [1965; 1968]'.

Bogdanoff (reported in Hobbs and Cole, 1976: 725) compared matched groups with and without Lamaze preparation for childbirth [32] and a parent support group, and found no statistically significant differences between the two groups. In both cases their scores on the Hobbs checklist were very similar to those of Hobbs (1965; 1968) and Russell (1974).

Cole (1974) also conducted a replication of Hobb's earlier research (1965), reported by Hobbs and Cole (1976). The decade replication of the random urban sample found 68.4% of

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[31] The distinction between prediction and explanation discussed above (section 1.4.4) should be remembered here.

[32] Lamaze preparation for childbirth is one of a number of approaches within the general 'natural childbirth' movement, involving breathing exercises and deliberate relaxation; it was relatively widely available in the United States of America in the 1970s. See Walton (1976: 17-18).

the couples experiencing 'slight' crisis compared with 86.8% a decade before, with 22.3% 'moderate' as compared with 13.2% previously. The later research showed a slightly flatter distribution over the five categories. When a middle class subsample was examined, Hobbs and Cole (1976) found even less evidence of crisis, which contradicts the general comparison of random and middle class samples which suggests that the latter report greater crisis. The weak long-term trend towards lower levels of crisis over the whole quarter-century of the literature is also contradicted by this decade replication. Again, attention could usefully be devoted to general theoretical orientation and conceptualisation, as well as to methodological and other aspects which could mediate their influence on the interpretation of results.

Some of the earlier studies (Hobbs, 1968; Uhlenberg, 1970; Russell, 1974; Bogdanoff, 1974) presented some separate data for husbands and wives, but Wentz and Crockerberg (1976) paid specific attention to the transition to fatherhood, examining Lamaze childbirth training, difficulty in adjusting to parenthood, and marital relationship characteristics. In a small-scale study, yielding somewhat inconclusive results on some aspects, they found (Wentz and Crockerberg 1976: 356) that :

'the majority of fathers in the study report only minimal to moderate difficulty in making the transition to fatherhood [although they] feel a need for information'.

In an interesting change from the usual pattern of research, Titus (1976) used family photographs to study aspects of the transition to parenthood. She found that for the transition period, when the first child was up to three months old (*cf.* Caplan, 1960b, for a rationale for this period), there were - compared with later - significantly more photographs of both mother and father in caretaker roles. This was interpreted as suggesting that there was a higher initial level of role learning. There were significantly more photographs of the child alone, interpreted as suggesting a parental focus of the stimulus to learn new role behaviours. Titus (1976: 529) further suggests that these family photographs may provide feedback for self-criticism and greater self-awareness, providing 'a mirror for what one is becoming' (Cooley, 1902: 152 quoted in Titus, 1976: 529).

Alternatively, we might speculate that these photographs may be evidence of transition procedures or rituals (*cf.* Burr, 1973: 138-9), which facilitate separation from old behaviours, transition, and then commitment to new behaviours (Van Gennep, 1960: 11). These peritransitional photographs were distributed extensively to significant others. This supports the notion of a ritual used to reinforce commitment to the new parental roles. Although emphatically an exploratory study, Titus (1976) has shown that non-reactive or unobtrusive research methods (Webb *et alia*, 1966) can be valuable in a multimethod strategy for validation of results from more conventional methods.

Gilman and Knox (1976) have sought to explain some of the inconsistencies in findings from the earlier research (viz. LeMasters, 1957; Dyer, 1963; Feldman, 1971 etc. 'versus' Hobbs, 1965; Hobbs, 1968; Russell, 1974; Hobbs and Cole, 1976 etc.). They suggest an examination of 'coping mechanisms' (see section 3.2.4.3) may account for these discrepancies, and implicitly (Gilman and Knox, 1976: 135) distinguish between husbands' coping mechanisms with negative consequences for the marital relationship ('offices, alcohol and/or other women') and other coping mechanisms which may be more positive ('fantasy ... and holidays'). The term 'coping mechanisms' could be used in the conceptualisation of social processes which reduce 'crisis', but in Gilman and Knox (1976) it is little more than a collective noun for the rather varied behaviours and distractions listed.

The hypothesis is that fantasy, remembering pleasures of the past, before the transition to parenthood, contributes to recognition that the 'crying baby days' will soon be over (i.e. that the duration of the most demanding phase of parental roles is finite and even fairly short: cf. Burr, 1973: 137). The other hypothesis is that holidays, or rather couple-focused activities away from the home, make the couple relationship and its gratifications more salient as a counter to the demands of the parental role.

Gilman and Knox (1976: 137-145) found that, as measured by the frequency of pre-transition fantasies, a sample of first-time fathers experienced:

'Less frequent crisis than reported by LeMasters [1957] and Dyer [1963] but more crisis than reported by Hobbs [1968]. The frequency of crisis experienced here is more in line with that reported by Russell [1974]'.

However there was a strong negative relationship between fantasy and marital happiness: the more fantasy, the greater the unhappiness. This might be interpreted to suggest that the fantasy content may be regarded as a reference group or standard (cf. Runciman, 1966).

It is further argued by Gilman and Knox (1976) that the finding of a strong positive association between holidays (as defined above) and marital happiness indicates that such outings are a coping mechanism, i.e. that the marital happiness is the dependent variable. As with fantasy, there is in fact no evidence of the direction of the causal relationship (i.e. perhaps happy couples go out more). Perhaps causal direction cannot finally be determined, and the most useful approach is to report the empirical association and theorise about the most satisfactory explanation(s)? This analytical weakness is illustrated by the reporting of a relationship between 'not specifically wanting a son' and these outings. These researchers seem to have reported all statistically significant findings without scrutiny, an unhappy example of the 'prediction' approach. The suggestion of a focus on coping mechanisms is a useful

one, however, and the research by Gilman and Knox (1976) leaves the topic open for further conceptualisation and investigation.

Hobbs and Wimbish (1977) report further data replicating earlier research by Hobbs (1965; 1968; Hobbs and Cole, 1976), on a sample of black couples. These black couples were found to have somewhat higher scores on the Hobbs Checklist than those found in earlier studies of white couples, with a similar difference between women and men, and some differences in the pattern of variables associated with ease or otherwise of transition. The earlier research by Geismar (1973) suggests caution in associating ethnicity with variation in extent of crisis.

The influence of theoretical orientation upon the determination of which data are isolated and presented in social research is clear when LeMasters (1957) is contrasted with LaRossa (1977). Of course it is difficult to determine the orientation with which a researcher originally entered a domain of inquiry. However LeMasters (1957: 352) began his report by stating that basic equilibrium or homeostasis assumptions of the symbolic interaction conceptual framework led him to look for disequilibrium, or 'crisis', when a third member was added to the marital dyad. LaRossa (1977: 29) notes that:

'the conflict approach to social life has a long tradition [but] .. nevertheless the idea that marriage is a conflict system does contradict the popular conceptions'.

He suggests however (*ibid.*) that his conflict model of transition to parenthood, and marriage in general, emerged from his data:

'What I have learned from the case studies as well as the total sample .. [a]fter reading and rereading the sixteen hundred pages of transcripts and trying to synthesise them into some coherent framework ... [is] that marriage in general and marriage during first pregnancy in particular are best understood from a conflict perspective. In other words, rather than conceptualizing marriage as a consensus-equilibrium relationship, the conjugal dyad is best viewed as a system in which confrontation ("conflicts of interest") is inevitable and agreement problematic (Sprey, 1969: 702)' (LaRossa, 1977: 29 emphasis added).

In this conflict approach the focus is on actors in any social system primarily working to further their own interests, pursuing their own goals with confrontation likely and consensus possible but not inevitable. Sprey (1969) has discussed the reasons why families and marriages are often arenas for conflict, and has suggested (Sprey, 1971) how this conflict may satisfactorily be managed. This discussion is elaborated later, when conflict is included in the model of

developmental change in family systems (see Chapter 3 especially section 3.2.5.13).

The work of LaRossa (1977), Rollins and Feldman (1970) and Rollins and Cannon (1974), provides alternative perspectives for making sense of the empirical data on the transition to parenthood. The former (LaRossa, 1977) shows that evidence of conflict is not necessarily evidence of crisis: conflict can be inherent, capably managed, and non-disruptive. The latter showed that any crisis (or dissatisfaction, unhappiness, etc.) experienced at the point of the transition to parenthood is likely to be exceeded at later points in the family career; this places the stress or 'crisis' experienced at the transition to parenthood in context, and places in sharp focus the influence of conceptual framework on the interpretation of data relating to stress or 'crisis' at that time.

The differences in most of the substantive literature as to whether first parenthood is a crisis (LeMasters, 1957; Dyer, 1963; Wainwright, 1966; Feldman, 1971; etc.) or a critical transition (Hobbs, 1965; Hobbs, 1968; Russell, 1974; Hobbs and Cole, 1976; etc.) are differences of interpretation; such differences may have a substantial portion of their origins in the theoretical orientation and conceptual framework of the researcher concerned.

LaRossa (1977), Rollins and Feldman (1970) and Rollins and Cannon (1974) illustrate how a different initial point of view, assumptions or expectations (cf. LeMasters, 1957) can lead to findings which are different in kind from those of most equilibrium-oriented researchers, especially those of the 1950s and 1960s. This underlines the relevance of the epistemological critique, to which reference is made in the present thesis (see Chapters 1 and 11).

Most recently Kirkpatrick (1978) has presented a 'structural' model of adjustment to parenthood, based on empirical research, which more closely approximates the game trees of Magrabi and Marshall (1965) and to some extent the model of developmental change in family systems presented in Chapter 3. She reviewed the research to date and devised a model to account for adjustment to parenthood which included attitudinal, social and biosocial variables.

The attitude variables were: attitudes to childbearing, attitudes specifically to pregnancy and 'conceptions' of (i.e. ideas about) infants. The social variables were education, present income, pre-pregnancy income of the woman, preparation for parenthood, marital adjustment and income at the time of the first birth. The biosocial variables were age at childbirth and duration of marriage prior to childbirth.

These were arranged in a game tree (Magrabi and Marshall, 1965). Paths between these variables were hypothesised (Kirkpatrick, 1978: 58, Figure 1A), for example education was hypothesised to influence present income, attitudes to

childbearing, wife's pre-pregnancy income, and wife's age at first birth. A total of seventeen relationships through eleven variables (arranged in five stages) were thus hypothesised to account statistically for variation in adjustment to parenthood as measured.

Using a random sample, but with a low ('about 25%') response rate, satisfactory instrumentation and the appropriate statistical routines, the hypothesised model was evaluated. One solution which accounted for 26% of the variance in the dependent variable (adjustment to parenthood or lack of crisis) involved seven significant path coefficients. The wife's education influenced childbearing attitudes (but these in turn had little influence), pre-pregnancy income and age at first birth. The latter two in turn influenced attitudes to pregnancy, which in turn influenced 'conceptions' of infants, which finally influenced adjustment to parenthood, the dependent variable. It should be noted that a simpler model accounted for almost as much of the variance (21%; see also Rollins and Cannon, 1974: 280): attitudes to pregnancy influenced marital adjustment and 'conceptions' of infants; these influenced adjustment to parenthood.

Kirkpatrick's (1978) modeling study was validated by a later replication (with one exception) and she concluded that attitude variables are important in respect of adjustment to parenthood. She pointed out that there may well be other relevant variables, the inclusion of which could modify the relationships of the variables in her research. Also of interest, albeit not so directly relevant to the present research, is her finding that adjustments required with second and subsequent births appear (this may be the mot juste) to be not less difficult than those at the initial transition. This may be regarded as a further contribution to putting the extant transition to parenthood research literature in perspective.

Rapoport, Rapoport and Strelitz (1977) share the objective of placing parenthood ('mothers, fathers and others') in perspective. They do so comprehensively. They begin with a chapter titled 'Parents are people too' which is a selective review of research on parents, widely gathered, and integrated. This process of integration requires an explicit statement of the authors' positions, on their contexts of study, assumptions, values and presentation of their material. They note (cf. Group for the Advancement of Psychiatry, 19) that the culturally predominant perspective has changed from the patriarchal Victorian ideology to the contemporary child-centred, mother-focussed, expert-guided ideology. They claim an intermediate position, in which they consider both parents and children. They also sought to integrate historical and cross-cultural material, which 'gives perspective' and provides a checklist of the range of variability in family forms and processes.

The concept of 'needs' is redefined as:

- a) preoccupations (intrinsic concerns, variable by family career phase, overt or not, yielding meaningful interests);
- b) needs (felt by the individual, ie s/he may have preoccupation but not felt as a need); and
- c) requirements (formulations/assessments by experts, not necessarily felt).

The authors also state their assumptions and values:

- a) parents are people, have needs etc;
- b) satisfactory family life requires appropriate skills, knowledge etc;
- c) parenthood can be a developmental stage for parents too;
- d) according to the configuration of home, work (paid employment) and school, parents' and childrens' needs may be met and harmonised, or unequally satisfied and conflicting;
- e) the place of parenthood in peoples' lives is being re-evaluated towards a balance of fulfilment within families, and between family and other activities;
- f) the needs of parents and children are not co-terminous: they coincide or they conflict, and thus negotiation and compromise are major family tasks;
- g) family structure and culture vary, and thus parenthood varies legitimately, but the social participation patterns of parents and family members is some safeguard against the abuse (especially but not only of children) which can occur as an extreme variation;
- h) parenting is diverse, and peoples' resources etc. are diverse, so that role allocation needs to be flexible (i.e. men can do almost everything);
- i) this flexibility maximises the extent to which family members' needs will be met;
- j) the exclusive parental responsibility of the biological parents is unnecessary, unusual (historically and cross-culturally) and not in best interests of children, their parents or the wider society;
- k) parenting is only one role among the many making up the adult's role complex in urban industrial societies, and hence a total emphasis on one role (e.g. the mother role) will lead to depression, conflict etc;

- l) there is no single 'formula' for parenting, no simple cause-effect relationship of childrearing and outcome, families vary among members and over time;
- m) some parenting (e.g. skills) can be learned;
- n) parenting is a learning opportunity;
- o) parenting creates as well as restricts opportunities;
- p) reciprocity is the key: mutual influence, balance, harmony, communication, learning and negotiation.

One of the components of a conceptual framework identified by Nye and Berardo (editors, 1966) is the assumptions and values which underlie the framework. The position statement by Rapoport, Rapoport and Strelitz (1977) is an excellent starting point for making explicit the assumptions which underlie the model of developmental change in families presented in the present work (Chapter 3). With appropriate reworking, many of these assumptions and values can be related to transitions between family career categories, and sources of change in families, more generally.

Rapoport, Rapoport and Strelitz (1977) argue that parenthood is a process of continuous change plus critical learning points or 'transitions'. This is very close to the view of the transition to parenthood presented in the present work.

They discuss social expectations of parenting in terms of the experts' ten dominant conceptions (cf. Swain, 1975), and their summary is that:

'[In the period after 1945 there was ... an authoritative set of formulations ... that idealised a conception of the nuclear conjugal family, with relatively standardised composition, division of labour and lifecycle timetable ... with its expectations that "normal", "mature" men will be economic providers, "normal", "mature" women will be housewives and mothers ...]' (Rapoport, Rapoport and Strelitz, 1977: 87).

'In the current decade [1970s] this model of family life has been increasingly questioned within each of the disciplines [social sciences, psychoanalysis, medicine, social work, law, education etc.]. The contemporary predicament of the family - for parents as well as the authorities who seek to guide them - involves searching for new models' (ibid.)

The authors also review the diversity of modern parental situations: divorce, childlessness (i.e. would-be parents), adoption, fostering, single parenthood, communes and experimental situations, dual career families, stepfamilies, and families with handicapped children. This underlines the importance (Rodgers, 1973: Chapter 8) of developing

conceptual frameworks and research designs which can be used to investigate these many variations from the breadwinner/caretaker nuclear family.

On the more specific topic of the transition to parenthood, Rapoport, Rapoport and Strelitz (1977: Chapter 4) reflect the earlier research. They follow LeMasters (1957) in commenting that the 'mystique' and 'romanticisation' of parenthood obscure its costs. They report that marital satisfaction declines with first parenthood, the 'parenthood as crisis' view, quoting Feldman (1971). They quote Skolnick, 1973: 304, 312 on its costs; Clausen and Clausen (1973) on how child-centred demands fatigue and confuse parents; and Kellmer Pringle (1974: 156) on the necessity for parenthood to be de-romanticised). It has been shown in the present work (Chapters 2 and 10) that this is an incomplete and misleading view of the transition to parenthood. Nevertheless, as a broad overview of the parenthood literature, and as a prototype statement of the assumptions and values which underlie the conceptual framework presented earlier (Chapter 3), this is an important work.

#### 1.4 Conclusions

The conclusions from this relatively extensive review of the overseas literature on pregnancy and parenthood are to be found integrated with the major argument of this thesis, especially in Chapters 1, 2 and 11. They are thus not repeated here.

PREGNANCY AND PARENTHOOD RESEARCH PROJECT - MAIN SAMPLE - FIRST INTERVIEW

INTERVIEWER

This questionnaire is used for interviews with primigravidae and multigravidae nulliparae whose 28th week of pregnancy falls in the period 1 March 1976 to 16 July 1976 inclusive (i.e. 1.D.D. 23/5/76 to 9/10/76 inclusive).

EXPLAIN THE RESEARCH PROJECT TO THE RESPONDENT:

Mrs .....

We are talking to a number of people like yourself during their pregnancies and after their babies are born, to find out what are the problems and what are the satisfactions of this experience of becoming a parent, what helps to make it a happy event, and how we might improve our maternity services.

The Pregnancy and Parenthood Research Project is under the supervision of Mr David Swain, a family sociologist at the University of Waikato. His address and telephone numbers are on this leaflet. (INTERVIEWER: Hand Factsheet to respondent) which you might like to keep for reference.

We would like to talk to you now, and again later in your pregnancy during a clinic visit, after your baby is born while you are still in Campbell-Johnstone, and finally once at home. We will also have either a short questionnaire for you to take home for your husband, or a simple diary of how you spend your time for you to keep.

Would you please read this short paragraph here (INTERVIEWER: show respondent paragraph below) and if you are prepared to help us, please sign it. Thank you.

RESPONDENT'S CONSENT

I have had the Pregnancy and Parenthood Research Project explained to me, and have received the leaflet describing it, and I hereby agree to participate in the Project.

.....  
Respondent's signature

.....  
Interviewer's signature

...../...../19.....

Pregnancy Parenthood Research Project - Main Sample - First Interview

INTERVIEWER:

I have here a list of statements that have been made by various women. I'd like you to read each of them, and then I'd like you to say whether you "strongly agree", "agree", "disagree" or "strongly disagree" with each statement. There are differences of opinion about these statements; we would like to know what you think.

Please mark a cross opposite each statement, in the appropriate column, to show whether you "strongly agree", "agree", "disagree" or "strongly disagree".

		Strongly agree	Agree	Disagree	Strongly disagree
M01	Most women feel sickness and nausea during the first three months of their pregnancy.				
M02	Looking forward to having a baby gives greater pleasure than actually having one.				
M03	At least half the babies born in New Zealand are not "planned".				
M04	Most women would have more babies if they did not have to be pregnant for nine months.				
M05	You can love a baby before it's actually born.				
M06	Most women want to be awake for the birth.				
M07	A woman looks her best during her pregnancy.				
M08	One out of every five babies in New Zealand is born with some physical defect.				
M09	A woman almost always gets her figure back after pregnancy.				
M10	A woman has to be treated gently during pregnancy because she is liable to get upset easily.				
M11	Many women feel they will lose their husband's interest when they are pregnant.				
M12	Most fathers cope with their new babies very well.				
		Strongly agree	Agree	Disagree	Strongly disagree

Pregnancy and Parenthood Research Project - Main Sample - First Interview

		Strongly agree	Agree	Disagree	Strongly disagree
M13	The delivery is a frightening part of pregnancy.				
M14	Most women know how their babies are born.				
M15	Most pregnant women do not really care whether they have a boy or a girl.				
M16	It is unusual for a woman to be sorry that she became pregnant.				
M17	A woman should not continue to work after she has a baby.				
M18	Most women feel especially well during their pregnancy.				
M19	Quite a lot of women are permanently injured during childbirth.				
M20	Most women would like to take care of their own new-born babies in the hospital.				
M21	Most women think about having an abnormal baby sometime during their pregnancy.				
M22	It is very unusual to lose a baby during pregnancy.				
M23	Most doctors take a great deal of interest in their patients.				
M24	Most women feel depressed some time during or soon after their pregnancy.				
M25	In New Zealand very few unborn babies are lost during the first three months of pregnancy.				
M26	The first three months of pregnancy are very easy.				
M27	It is important to have help at home for several weeks because most mothers do not know how to take care of their new baby.				
M28	Breastfeeding does not ruin the mother's figure.				
M29	The labour is a horrible part of pregnancy.				
M30	It is usual for the mother to love her baby immediately.				
		Strongly agree	Agree	Disagree	Strongly disagree

Pregnancy and Parenthood Research Project - Main Sample - First Interview

		Strongly agree	Agree	Disagree	Strongly disagree
M31	Most women are concerned about being able to carry their babies to term (the full 40 weeks).				
M32	If a woman has a bad shock during her pregnancy, her baby may be born deformed.				
M33	Most new-born babies are alike.				
M34	Most women enjoy wearing maternity clothes.				
M35	Very often, a father pays more attention to the new baby than to his wife.				
M36	It takes a long time for the mother to feel that her baby is "really" her own.				
M37	Many women would prefer to have their babies delivered at home.				
M38	Most mothers need a lot of advice from doctors and nurses about their new babies.				
M39	If a pregnant woman is hurt, her unborn baby is hurt also.				
M40	The unborn baby gets its food from the mother's stomach.				
M41	Breastfed babies are healthier than bottlefed babies.				
M42	Most women are unprepared for having a baby.				
M43	Worry cannot make a mother lose her unborn baby.				
M44	A new mother should stay at least 10 days in the hospital.				
M45	Pregnancy can be an awful time.				
M46	Most women want to breastfeed their babies.				
M47	Putting the mother to sleep (giving a general anaesthetic) for the birth can hurt the baby.				
M48	Most women feel that being a mother is the happiest thing in their lives.				
		Strongly agree	Agree	Disagree	Strongly disagree

|| Thankyou.

INTERVIEWER

Go to page 7. Code these responses afterwards on pages 5-6.

Pregnancy and Parenthood Research Project - Main Sample - First Interview

FOR OFFICE USE ONLY				
Cols. 1-4	Respondent number	<input type="text"/>		
Col. 5	Card number	<input type="text"/>		
Col. 6	Interview number	<input type="text"/>		
Cols. 7-12	Interview date	<input type="text"/>		
Cols. 13-20	Register number (W316)	<input type="text"/>		
INTERVIEWER				
After interview code the responses for M01-M48 onto the coding frame below.				

<u>Item</u>	<u>Card col.</u> <u>Number</u>	<u>Strongly</u> <u>Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>
M01	C21	1	2	3	4
M02	C22	1	2	3	4
M03	C23	1	2	3	4
M04	C24	1	2	3	4
M05	C25	4	3	2	1
M06	C26	4	3	2	1
M07	C27	4	3	2	1
M08	C28	1	2	3	4
M09	C29	4	3	2	1
M10	C30	1	2	3	4
M11	C31	1	2	3	4
M12	C32	4	3	2	1
M13	C33	1	2	3	4
M14	C34	4	3	2	1
M15	C35	4	3	2	1
M16	C36	4	3	2	1
M17	C37	4	3	2	1
M18	C38	4	3	2	1
M19	C39	1	2	3	4
M20	C40	4	3	2	1
M21	C41	1	2	3	4
M22	C42	4	3	2	1
M23	C43	4	3	2	1
M24	C44	1	2	3	4
M25	C45	4	3	2	1

Pregnancy and Parenthood Research Project - Main Sample - First Interview

		<u>Strongly</u> <u>Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>
M26	C46	4	3	2	1
M27	C47	1	2	3	4
M28	C48	4	3	2	1
M29	C49	1	2	3	4
M30	C50	4	3	2	1
M31	C51	1	2	3	4
M32	C52	1	2	3	4
M33	C53	1	2	3	4
M34	C54	4	3	2	1
M35	C55	1	2	3	4
M36	C56	1	2	3	4
M37	C57	4	3	2	1
M38	C58	1	2	3	4
M39	C59	1	2	3	4
M40	C60	1	2	3	4
M41	C61	4	3	2	1
M42	C62	1	2	3	4
M43	C63	4	3	2	1
M44	C64	1	2	3	4
M45	C65	1	2	3	4
M46	C66	4	3	2	1
M47	C67	4	3	2	1
M48	C68	4	3	2	1

FOR OFFICE USE ONLY	
C69-70	1
C71-72	1
C73-74	1
C75-76	1
C77-78	1
C79-80	1

Pregnancy and Parenthood Research Project - Main Sample - First Interview

FOR OFFICE USE ONLY	
Cols. 1-4	Duplicate
Col. 5	2
Cols. 6-20	Duplicate

INTERVIEWER

Now, I'd like to check some information you have already given us, and ask you a little more about some things.

001 Your surname is .....

002 Your first name(s) is (are) .....

Ask only if applicable ] → 003 Your maiden name was .....

004 What is your marital status? (C21)

READ	Married	1	} Go to 005
LIST	De facto married	2	
OUT	Divorced/legally separated	3	} Go to 006
	Informally separated/living apart	4	
	Single	5	
	No answer/refusal	6	

Ask only if 1-4 to 004 ] → 005 What was the date of your marriage? (C22-27) 

--	--	--	--	--	--

INTERVIEWER: If date n/a (codes 5-6 to 004) code 99 99 99

006 To which of the following religious groups do you belong? (C28)

READ	Protestant	1	} Go to 007
LIST	Roman Catholic	2	
OUT	Other (please specify) .....	3	} Go to 008
	None	4	
	No answer/refusal	5	

Ask only if 1-3 or 5 to 006 ] → 007 Are you a practicing member of the church? (C29)

	Yes	1
	No	2
	No answer/refusal	3

008 To which of the following ethnic groups do you consider you belong? (C30)

READ	Pakeha (European)	1
OUT	N.Z. Maori	2
LIST	Other Polynesian	3
	Indian/Chinese	4
	Other (please specify) .....	5
	No answer/refusal	6

Pregnancy and Parenthood Research Project - Main Sample - First Interview

Q09 How many years did you spend at secondary school? (C31)

None	1
One	2
Two	3
Three	4
Four	5
Five	6
Six or more	7
No answer	8

Q10 Do you have any educational qualifications or job training certificates? (C32)

None	1
School Certificate (inc. partial passes)	2
U.S. and/or other higher school qualifications	3
Job training certificates (e.g. nursing, library, teaching, public service, incomplete degree)	4
University degree or equivalent and above	5
No answer	6

Q11 Are you working now? (C33)

Yes	1	Go to O14*
No	2	Go to O12

INTERVIEWER

"Working" (Q011) includes both part-time and full-time employment for money or other material advantage.

"Ever" (Q012) means since leaving school, including before marriage.

Check O11  
Code 2 only

→O12 Have you ever worked? \* Code 3 to O12 (C34)

Yes	1	Go to O13
No	2	Go to O23
Now	3	Go to O14

Check O12  
Code 1 only

→O13 When did you finish working? (C35)

Before marriage (not just before)	1
At or just before marriage	2
After marriage but before pregnancy	3
As soon as pregnant (1st and 2nd months)	4
During 3rd/4th months of pregnancy	5
During 5th/6th months of pregnancy	6
During 7th or later months of pregnancy	7
Still working (Code 1 to O11) i.e. n/a	8
No answer	9

} Go to O17

Check O11  
Code 1 only

→O14 Do you intend to stop working before the baby is due? (C36)

Yes	1	Go to O15
No	2	Go to O16
D/k	3	

Check O14  
Code 1 only

→O15 When do you intend to stop working? (C37)

During 8th month of pregnancy	1
During 9th month of pregnancy	2
When the baby is born	3
D/k	4
Does not intend to stop working (Codes 2 or 3 to O14)	5

Pregnancy and Parenthood Research Project - Main Sample - First Interview

Check 014  
Codes 2 or 3 only } → 016 Would you tell me about your plans please?

	C38-39
	C40-41

INTERVIEWER:  
 If respondent not working (Code 2 to 011) AND has never worked (Code 2 to 012) go to 019.  
 If respondent is working (Code 1 to 011) OR has worked (Code 1 to 012) go to 017.

Check 011 code 1  
or 012 code 1 } → 017 What is (or was) your occupation?

	C42-43

INTERVIEWER:  
 Write in answer in box above; then code occupation into one of the categories below.

- Professional/managerial (C44) 1
- Minor professional/managerial 2
- Trained clerical/sales (including responsibility) 3
- Other clerical sales (untrained, no responsibility) 4
- Skilled/qualified manual 5
- Semi-skilled/unskilled manual 6
- Domestic 7
- No answer/refusal/unclassifiable 8
- Not working, never worked (Code 2 to 011; Code 2 to 012) 9

Pregnancy and Parenthood research Project - Main Sample - First Interview

- 018 Do you (or did you) work part-time (under 30 hours p.w.) or full-time (30 hours p.w. or more)? (C45)
- Part-time (under 30 hrs. p.w.) 1
  - Full-time (30 hrs. p.w. or more) 2
  - Both part-time and full-time 3
  - No answer, d/k. 4

- 019 How long have you (or had you) been in your occupation (not necessarily with the same employer)? (C46)
- Under 1 year 1
  - Over 1, up to 2 years 2
  - Over 2, up to 3 years 3
  - Over 3, up to 4 years 4
  - Over 4, up to 5 years 5
  - Over 5, up to 10 years 6
  - Over 10, up to 15 years 7
  - Over 15 years 8
  - Not working, never worked (Code 2 to 011, 012) 9

INTERVIEWER: If respondent is still working (code 1 to 011) go to 023 otherwise go to 020.

- 020 Do you intend to return to work after the baby is born? (C47)
- Yes 1 Go to 021
  - No 2 Go to 023
  - Does not intend to stop working 3 Go to 023
  - D/K (Code 2 to 014) 4 Go to 023

Check 020 Code 1 only 021 When do you intend to return to work?

	C48
--	-----

022 Why do you intend to return to work?

	C49-50
--	--------

Pregnancy and Parenthood Research Project - Main Sample - First Interview

INTERVIEWER:

Thank you. Now there are a few more details I'd like to check.

023 Your address is .....  
.....  
.....

Your telephone number is ..... (daytime)  
..... (evening)

024 What is your date of birth? (051-56)

025 When your age in years is ..... (057-58)

026 Where were you born?

	059-60

027 Can you please tell me the places (towns, suburbs of major cities and/or country areas) in which you have lived for at least a year since you left home?

Place living now	.....	(061)	<input type="text"/>
Place living previously	.....	(062)	<input type="text"/>
And before that	.....	(063)	<input type="text"/>
And before that	.....	(064)	<input type="text"/>
And before that	.....	(065)	<input type="text"/>
Number of places still to be listed		(066)	<input type="text"/>

Pregnancy and Parenthood Research Project - Main Sample - First Interview

028 Who is your G.P. (family doctor)?

	C67-68

029 How long has she/he been your G.P.? (C69-70)

--

030 Who was your previous G.P.?

INTERVIEWER: If no previous G.P. code C71-72 and C73-74 "99".

	C71-72

031 How long was she/he your G.P.? (C73-74)

--

FOR OFFICE USE ONLY	C75		C78	
	C76		C79	
	C77		C80	
-----				
BEGIN SECOND CARD		Duplicate cols. 1-4 Column 5 Card No. <input type="text" value="2"/> Duplicate cols. 6-20		

032 Do you feel at ease with your present G.P.?

(C21)

- Yes - definitely 1
- Yes - qualified 2
- D/k 3
- No - qualified 4
- No - definitely 5

INTERVIEWER:  
Check Ante-Natal Record (W316) to see if respondent is a private patient of an obstetrician. If she is go to 033; if she is not go to 034.

033 I see you are a private patient.  
Is there any particular reason why you chose to be a private patient?

	C22
	C23
<b>437</b>	

Pregnancy and Parenthood Research Project - Main Sample - First Interview

034 Is this your first pregnancy?

	(C24)	
Yes	1	Go to 037
No	2	Go to 035

035 How many previous pregnancies have you had? (C25)

036 What was (were) the outcome(s) of that (those) pregnancy (pregnancies)?

Last/only previous pregnancy: (C26)

Miscarriage/spontaneous abortion	1
Induced abortion/termination	2
Stillbirth	3
No answer/refusal	4

Pregnancy before that: (C27)

Miscarriage/spontaneous abortion	1
Induced abortion/termination	2
Stillbirth	3
No answer/refusal	4

037 At what age did menstruation begin? (C28-29)

038 Is your menstrual cycle regular or irregular?

	(C30)
Regular	1
Irregular	2

039 On what date did you book in to Campbell-Johnstone?

(C31-36)

040 On what date did you first feel the baby move?

(C37-42)

<u>or</u>	weeks of pregnancy
INTERVIEWER: Calculate date afterwards.	

041 When is the baby due? (C43-48)

<p>INTERVIEWER:          Check 004. If respondent is married (code 1) or de facto married (code 2) go to 042. If respondent is other than married or de facto married, skip 042-048 and go to 049. Code 043-048 with 9's.</p>
---

## Pregnancy and Parenthood Research Project - Main Sample - First Interview

042 Now I'd like to ask you a few questions about your husband.

What is his full name?

.....  
first name(s)

.....  
surname

043 What is his present occupation?

	C49-50
<p>INTERVIEWER: Write in answer in the box above; then code occupation into one of the categories below.</p>	

	(C51)
Professional/managerial	1
Minor professional/managerial	2
Trained clerical/sales (includes responsibility)	3
Other clerical/sales (untrained, no responsibility)	4
Skilled/qualified manual	5
Semi-skilled/unskilled manual	6
Farming	7
No answer/refusal/unclassifiable	8
Respondent not married (codes 3-6 on 004)	9

044 How many years did your husband spend at secondary school?

	(C52)
None	1
One	2
Two	3
Three	4
Four	5
Five	6
Six or more	7
No answer/refusal/don't know	8
Respondent not married (codes 3-6 on 004)	9

045 Does he have any educational qualifications or job training certificates?

	(C53)
None	1
School Certificate (including partial passes)	2
U.E. and/or other higher school qualifications	3
Job training certificates, vocational qualifications, completed apprenticeships etc., incomplete university degrees	4
University degree or equivalent and above	5
No answer/refusal/don't know	6
Respondent not married (codes 3-6 on 004)	9

046 What is his age? (C54-55)

Q047-052

Pregnancy and Parenthood Research Project - Main Sample - First Interview

047 To which of the following religious groups does your husband belong?

		(C56)
READ	Protestant	1
CUT	Roman Catholic	2
LIST	Other .....	3
	please specify	
	None	4
	No answer/refusal/don't know	5
	Respondent not married	9

048 To which of the following ethnic groups does your husband consider he belongs?

		(C57)
READ	Pakeha (European)	1
CUT	M.M. Maori	2
LIST	Other Polynesian	3
	Indian/Chinese	4
	Other .....	5
	please specify	
	No answer/refusal/don't know	6
	Respondent not married	9

INTERVIEWER:  
Thank you. Now I'd like to ask you a few more questions about your pregnancy.

049 Was this pregnancy planned?

		(C58)
	Yes - both having the baby and the timing	1
	Yes - having the baby, but not the timing	2
	No but - didn't matter, O.K. if fell, casual	3
	No - accident, contraceptive failure	4
	No answer/refusal	9

050 How many children do you wish or intend to have, including this one?

C59  INTERVIEWER: If one to seven, write in number; if eight or more, code 8; if don't know/no answer/refusal, code 9.

051 Are you looking forward to your new baby?

		(C60)
	Yes - definitely	1
	Yes - suppose so	2
	Don't know	3
	No - not really	4
	No - definitely not	5

Check 004  
Codes 1-2  
only } → 052 Is your husband looking forward to your new baby?

		(C61)
	Yes - definitely	1
	Yes - suppose so	2
	Don't know	3
	No - not really	4
	No - definitely not	5

Respondent not married (3-6 on 004) 9

Pregnancy and Parenthood Research Project - Main Sample - First Interview

053 What sort of contraception, if any, were you using before you decided to have the baby (or became pregnant)?

	(C62)		
Oral contraceptive pill	1	Condom (sheath, Durex)	6
Contraceptive injection	2	Other (inc. refusal and comb)	7
Diaphragm (cap)	3	.....	
I.U.D. (loop)	4	None	8
Spermicide (foam, cream etc.)	5	Refusal/no answer	9

054 Do you have any preference as to whether the baby is a boy or a girl?

	(C63)
Strong preference for a boy	1
Mild preference for a boy	2
No preference, don't know	3
Mild preference for a girl	4
Strong preference for a girl	5

055 How have you felt so far during your pregnancy?

	(C64)
Very well, general sense of wellbeing, no health problems	1
Well (with reservations), minor health problems	2
Not well, but able to cope	3
Ill, health problems requiring special medical care	4

056 Do you expect your labour and delivery to be normal?

	(C65)	
Yes	1	Go to 062
No	2	Go to 057
Don't know	3	Go to 062

Check 056  
Code 2  
only

057 Is there a possibility of a caesarian section?

	(C66)
Yes	1
No	2

058 Is there a possibility of a forceps delivery?

	(C67)
Yes	1
No	2

059 Is there a possibility of a vacuum extraction?

	(C68)
Yes	1
No	2

060 Is there a possibility of a breech delivery?

	(C69)
Yes	1
No	2

061 Is there any other difficulty you expect?

	C70-71
--	--------

Pregnancy and Parenthood Research Project - Main Sample - First Interview

062 What do you expect labour to be like?

	C72-73

063 Do you expect to have analgesics (pain-killers) during labour? (C74)

- Yes - gas or gas and air only 1
- Yes - gas etc. and tablets/injection 2
- Yes - tablets/injection only 3
- No 4
- Don't know 5

FOR OFFICE USE ONLY		
C75 <input type="checkbox"/>	C77 <input type="checkbox"/>	C79 <input type="checkbox"/>
C76 <input type="checkbox"/>	C78 <input type="checkbox"/>	C80 <input type="checkbox"/>
-----		
BEGIN THIRD CARD		
Cols. 1-4 duplicate	Col. 5 <input type="checkbox" value="3"/>	Cols. 6-20 duplicate

064 Have you planned for the baby's father, or a friend or relative, to be with you during labour?

- (C21)
- Yes - father (husband) 1
- Yes - friend 2
- Yes - other relative 3
- No 4

065 Have you planned for the baby's father, or a friend or relative, to be with you when the baby is born?

- (C22)
- Yes - father (husband) 1
- Yes - friend 2
- Yes - other relative 3
- No 4

066 How do you think you are going to cope with labour?

442	C23-24

Pregnancy and Parenthood Research Project - Main Sample - First Interview

067 Where have you obtained information about labour and delivery so far?

Clinic ante-natal classes	1	INTERVIEWER: Circle the code for each answer given; afterwards add up the total and write it in the box below.
Parents Centre classes	2	
Friends	4	
Parents, in-laws, brothers, sisters	8	
Clinic staff (NOT in classes)	16	
Doctor (G.P.)	32	
Books, magazines, pamphlets etc.	64	
Nowhere (no information so far)	128	
Others (please specify below)	256	
.....		

TOTAL SCORE:- (25-27)

068 Which has been your most important single source of information about labour and delivery?

	(C28)
Clinic ante-natal classes	1
Parents Centre classes	2
Friends	3
Parents, in-laws, brothers, sisters	4
Clinic staff (NOT in classes)	5
Doctor (G.P.)	6
Books, magazines, pamphlets	7
Not applicable (No information so far - code 128 to 067)	8
Other (please specify below)	9

.....  (C29)

069 Do you feel you know enough about labour and delivery so far?

	(C30)
Yes - definitely	1
Yes - with qualifications	2
Don't know, perhaps not	3
No - but with qualifications	4
No - definitely not	5

070 Do you yourself intend to breastfeed your baby?

	(C31)
Yes - definitely	1
Yes - with qualifications	2
Don't know, perhaps not	3
No-but with qualifications	4
No-definitely not	5

Check 004  
Codes 1 or 2  
only

071 What does your husband feel about whether or not you breastfeed your baby?

	(C32)
Definitely approves/supports	1
O.K. if I want to breastfeed	2
No opinion, not for him to say	3
Not at all enthusiastic, rather not	4
Definitely opposed	5
Don't know what he thinks	6
Respondent not married (codes 3-6 on 004)	9

Q072-076

Pregnancy and Parenthood Research Project - Main Sample - First Interview

072 Where have you obtained information about breastfeeding, so far?

- Clinic ante-natal classes 1
- Parents Centre Classes 2
- Friends 4
- Parents, in-laws, brothers, sisters 8
- Clinic staff (NOT in classes) 16
- Doctor (G.P.) 32
- Books, magazines, pamphlets etc. 64
- Nowhere (no information so far) 128
- La Leche League 256
- Others (please specify below) 512

INTERVIEWER:  
Circle the code  
for each answer  
given; add up the  
total and write it  
in the box below.

→ Go to 074

.....  
TOTAL SCORE:- (033-35)

073 Which has been your most important single source of information about breastfeeding?

- Clinic ante-natal classes (036) 1
- Parents Centre classes 2
- Friends 3
- Parents, in-laws, brothers sisters 4
- Clinic staff (NOT in classes) 5
- Doctor (G.P.) 6
- Books, magazines, pamphlets etc. 7
- Not applicable (no information so far, code 128 to 072) 8
- La Leche League 9
- Others (please specify below)

.....  (037)

074 Do you feel you know enough about breastfeeding so far?

- (038)
- Yes - definitely 1
- Yes-with qualifications 2
- Don't know, perhaps not 3
- No - but with qualifications 4
- No - definitely not 5

075 How many children were there in your family, counting yourself?

(039)  If 2 or more go to 076  
If 1 go to 079

Check 075  
If 2 or more  
only

076 I would like to know about the order of your brothers and sisters, and how old each was when the youngest was born. First, starting with the oldest, can you tell me whether each was a brother, a sister, or yourself of course.

INTERVIEWER: Write in B for brother, S for sister, or X for the respondent, opposite "1st (oldest)" below. Continue down the list for the number of children already entered in 075 above.

1st (oldest)	<input style="width: 20px; height: 20px;" type="text"/>	2nd	<input style="width: 20px; height: 20px;" type="text"/>	3rd	<input style="width: 20px; height: 20px;" type="text"/>	4th	<input style="width: 20px; height: 20px;" type="text"/>
5th	<input style="width: 20px; height: 20px;" type="text"/>	6th	<input style="width: 20px; height: 20px;" type="text"/>	7th	<input style="width: 20px; height: 20px;" type="text"/>	8th	<input style="width: 20px; height: 20px;" type="text"/>

Now, when the youngest was born, how old was each of the others?

FCR OFFICE USE ONLY
(C40-53) <input style="width: 90%; height: 20px;" type="text"/>
40

Q077-081

Pregnancy and Parenthood Research Project - Main Sample - First Interview

Check 075  
If 2 or more  
only } → 077 Do any of your brothers or sisters already have children?  
(C54)  
Yes 1  
No 2  
N/a 3 (No siblings - check 075)

Check 075  
& 076  
If younger  
siblings  
only } → 078 Did you do much in the way of looking after younger brothers or sisters?  
(C55)  
Yes - a lot 1  
Yes - some 2  
Not really 3  
No 4  
Not applicable 5 (No siblings - check 075)

079 More generally, have you had any experience of looking after babies?  
(C56)  
Yes - a lot 1  
Yes - some 2  
Not really 3  
No 4

"Babysitting only" is coded 2

080 Have you had any experience of looking after children?  
(C57)  
Yes - a lot 1  
Yes - some 2  
Not really 3  
No 4

081 What changes, if any, do YOU expect in your life once the baby is born?

	C58-59
	C60-61
	C62-63
	C64-65

FOR OFFICE USE ONLY  
(C66-68)

Pregnancy and Parenthood Research Project - Main Sample - First Interview

Check COL  
Codes 1 & 2  
only

→082 What changes, if any, do YOU expect in your husband's life once the baby is born?

	C69-70
	C71-72
	C73-74
	C75-76

FOR OFFICE USE ONLY  
(C77-79)

FOR OFFICE USE ONLY  
Begin fourth card  
Cols. 1-4 duplicate Col. 5  4 Cols. 6-20 duplicate

083 Do you have any other comments to make about your pregnancy, or more generally about starting your family?

	C21-22

084 Finally, do you have any comment to make about this interview?

	C23-24

PREGNANCY AND PARENTHOOD RESEARCH PROJECT - MAIN SAMPLE - SECOND INTERVIEW

INTERVIEWER

This questionnaire is used for interviews with primigravidae and multigravidae nulliparae whose 36th week of pregnancy falls in the period 25 April 1976 to 12 September 1976 inclusive (i.e. E.D.D. 23/5/76 to 9/10/76 inclusive). It is the SECOND QUESTIONNAIRE. Check (in the alphabetical cards) that the respondent received a 28-week interview, and note her serial number, for use below. Check her Chart (Ante-natal Record) to ensure there are no untoward circumstances of which you should be aware. In the event of a miscarriage (spontaneous abortion) do not proceed with the interview; note the information on the alphabetical card. Check marital status and avoid Questions 04, 05, 07, 108, 113, 131 and 132 where the respondent is not married.

EXPLAIN THIS SECOND INTERVIEW TO THE RESPONDENT

Mrs

You will remember that one of the research team talked to you about two months ago , and we said then that we would like to talk to you once more before the baby was born.

Today we have some more questions to ask you, and we have a questionnaire for you to fill in and return to us.

FOR OFFICE USE ONLY

Cols. 1-4 Respondent no.

Col. 5 Card no.

Col. 6 Interview no.

Cols. 7-12 Interview date

Cols. 13-20 Register no. (W316).

INTERVIEWER

To begin with, I'd like to ask you a few questions about ante-natal classes.

1 Which ante-natal classes, if any, have you attended?

- |                                |     |            |
|--------------------------------|-----|------------|
|                                | C21 |            |
| Parents Centre                 | 1   | } Go to Q2 |
| Hospital (C.J.)                |     |            |
| Day (incs. 2 evening classes)  | 2   |            |
| Evening (full evening classes) | 3   |            |
| Single girls course            | 4   |            |
| Refresher course (2 classes)   | 5   |            |
| Other (please specify below)   |     |            |

.....  
 .....

Ask question below and then go to page 9, question 89

None (did not enrol) 9

Why did you not enrol in ante-natal classes?

	C22-23
--	--------

Now go to page 9, question 89

2 How many classes are there in all?

P.C. = 8	
C.J. (D.) = 8 (6 + 2)	CJ (SG) = 8
C.J. (E.) = 8	CJ (R) = 2

C24

3 How many of the classes have you managed to attend, or do you definitely expect and intend to attend?

C25

INTERVIEWER

Some respondents may be interviewed before they have completed an ante-natal course. In this case we have to estimate the number of classes they will turn out to have attended. The estimate is written in the C25 box by this question, and the actual number attended so far is written in the C26 box here: C26

[Skip if not married]

4 Did your husband attend any of the ante-natal classes, or is he planning to do so?

- |  |     |   |
|--|-----|---|
|  | C27 |   |
| Not married, n/a   | 1   | Go to Q6  |
| Yes - Parents Centre   | 2   | } Go to Q5  |
| Yes - The two hospital (CJ) evening sessions of the daytime course | 3   |   |
| Yes - Hospital (CJ) evening course of eight sessions               | 4   |   |
| Yes - Other course   | 5   |   |
| No - Planned to do so but cannot/could not                         | 6   | } Go to Q6  |
| No - Did/does not intend to do so                                  | 7   |   |
| Other answer (please write in below)                               | 8   | } Go to Q5 or Q6 as appropriate, depending on whether attends course or not |
| .....  |     |   |
| .....  |     |   |

[Codes 2-5  
to Q4]

5 How many of the classes has he managed to attend, or does he definitely expect and intend to attend?

C28

[Skip if  
code 9 to  
Q1]

6 How useful have you found the classes you have attended?

- |  |       |
|--|-------|
|  | C29   |
| Very useful                              | 1     |
| Quite useful                             | 2     |
| Not very useful                          | 3     |
| Not at all useful                        | 4     |
| Worse than useless                       | 5     |
| <br>Did not attend classes (code 9 to 1) | <br>6 |

[Skip 7 if  
not married  
or codes  
6-7 to 4]

7 How useful has YOUR HUSBAND found the classes he attended?

- |  |     |
|--|-----|
|  | C30 |
| Not married  | 1   |
| Husband did not attend classes (codes<br>6-7 to 4)                             | 2   |
| Husband intends to go, but evening<br>sessions not yet held for daytime course | 3   |
| Very useful  | 4   |
| Quite useful   | 5   |
| Not very useful  | 6   |
| Not at all useful  | 7   |
| Worse than useless   | 8   |

8 What were the three most important topics, or pieces of information, in the classes you attended?

	C31-32
	C33-34
	C35-36

9 How easy was it to ask questions or make comments at the classes?

	C37
Very easy - obviously welcome	1
Possible but not always easy	2
Sometimes easy, sometimes difficult	3
Difficult but could be done	4
Impossible for one reason or another	5

10 Did you feel that the classes you attended were particularly suited to your needs, requirements or situation?

	C38
Yes - definitely	1 Go to 14
Yes - with qualifications	2 Go to 11
Don't know - no opinion	3 Go to 12
No - with qualifications	4 Go to 13
No - definitely not	5 Go to 13

11 In what way could they be improved?

	C39-40
--	--------

Go to 14

12 If you could change any aspects of the classes, what would you change?

	C41-42
--	--------

Go to 14

13 In what ways were the classes unsuited to your needs, requirements or situation?

	C43-44
--	--------

450

INTERVIEWER:

I have here a list of statements that have been made by various women about ante-natal classes. I'd like you to read each of them and then I'd like you to say whether you "strongly agree", "agree", "disagree" or "strongly disagree" with each statement. There are differences of opinion about these statements; we would like to know what you think.

Please mark a tick apposite each statement, in the appropriate column, to show whether you "Strongly agree", "agree", "disagree" or "strongly disagree".

		Strongly Agree	Agree	Disagree	Strongly Disagree
14	The classes I attended were at a convenient time				
15	Some of the things they talk about in classes are a bit above our heads				
16	It's difficult to get to know the people taking classes, especially when the classes are quite big				
17	It's better to be in a small group and talk about things than listen to a lecture				
18	I was glad of the chance to learn about breathing and relaxation				
19	There's not much opportunity to talk about how you feel at ante-natal classes				
20	I learned quite a lot of new things at the classes				
21	I wish the classes had covered more of the things I wanted to learn about				
22	It's important for the "expectant father" to attend <u>ante-natal classes</u>				
		Strongly Agree	Agree	Disagree	Strongly Disagree

Item	Col. no.	Strongly Agree	Agree	Disagree	Strongly Disagree
14	45	4	3	2	1
15	46	1	2	3	4
16	47	1	2	3	4
17	48	1	2	3	4
18	49	4	3	2	1
19	50	1	2	3	4
20	51	4	3	2	1
21	52	1	2	3	4
22	53	4	3	2	1

We have here a list of topics that are or could be included in ante-natal classes. Would you please read each one, and then put a tick in the box opposite, to show to what extent, from "Not at all" to "Completely", the topic was covered in the classes you attended.

		This topic was covered ...				
		Not at all	Just a little	Somewhat	Quite well	Completely
23	Physiology (how your body works)					
24	Labour - what is happening					
25	Labour - some usual difficulties					
26	The actual birth - what happens					
27	Breastfeeding - reasons for breastfeeding					
28	Breastfeeding - how to be successful					
29	Mothercraft - bathing baby, nappies etc.					
30	Your feelings about your baby					
31	Your feelings about your husband/the baby's father					
32	Your feelings about yourself as a new mother					
33	Your feelings and emotions in general					
34	Sexual relations					
35	Grandparents and in-laws					
36	After you have the new baby at home					
37	Tiredness and its effects					
38	Post-partum depression/"new baby blues"					
39	Family planning/contraception					
40	The new father's role					
41	Hospital routines and procedures					
42	Help/advice you can get from Plunket, Public Health nurses, La Leche League, Parents Centre etc.					
43	Child development, the toddler and later					
		Not at all	Just a little	Somewhat	Quite well	Completely
		This topic was covered ...				

Item	Col. no.	Not at all	Just a little	Somewhat	Quite Well	Completely
23	54	1	2	3	4	5
24	55	1	2	3	4	5
25	56	1	2	3	4	5
26	57	1	2	3	4	5
27	58	1	2	3	4	5
28	59	1	2	3	4	5
29	60	1	2	3	4	5
30	61	1	2	3	4	5
31	62	1	2	3	4	5
32	63	1	2	3	4	5
33	64	1	2	3	4	5
34	65	1	2	3	4	5
35	66	1	2	3	4	5
36	67	1	2	3	4	5
37	68	1	2	3	4	5
38	69	1	2	3	4	5
39	70	1	2	3	4	5
40	71	1	2	3	4	5
41	72	1	2	3	4	5
42	73	1	2	3	4	5
43	74	1	2	3	4	5

FOR OFFICE USE ONLY	
C.75	<input type="checkbox"/>
C.76	<input type="checkbox"/>
C.77	<input type="checkbox"/>
C.78	<input type="checkbox"/>
C.79	<input type="checkbox"/>
C.80	<input type="checkbox"/>

Now I would like you to think about how well each of those topics was treated or presented. A topic has been well treated or presented if it is discussed in an interesting, clear, helpful way. If the topic was not covered ("Not at all" ticked previously) please tick the "Not covered" box on the extreme right.

	This topic was treated/presented			Not covered at all	
	<u>Not</u> very well	O.K.	Well		
44	Physiology (how your body works)				
45	Labour - what is happening				
46	Labour - some usual difficulties				
47	The actual birth - what happens				
48	Breastfeeding - reasons for breastfeeding				
49	Breastfeeding - how to be successful				
50	Mothercraft - bathing baby, nappies etc.				
51	Your feelings about your baby				
52	Your feelings about your husband/the baby's father				
53	Your feelings about yourself as a new mother				
54	Your feelings and emotions in general				
55	Sexual relations				
56	Grandparents and in-laws				
57	After you have the new baby at home				
58	Tiredness and its effects				
59	Post-partum depression/"new baby blues"				
60	Family planning/contraception				
61	The new father's role				
62	Hospital routines and procedures				
63	Help/advice you can get from Plunket, Public Health nurses, La Leche League, Parents Centre etc.				
64	Child development, the toddler and later				
		<u>Not</u> very well	O.K.	Well	Not covered at all
		This topic was treated/presented			

7a.

FOR OFFICE USE ONLY	
Cols 1-4	Duplicate
Col. 5	2
Cols 6-20	Duplicate

Item	Col. no.	Not very well	O.K.	Well	Not covered at all
44	21	1	2	3	9
45	22	1	2	3	9
46	23	1	2	3	9
47	24	1	2	3	9
48	25	1	2	3	9
49	26	1	2	3	9
50	27	1	2	3	9
51	28	1	2	3	9
52	29	1	2	3	9
53	30	1	2	3	9
54	31	1	2	3	9
55	32	1	2	3	9
56	33	1	2	3	9
57	34	1	2	3	9
58	35	1	2	3	9
59	36	1	2	3	9
60	37	1	2	3	9
61	38	1	2	3	9
62	39	1	2	3	9
63	40	1	2	3	9
64	41	1	2	3	9

Finally I would like you to decide how important it is to include each of those topics in an ante-natal class programme. Would you please rate each topic as "Not important", "Of some importance", "Quite important", "Very important" or "Essential".

		This topic is ...				
		Not important	Of some importance	Quite important	Very important	Essential
65	Physiology (how your body works)					
66	Labour - what is happening					
67	Labour - some usual difficulties					
68	The actual birth - what happens					
69	Breastfeeding - reasons for breastfeeding					
70	Breastfeeding -- how to be successful					
71	Mothercraft - bathing baby, nappies etc.					
72	Your feelings about your baby					
73	Your feelings about your husband/the baby's father					
74	Your feelings about yourself as a new mother					
75	Your feelings and emotions in general					
76	Sexual relations					
77	Grandparents and in-laws					
78	After you have the new baby at home					
79	Tiredness and its effects					
80	Post-partum depression/ "new baby blues"					
81	Family planning/ contraception					
82	The new father's role					
83	Hospital routines and procedures					
84	Help/advice you can get from Plunket, Public Health nurses, La Leche League, Parents Centre etc.					
85	Child development, the toddler and later					
		Not important	Of some importance	Quite important	Very important	Essential
		This topic is ...				

## 8a.

Item	Card no.	Not important	Of some importance	Quite important	Very important	Essential
65	42	1	2	3	4	5
66	43	1	2	3	4	5
67	44	1	2	3	4	5
68	45	1	2	3	4	5
69	46	1	2	3	4	5
70	47	1	2	3	4	5
71	48	1	2	3	4	5
72	49	1	2	3	4	5
73	50	1	2	3	4	5
74	51	1	2	3	4	5
75	52	1	2	3	4	5
76	53	1	2	3	4	5
77	54	1	2	3	4	5
78	55	1	2	3	4	5
79	56	1	2	3	4	5
80	57	1	2	3	4	5
81	58	1	2	3	4	5
82	59	1	2	3	4	5
83	60	1	2	3	4	5
84	61	1	2	3	4	5
85	62	1	2	3	4	5

86 Are you working now?

	C63	
Yes	1	Go to 87
No	2	Go to 89

87 Do you intend to stop working before the baby is due?

	C64	
Yes	1	Go to 88
No	2	Go to 90

88 When do you intend to stop working?

	C65	
Before the baby is born (not just before)	1	
When the baby is born	2	Go to 91
Other answer (please specify)	3	

.....

89 When did you finish working?

	C66	
Before marriage (not just before)	1	
At or just before marriage	2	
After marriage but before pregnancy	3	
As soon as pregnant (1st and 2nd months)	4	Go to 91
During 3rd/4th months of pregnancy	5	
During 5th/6th months of pregnancy	6	
During 7th/8th months of pregnancy	7	
Still working (code 1 to 86)	8	
No answer	9	

90 Would you tell me about your plans?

	C 67-68
--	---------

91 Do you intend to return to work at any time after you have had the baby?

	C69	
Yes	1	Go to 92
No	2	} Go to 94
Does not intend to stop working	3	
Doesn't know	4	

92 When do you intend to return to work?

	C70-71

93 Why do you intend to return to work?

	C72-73

94 Could I have your address please?

.....  
 .....  
 And telephone number? .....

95 We shall need to keep in touch with you until your baby is up to 6 months old. We find it helps to have the names and addresses of some people who can help us to contact you if you move. Can you give me the names and addresses of three friends or relatives, preferably in this area, who could help us to get in touch with you if you move?

1. Name: .....  
 Address: .....  
 Description: ..... Phone: .....
2. Name: .....  
 Address: .....  
 Description: ..... Phone: .....
3. Name: .....  
 Address: .....  
 Description: ..... Phone: .....

INTERVIEWER  Please write in "parents", "friend", "neighbour" or similar description for each contact.
--

95 Could we have the name of your G.P. (family doctor) again please?

	C 74-75
--	---------

FOR OFFICE USE ONLY		
Col. 76 <input type="checkbox"/>	Col. 78 <input type="checkbox"/>	Col. 80
Col. 77 <input type="checkbox"/>	Col. 79 <input type="checkbox"/>	<input type="checkbox"/>
BEGIN THIRD CARD		
Cols 1-4	Duplicate	
Col. 5	<input type="checkbox" value="3"/>	
Cols 6-20	Duplicate	

96 Are you looking forward to your new baby?

- |                                       |     |
|---------------------------------------|-----|
|                                       | C21 |
| Yes definitely                        | 1   |
| Yes - suppose so, with qualifications | 2   |
| Don't know                            | 3   |
| No - not really, with qualifications  | 4   |
| No - definitely not                   | 5   |

97 How have you felt recently in your pregnancy?

- |   |     |
|---|-----|
|   | C22 |
| Very well, general sense of wellbeing, no health problems | 1   |
| Well (with reservations), minor health problems           | 2   |
| Not well, but able to cope                                | 3   |
| Ill, health problems requiring special medical care       | 4   |

98 Do you expect your labour and delivery to be normal?

- |            |     |           |
|------------|-----|-----------|
|            | C23 |           |
| Yes        | 1   | Go to 100 |
| No         | 2   | Go to 99  |
| Don't know | 3   | Go to 100 |

11a.

99 What do you expect, then, that is at all unusual?

	C. 24-25

100 What do you expect labour to be like?

	C. 26-27

101 Do you expect to have analgesics (pain-killers) during labour?

- |                                      |     |
|--------------------------------------|-----|
|                                      | C28 |
| Yes - gas or gas and air only        | 1   |
| Yes - gas etc. and tablets/injection | 2   |
| Yes - tablets/injection only         | 3   |
| No                                   | 4   |
| Don't know                           | 5   |

102 Have you planned for the baby's father, or a friend or relative, to be with you during labour?

- |                        |     |
|------------------------|-----|
|                        | C29 |
| Yes - father (husband) | 1   |
| Yes - friend           | 2   |
| Yes - other relative   | 3   |
| No                     | 4   |

103 Have you planned for the baby's father, or a friend or relative, to be with you when the baby is born?

- |                        |     |
|------------------------|-----|
|                        | C30 |
| Yes - father (husband) | 1   |
| Yes - friend           | 2   |
| Yes - other relative   | 3   |
| No                     | 4   |

104 How do you think you are going to cope with labour?

	C 31-32
--	---------

104 Where have you obtained information about labour and delivery so far?

Clinic ante-natal classes	1
Parents Centre classes	2
Friends	4
Parents, in-laws, brothers, sisters	8
Clinic staff (NOT classes)	16
Doctor (G.P.)	32
Books, magazines, pamphlets etc.	64
Nowhere (no information so far)	128 → Go to 106
Others (please specify below)	256

.....

INTERVIEWER

Circle the code for each answer given, afterwards add up the total and write it in the box below.

C33-35

105 Which has been your most important single source of information about labour and delivery?

	C36
Clinic ante-natal classes	1
Parents Centre classes	2
Friends	3
Parents, in-laws, brothers, sisters	4
Clinic staff (NOT in classes)	5
Doctor (G.P.)	6
Books, magazines, pamphlets	7
Not applicable (No information so far - code 128 to 104)	8
Other (please specify below)	9

.....

C37

106 Do you feel you know enough about labour and delivery so far?

	C38
Yes definitely	1
Yes - with qualifications	2
Don't know, perhaps not	3
No - but with qualifications	4
No - definitely not	5

107 Do you yourself intend to breastfeed your baby?

	C39
Yes - definitely	1
Yes - with qualifications	2
Don't know, perhaps not	3
No - but with qualifications	4
No - definitely not	5

108 What does your husband feel about whether or not you breastfeed your baby?

	C40
Definitely approves/supports	1
O.K. if I want to breastfeed	2
No opinion, not for him to say	3
Not at all enthusiastic, rather not	4
Definitely opposed	5
Don't know what he thinks	6
Respondent not married	9

109 Where have you obtained information about breastfeeding so far?

Clinic ante-natal classes	1
Parents Centre classes	2
Friends	4
Parents, in-laws, brothers, sisters	8
Clinic staff (NOT in classes)	16
Doctor (G.P.)	32
Books, magazines, pamphlets etc.	64
Nowhere (no information so far)	128 → Go to 111
La Leche League	256
Others (please specify below)	512

.....

INTERVIEWER

Circle the code for each answer given, afterwards add up the total and write it in the box below.

C41-43

110 Which has been your most important single source of information about breastfeeding?

	C44
Clinic ante-natal classes	1
Parents Centre classes	2
Friends	3
Parents, in-laws, brothers, sisters	4
Clinic staff (NOT in classes)	5
Doctor (G.P.)	6
Books, magazines, pamphlets etc.	7
Not applicable (no information so far)	8
La Leche League	9
Others (please specify below)	

.....

111 Do you feel you know enough about breastfeeding so far?

- |                              |     |
|------------------------------|-----|
|                              | C45 |
| Yes - definitely             | 1   |
| Yes - with qualifications    | 2   |
| Don't know, perhaps not      | 3   |
| No - but with qualifications | 4   |
| No - definitely not          | 5   |

112 What changes, if any, do YOU expect in your life once the baby is born?

	C 46-47

113 What changes, if any, do YOU expect in your husband's life once the baby is born?

	C48-49

INTERVIEWER:

I have here a list of statements that have been made by various women about ante-natal clinics. I'd like you to read each of them and then I'd like you to say whether you "strongly agree", "agree", "disagree" or "strongly disagree" with each statement. There are differences of opinion about these statements, we would like to know what you think.

Please mark a tick opposite each statement, in the appropriate column, to show whether you "strongly agree", "agree", "disagree" or "strongly disagree".

	Strongly agree	Agree	Disagree	Strongly disagree
114 The clinic staff have time to talk to me and discuss questions I have				
115 The clinic staff do not have time to explain examinations or treatments to me				
116 The clinic staff have time to explain breast care and breastfeeding to me				
117 The clinic staff are especially nice to me				
118 The clinic staff use some medical words which are difficult to understand				
119 I often have to wait too long at the clinic from when I arrive until I am examined				
120 I often have to wait too long at the clinic from my examination until the class				
121 There is a good, friendly atmosphere at the clinic				
122 I find my visits to the clinic very helpful and reassuring				
	Strongly agree	Agree	Disagree	Strongly disagree

Item	Col. no.	Strongly Agree	Agree	Disagree	Strongly Disagree
114	50	4	3	2	1
115	51	1	2	3	4
116	52	4	3	2	1
117	53	4	3	2	1
118	54	1	2	3	4
119	55	1	2	3	4
120	56	1	2	3	4
121	57	4	3	2	1
122	58	4	3	2	1

4663

123 What are your overall impressions of the Clinic, the staff and the maternity care provided there?

	C 59-60
	C 61-62
	C 63-64

124 What improvements, if any, would you suggest in the Clinic?

	C 65-66

## INTERVIEWER:

I have a list of statements that have been made by various women about the maternity care provided by G.P.s (family doctors). I'd like you to read each of them and then I'd like you to say whether you "strongly agree", "agree", "disagree" or "strongly disagree" with each statement. There are differences of opinion about these statements, we would like to know what you think.

Please mark a tick in the appropriate box as before.

		Strongly Agree	Agree	Disagree	Strongly Disagree
125	My G.P. (family doctor) has time to talk to me and discuss questions I have				
126	My G.P. (family doctor) does not have time to explain examinations or treatments to me				
127	My G.P. (family doctor) has time to explain breast care and breastfeeding to me				
128	My G.P. (family doctor) uses some medical words which are difficult to understand				
129	I often have to wait too long at my G.P.'s (family doctor's) surgery				
		Strongly Agree	Agree	Disagree	Strongly Disagree

Item	Col. no.	Strongly Agree	Agree	Disagree	Strongly Disagree
125	67	4	3	2	1
126	68	1	2	3	4
127	69	4	3	2	1
128	70	1	2	3	4
129	71	1	2	3	4

130 What are your overall impressions of the maternity care provided by G.P.s (family doctors)?

	c 72-73

131 What improvements, if any, would you suggest in the maternity care provided by G.P.s (family doctors)?

	c 74-75

132 Which of the following best describes how happy your marriage is at present?

- |   |     |
|---|-----|
|   | C75 |
| It is very happy indeed                           | 1   |
| It is as happy as most                            | 2   |
| It is mostly quite happy                          | 3   |
| It is not very happy really                       | 4   |
| It is unhappy at present                          | 5   |
| Not applicable (not married, separated, divorced) | 9   |

133 Which of the following best describes any problems you have recently experienced in your marriage?

- |   |     |
|---|-----|
|   | C77 |
| No problems at all  | 1   |
| Only minor problems   | 2   |
| Some major problems but we're coping with them              | 3   |
| Some major problems that are proving difficult to cope with | 4   |
| Major problems are causing the marriage to break down       | 5   |
| Not applicable (not married, separated, divorced)           | 9   |

134 Do you have any other comments to make about your pregnancy, or more generally about starting your family?

	c 78-79

135 Finally, do you have any comment to make about this interview?

	c 80

Finally, we have the last section of this questionnaire for you to fill in. It consists of a number of pairs of statements about things you may or may not like; about ways in which you may or may not feel. For example, here are two statements:

- A. I like to talk about myself to others
- B. I like to work toward some goal that I have set for myself

Which of these two statements is more characteristic of what you like, A or B? You may like both A and B. In this case, you would have to choose between the two and you should choose the one that you like better. If you dislike both A and B, then you should choose the one that you dislike less.

Some of the pairs of statements in this section of the questionnaire have to do with your likes, such as the example already given. Other pairs of statements have to do with how you feel, for example:

- A. I feel depressed when I fail at something
- B. I feel nervous when giving a talk before a group

Which of these statements is more characteristic of how you feel, A or B? If neither statement accurately describes how you feel, then you should choose the one which you consider to be less inaccurate.

Your choice, in each instance, should be in terms of what you like and how you feel at the present time, and not in terms of what you think you should like or how you think you should feel. This is not a test. There are no right or wrong answers. Your choices should be a description of your own personal likes and feelings.

Please make a choice for every pair of statements; please do not skip any.

INTERVIEWER

Give EPPS statements to respondent.

Please read each pair of statements, and put a ring around A or B to show which statement you choose.

INTERVIEWER

If respondent is short of time, she may take the EPPS statements with her, to fill in and post back to us. In this case please give her a reply-paid envelope.

Statements rated at interview

Tick


Statements taken home

When respondent has completed EPPS statements, please code her responses below. Please enclose her statements sheets with the questionnaire.

FOR OFFICE USE ONLY / START CARD FOUR

Cols. 1-4	Duplicate
Col. 5	<input type="text" value="4"/>
Cols. 6-20	Duplicate

470



Write the "s" scores for each variable ("ach", "def" etc.) below (the last variable, "con", is scored below):

<u>Variable</u>	<u>Col. no.</u>	<u>"s" Score</u>	<u>Variable</u>	<u>Col. no.</u>	<u>"s" Score</u>
ach	c. 21-22	<input type="checkbox"/>	dom	c. 37-38	<input type="checkbox"/>
def	c. 23-24	<input type="checkbox"/>	aba	c. 39-40	<input type="checkbox"/>
ord	c. 25-26	<input type="checkbox"/>	nur	c. 41-42	<input type="checkbox"/>
exh	c. 27-28	<input type="checkbox"/>	chg	c. 43-44	<input type="checkbox"/>
aut	c. 29-30	<input type="checkbox"/>	end	c. 45-46	<input type="checkbox"/>
aff	c. 31-32	<input type="checkbox"/>	het	c. 47-48	<input type="checkbox"/>
int	c. 33-34	<input type="checkbox"/>	agg	c. 49-50	<input type="checkbox"/>
suc	c. 35-36	<input type="checkbox"/>	con	c. 51-52	<input type="checkbox"/>

Now calculate the consistency score. Note that in each column one item is crossed out (e.g. item 1 in the first column) and one is bracketed (e.g. item 151 in the first column). For each column check the letter encircled for these two items (the crossed out one and the bracketed one), and put a tick at the bottom of the column if the same letter is encircled. Add up the number of ticks and write this number in "con" at the bottom of the above list of variables.

PREGNANCY AND PARENTHOOD RESEARCH PROJECT - MAIN SAMPLE - THIRD INTERVIEW

INTERVIEWER

This questionnaire is used for interviews with primigravidae and multigravida nulliparae whose E.D.D. falls in the period 23 May 1976 to 9 October 1976 inclusive, and who have delivered their babies. When a sample member delivers, a card is detached from her chart and left in a box provided in the Delivery Suite Office. This means we usually have 7-10 days in which to conduct an interview in Campbell-Johnstone. Sample members will be in one of Wards 52, 53, 54 or 55. The first two are in the C-J building; the latter two are a short distance away in front of Hockin Nurses Home. A board in the lobby of C-J indicates the location of all C-J patients. Check with the Charge Nurse (Ward Sister) or senior nurse present before proceeding with an interview, and fit in with Ward requirements and procedures. DO NOT PROCEED in the event of a neonatal death or stillbirth; in case of other obstetric or neonatal complications please seek advice before proceeding, by contacting myself (62889 extension 4957 or 52202) or Heather Rigg (57254).

Check the following with the Charge Nurse (Ward Sister) or senior nurse present:

- a) stillbirth or neonatal death: DO NOT INTERVIEW
- b) obstetric or neonatal complications: SEEK ADVICE
- c) vaginal or caesarian birth: VAGINAL, Q.5; CAESARIAN. Q.6 & Q.7.
- d) marital status: MARRIED/DE FACTO, Q.11 & Q.12; OTHERS, Q.13 - 14.
- e) Baby in Intensive Care Nursery/was there: Q.15 - 18.

Fill in details required for page 12.

EXPLAIN THE THIRD INTERVIEW TO THE RESPONDENT

Mrs

We have talked to you twice during your pregnancy, and we would like a few minutes with you now.

FOR OFFICE USE ONLY

Cols. 1-4 Respondent no.

Col.5 Card no.

Col.6 Interview no.

Cols.7-12 Interview date **473**

Cols.13-20 Register no. (W316)

INTERVIEWER

To begin with I'd like to ask you a few questions about yourself.

01 How do you feel in yourself (not physical condition)?

	C21
Wonderful, marvellous, very good	1
Good, quite good	2
All right, O.K., not so bad	3
Not very good, bit down	4
Bad, awful, angry, upset, humiliated, depressed	5

02 How do you think your labour and delivery went?

	C22
Easy, good	1
Short and sharp	2
O.K., all right	3
Long, tiring, very hard work	4
Very painful, agonising, extremely distressing	5

03 How do you think you coped with your labour and delivery?

	C23
Very well, well, satisfied	1
Quite well, not bad really	2
About average, neither especially well nor badly	3
Disappointed, depressed because not very well	4
Ashamed, guilty at felt inadequacy, incompetence	5

04 Were there any aspects of the labour and delivery that you enjoyed, or felt good about?

Support of husband	1
Starting labour, this is it	2
Doing breathing/relaxation	4
Starting to push, pushing	8
Actually delivering the baby	16
Seeing/holding/feeding the baby	32
Knowing it was all over	64
Other (please specify - first)	128
.....	
Other (please specify - second)	256
.....	

TOTAL  C24-26

INTERVIEWER

Circle the code for each answer given; afterwards add up the total and write it in the C24-26 box provided above.

INTERVIEWER

If the baby was born vaginally code 1 in C27 box below, ask Question 5, then skip Questions 6 and 7.

If the baby was born by caesarian section code 2 in C27 box below, skip Question 5 and ask Questions 6 and 7.

C27 Vaginal delivery

05 Were there any aspects of the actual labour and delivery that you particularly didn't like, felt bad about? (DO NOT PROMPT)

Stages

When contractions were just about beginning, is this it?	1
First stage labour, before pushing	2
Pushing, delivering the baby	4
Delivering the placenta/afterbirth	8

"Stages" total C28-29 Events

Enema	1
Shave	2
Induction	4
Vaginal examination	8
Episiotomy	16
Stitching	32
Forceps	64
Other delivery assistance (eg.vacuum extraction)	128
Other electronic/mechanical aids (eg.cardio-topograph)	256
Other events (please specify)	512

"Events" total C30-32 Situation

Husband not there because	
not allowed by staff	1
he didn't want to be	2
couldn't be there (e.g. work)	4
she had thought she didn't want him (changed mind)	8
Relative/friend not there because	
not allowed by staff	16
they didn't want to be	32
couldn't be there	64
she had thought she didn't want them (changed mind)	128

"Situation/support" total C33-35 Staff

did not keep informed re progress	1
seemed too busy to talk	2
difficult to talk to	4
left her alone "too much"	8
other (please specify)	16

Delivery Suite

too crowded	32
too noisy	64
too lonely	128
other (please specify)	256

"Situation/official" total C36-38 Feelings

scared, frightened	1
lonely	2
worried	4
not knowing/understanding	8
pain	16
nausea	32
backache	64
other discomfort	128
other (please specify)	256

"Feelings" total C39-41 

Go to Question 8

Caesarian

06 Were there any aspects of the actual labour, up until you received the anaesthetic for your caesarian, that you particularly didn't like, felt bad about? (DO NOT PROMPT)

Stages

When contractions were just about beginning, is this it? 1  
 First stage labour, before pushing 2  
 Other (please specify) 4

"Stages" total C42

Events

Enema 1  
 Shave 2  
 Induction 4  
 Vaginal examination 8  
 Other electronic/mechanical aids (eg. cardiotopograph) 16  
 Being told that a caesarian was necessary 32  
 Other (please specify) 64

"Events" total C43-45

Situation

Husband not there because  
 not allowed by staff 1  
 he didn't want to be 2  
 couldn't be there (eg. work) 4  
 she had thought she didn't want him (changed mind) 8  
 Relative/friend not there because  
 not allowed by staff 16  
 they didn't want to be 32  
 couldn't be there 64  
 she had thought she didn't want them (changed mind) 128

"Situation/support total C46-48

Staff

did not keep informed re progress 1  
 seemed too busy to talk 2  
 difficult to talk to 4  
 left her alone "too much" 8  
 other (please specify) 16

Delivery Suite

too crowded 32  
 too noisy 64  
 too lonely 128  
 other (please specify) 256

"Situation/official" total C49-51

Feelings

scared, frightened 1  
 lonely 2  
 worried 4  
 not knowing/understanding 8  
 pain 16  
 nausea 32  
 backache 64  
 other discomfort 128  
 other (please specify) 256

"Feelings" total C52-54

07 How do you feel about your baby having been born by caesarian?

	C55-56
--	--------

08 Overall, was your labour and delivery

	C57
<u>far better than you expected</u>	1
<u>better than you expected</u>	2
<u>about what you expected</u>	3
<u>worse than you expected</u>	4
<u>far worse than you expected</u>	5

09 What helped you with your labour and delivery?

Own doctor in attendance	1	TOTAL
Husband being there	2	
Relative/friend being there	4	
Staff of Delivery Suite	8	
Antenatal classes - breathing, relaxation	16	
Antenatal classes - information, discussion	32	
Antenatal clinic staff advice	64	
Reading books, leaflets etc.	128	
Parents Centre, La Leche League	256	
Analgesics (injections,tablets,gas and air)	512	
Other (please specify)	C58 <input style="width: 30px; height: 15px;" type="text"/>	TOTAL

INTERVIEWER

Circle the code for each answer given, afterwards add up the total and write it in the C59-61 box below.

C59-61

10 What was the single greatest help with your labour and delivery?

C62-63

Own Doctor in attendance	01
Husband being there	02
Relative/friend being there	03
D.S. staff	04
Antenatal classes - breathing, relaxation	05
Antenatal classes - information, discussion	06
Antenatal clinic staff advice	07
Reading books, leaflets etc.	08
Parents Centre	09
La Leche League	10
Analgesics (injections, tablets, gas and air)	11
Other (please specify)	

12

C64

Married or de facto married only (others go to Q.13):-

11 How important was it to you for your husband to be with you during labour (first stage)?

C65

Very important, essential		1
Important, not essential		2
Helpful, not very important	He was there	3
Not important, O.K.,		4
Not at all important, his choice, no opinion/preferred not but ...		5
N/a, wasn't there, wished he was	He was not there	6
N/a, wasn't there, didn't mind		7
N/a, wasn't there, didn't want him		8
N/a, not married		9

Married or de facto married only (others go to Q.13):-

12 How important was it to you for your husband to be with you when the baby was born?

C66-67

Very important, essential		01
Important, not essential		02
Helpful, not very important	He was there	03
Not important, O.K.,		04
Not at all important, his choice, no opinion/preferred not but ...		05
N/a, wasn't there, wished he was	He was not there	06
N/a, wasn't there, didn't mind		07
N/a, wasn't there, didn't want him		08
N/a, not married		09
N/a, caesarian		10

Go to Q.15.

Not married or de facto.

13 How important was it to you for a friend or relative to be with you during labour (first stage)?

		C68
Very important, essential	} Somebody	1
Important, not essential		2
Helpful, not very important		3
Not important, O.K.		4
Not at all important, their choice, no opinion/preferred not but ..		5
N/a, wasn't there, wished somebody was		6
N/a, wasn't there, didn't mind		7
N/a, wasn't there, didn't want anybody		8

Not married or de facto.

14 How important was it to you for a friend or relative to be with you when the baby was born?

		C69
Very important, essential	} Somebody	1
Important, not essential		2
Helpful, not very important		3
Not important, O.K.		4
Not at all important, their choice, no opinion/preferred not but ..		5
N/a, wasn't there, wished somebody was		6
N/a, wasn't there, didn't mind		7
N/a, wasn't there, didn't want anybody		8
N/a, caesarian		9

Baby is/has been in I.C.N. (others go to Q.19)

15 I understand your baby is/has been in the Intensive Care Nursery. Do you fully understand why she/he is there?

		C70
Yes - fully understood	1	Go to Q.16
Not fully understood	2	Go to Q.16
No - do not understand	3	Go to Q.17

Baby is/has been in I.C.N.

16 Could you explain the reason(s) to me please?

Prematurity	1
Low birth weight	2
Respiratory trouble	4
Instrumental delivery (eg.forceps, vacuum extraction)	8
Prolonged ruptured membranes	16
Observation	32
Jaundice	64
Other (please specify)	128
.....	

TOTAL C71-73

INTERVIEWER

If ansered "Yes - fully understood", code 1, to Q.15 go to Q.18.

If answered "Not fully understood", code 2, to Q.15 go to Q.17.

(If answered "No - do not understand", code 3, to Q.15 should have skipped Q.16 and gone to Q.17).

Baby is/has been in I.C.N.

17 What is it you need to know, or have explained to you?

1.	C74-75
2.	C76-77

Baby is/has been in I.C.N.

18 How do you feel about the baby being/having been in the Intensive Care Nursery?

- |  |     |
|--|-----|
|  | C78 |
| Fully understand, it's routine, not unduly worried                   | 1   |
| Fully understand, reasonably hopeful/confident it'll be O.K.         | 2   |
| Fully understand, worried or concerned, have to wait and see         | 3   |
| Don't (fully) understand, not unduly worried                         | 4   |
| Don't (fully) understand, reasonably hopeful/confident it'll be O.K. | 5   |
| Don't (fully) understand, worried or concerned, have to wait and see | 6   |

FOR OFFICE USE ONLY

C79-80

FOR OFFICE USE ONLY	
Cols. 1-4	Duplicate
Col. 5	2
Cols. 6-20	Duplicate

19 Is the baby a boy or a girl?

C21

Boy	1
Girl	2

20 Did you particularly want a ..... (Whatever sex it is)?

C22

Yes definitely	1
Yes but didn't really matter	2
Didn't mind	3
No but doesn't really matter	4
No definitely not	5

Baby not in I.C.N.

21 How is the baby?

Physical condition C23

Good, well, fine	1
O.K., all right	2
Other (please specify)	3

Behaviour/"personality"

Positive comment(s)	4
Negative comment(s)	5

Ask all

22 Can you try to remember how you felt about the baby when she/he had just been born?

C24

Thrilled, delighted, rush of love/tenderness, etc	1
Pleased, interested, cared about baby, but also tired, emotionally drained, not feeling much	2
Basically glad it was all over, relieved, tired etc., not especially interested <u>then</u>	3
Mildly hostile, critical, rejecting, definitely not interested	4
Hostile, very rejecting, angry etc.	5

23 How do you feel, in yourself, about being a new mother?

	C25-26
	C27-28
	C29-30
	C31-32

24 How do you think the baby is going to change YOUR life?

	C33-34

Married/de facto only

25 How do you think the baby is going to change your HUSBAND'S life?

	C35-36

26 Do you have any other comments to make about being a new mother?

	C37-38

27 Do you have any comments to make about this interview?

483	C39-40

INTERVIEWER

Obtain this information from Charge Nurse (Ward Sister) and/or patient's chart as appropriate.

Date of admission to Delivery Suite	C41-46	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Time of admission to Delivery Suite	C47-50	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Date of delivery	C51-56	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Time of delivery	C57-60	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Date of baby's admission to ICN (if applic.)	C61-66	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Date of baby's discharge from ICN (if applic.)	C67-72	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Ward to which respondent admitted		C73 <table border="1"><tr><td> </td></tr></table>			
Ward 52 = code 2	Mothercraft Unit = code 6				
Ward 53 = code 3	Other ward CJ = code 7				
Ward 54 = code 4	Other hospital etc. = code 8				
Ward 55 = code 5	Other procedure = code 9				

.....

Transfer (use above codes)	C74	<table border="1"><tr><td> </td></tr></table>		<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Date of mother's admission to MCU (if applic.)	C75-80	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>					

FOR OFFICE USE ONLY		
START CARD 3		
Cols.1-4	Duplicate	
Col.5	<table border="1"><tr><td>3</td></tr></table>	3
3		
Cols6-20	Duplicate	

Date of mother's discharge from MCU (if applic)	C21-26	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			

Method of delivery	C27	<table border="1"><tr><td> </td></tr></table>	
vaginal - no intervention = code 1			
vaginal - manual manipulation = code 2			
vaginal - forceps = code 3			
vaginal - other intervention (eg. vacuum) = code 4			
caesarian = code 5			

Other notes	C28-29

PREGNANCY & PARENTHOOD RESEARCH PROJECT - MAIN SAMPLE - FOURTH INTERVIEW

INTERVIEWER

This questionnaire is used for interviews at home with sample members either eight weeks or twentysix weeks after the birth of their baby.

This questionnaire is for use at eight/twentysix weeks.

The interview is due on ...../...../19.....

Cols. 1-4	Respondent no.	<input type="text"/>
Col. 5	Card no.	<input type="text" value="1"/>
Col. 6	Interview no.	<input type="text" value="4"/>
Cols. 7-12	Interview date	<input type="text"/>
Cols. 13-20	Register no.	<input type="text"/>

Address:

Telephone:

The following questions are not applicable:

Special instructions:

Mrs

This is the last occasion on which we would like to talk to you about pregnancy and parenthood. We are very grateful that you have helped us so far, and hope you have found your participation in the Project of interest.

If you would like to know when the report on this Project is published, and to receive a summary of the findings, we would be glad to know. This will take one to two years as we have 350 women to interview.

Respondent would like to receive summary report: Yes..... No.....

- 1 -

Could I begin by checking some information about your time in Campbell-Johnstone?

001 Did you spend any time in Ward One, the ante-natal ward?

	c21	
Yes	1	Go to 002
No	2	Go to 006

002 What were the dates of your time in Ward One?

Came in to Ward One (initially)	c22-27	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Went home (or had baby, changed wards)	c28-33	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Came back to Ward One (if applicable)	c34-39	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
Went home (or had baby, changed wards)	c40-45	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			

003 So how many days in all did you spend in Ward One? c46-47 

--

004 Why were you admitted to Ward One?

	c48-49

005 What do you think of your time in Ward One?

	c50-51

006 What was the date and time of your admission to the Delivery Suite at C-J?

c52-57	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			
c58-61	<table border="1"><tr><td> </td><td> </td></tr></table>			

007 Did you deliver your baby routinely, or did you have a caesarian section?

	c62	
Routine (vaginal) birth	1	Go to 008
Caesarian section	2	Go to 009

008 Were any of the following part of your routine birth:

Induction (e.g. drip, injection, breaking of membranes etc.)	1	} Go to 009	
Manual manipulation (by midwife, doctor, to assist birth)	2		
Forceps delivery	4		
Other intervention in birth	8		
Episiotomy (incision in perineum)	16		
N/a (caesarian) = 99	486		
	c63-64	<table border="1"><tr><td> </td></tr></table>	

009 Routine birth: For how long were you in labour in total, including before you came into C-J? (Go to 011)  
Caesarian birth: For how long were you in labour in total, from when labour started until you went for your caesarian?

(hours) c65-66

Caesarian only:

010 Did your caesarian occur after a routine beginning to your labour, or after an induction?

	c67
Routine beginning	1
Induction	2
N/a (not a caesarian)	9

011 What was the date and time of your baby's birth (either routine birth or caesarian)?

c68-73   
c74-77

012 Routine birth: How do you think your labour and delivery went?  
Caesarian birth: How do you think your labour went up to the time when you went for your caesarian?

	c78
Easy, good	1
Short and sharp	2
O.K., all right	3
Long, tiring, very hard work	4
Very painful, agonising, extremely distressing	5
N/a (caesarian; no labour)	9

013 Routine birth: How do you think you coped with your labour and delivery?  
Caesarian birth: How do you think you coped with your labour up to the time when you went for your caesarian?

	c79
Very well, well, satisfied	1
Quite well, not bad really	2
About average, neither especially well nor badly	3
Disappointed, depressed because not very well	4
Ashamed, guilty at felt inadequacy or incompetence	5
N/a (caesarian; no labour)	9

FOR OFFICE USE ONLY  
 Cols. 1-4 Duplicate  
 Col. 5  c80   
 Cols. 6-20 Duplicate

014 Did you experience the "new baby blues" at all after your baby was born (i.e. feel depressed, tearful and/or miserable)?

- Yes c21 1 Go to 015
- No 2 Go to 021
- Other answer 3 Go to 019

015 When did this happen (first)?

- In C-J (post-partum) c22 1
- Just when/after getting home 2
- About 3-4 weeks after getting home 3
- About 5-6 weeks after getting home 4
- About 7-8 weeks after getting home 5
- About 3 months after getting home 6
- About 4 months after getting home 7
- About 5-6 months after getting home 8
- Other answer 9
- .....
- .....

016 What was it like? Can you tell me about it?

	c23-24
--	--------

017 Did this happen again? (If so: When?)

- No (only experienced once) c25 1 Go to 020
- Just when/after getting home 2
- About 3-4 weeks after getting home 3
- About 5-6 weeks after getting home 4
- About 7-8 weeks after getting home 5 } Go to 018
- About 3 months after getting home 6
- About 4 months after getting home 7
- About 5-6 months after getting home 8
- Other answer 9

.....  
.....

018 What was it like? Can you tell me about it?

Go to 020	c26-27

019 Could you tell me more about .... (Answer to Q. 014 )

	c28-29

020 Did you have any help or treatment for your "new baby blues"? This includes practical help, counselling or advice, and treatment by your G.P. etc.

489	c30-32

Before you had your baby, and not counting classes, had you actually done any of the following tasks for a baby (under one year), either frequently, occasionally or never?

	Never	Occasionally (1-6 times)	Frequently (more than 6 times)
021			
022			
023			
024			
025			
026			
027			
028			
029			
030			
031			
032			
033			
034			
035			
036			
037			
038			
039			
040			
041			
042			
043			

Coding (Interviewer)

021	c33	1	2	3	026	c38	1	2	3	031	c43	1	2	3
022	c34	1	2	3	027	c39	1	2	3	032	c44	1	2	3
023	c35	1	2	3	028	c40	1	2	3	033	c45	1	2	3
024	c36	1	2	3	029	c41	1	2	3	034	c46	1	2	3
025	c37	1	2	3	030	c42	1	2	3	035	c47	1	2	3
036	c48	1	2	3	039	c51	1	2	3	042	c54	1	2	3
037	c49	1	2	3	040	c52	1	2	3	043	c55	1	2	3
038	c50	1	2	3	041	c53	1	2	3					

Now we have some questions about health care.

044 How would you describe your present health?

- |           |     |
|-----------|-----|
| Excellent | c56 |
| Good      | 1   |
| Fair      | 2   |
| Poor      | 3   |
| Very poor | 4   |
|           | 5   |

045 During your pregnancy, how often did you see

- |  |        |                          |
|--|--------|--------------------------|
| <u>Your G.P. about your pregnancy</u>    | c57-58 | <input type="checkbox"/> |
| <u>C-J Ante-natal Clinic - Sisters</u>   | c59-60 | <input type="checkbox"/> |
| <u>C-J Ante-natal Clinic - Doctor(s)</u> | c61-62 | <input type="checkbox"/> |
| <u>Obstetrician (specialist)</u>         | c63-64 | <input type="checkbox"/> |

046 In the two/six months since your baby was born, how often has s/he been seen by:

- |  |        |                          |
|--|--------|--------------------------|
| <u>The Plunket Nurse at home</u>                               | c65-66 | <input type="checkbox"/> |
| <u>The Plunket Nurse at Plunket Rooms</u>                      | c67-68 | <input type="checkbox"/> |
| <u>The Public Health Nurse</u>                                 | c69-70 | <input type="checkbox"/> |
| <u>A G.P. (family doctor)</u>                                  | c71-72 | <input type="checkbox"/> |
| <u>Practise Nurse (at G.P.)</u>                                | c73-74 | <input type="checkbox"/> |
| <u>A specialist (paediatrician etc)</u><br><u>at his rooms</u> | c75-76 | <input type="checkbox"/> |
| <u>The Paediatric Clinic (held at</u><br><u>the Hospital)</u>  | c77-78 | <input type="checkbox"/> |
| <u>Other health professional(s)</u>                            | c79-80 | <input type="checkbox"/> |

.....

FOR OFFICE USE ONLY	
Cols 1-4	Duplicate
Col. 5	<input type="checkbox"/> 3
Cols 6-20	Duplicate

047 Were any of these visits or consultations for other than routine reasons (eg a check-up)? (If other than routine specify below please).

1.	c21-22
2.	c23-24

048 And how often have you seen a doctor or specialist about yourself for any reason related to your pregnancy or the birth of your baby?

G.P. (family doctor)	c25-26	<input type="checkbox"/>
Specialist (obstetrician etc)	c27-28	<input type="checkbox"/>
O & G clinic doctor at C-J	c29-30	<input type="checkbox"/>
Other health professional	c31-32	<input type="checkbox"/>
.....		

049 Were any of these visits or consultations for other than routine reasons (eg a check-up)? (If other than routine specify below please).

1.	c33-34
2.	c35-36

050 Could you tell me how many children you intend to have after this child?

	c37
One more (total of 2)	1
Two more (total of 3)	2
Three more (total of 4)	3
Four more (total of 5)	4
Five more (total of 6)	5
Six more (total of 7)	6
Seven more (total of 8) or more	7
No more (only child)	8
Don't know, not planning	9

051 Are you using contraception methods at this time?

	c38
Yes	1
No	2

052 Do you intend using contraceptive methods within the next 12 months?

	c39	
Yes	1	Go to 053
No	2	Go to 054

053 What method do you use or intend using?

Coitus interruptus (withdrawal)	1	} Go to 055
Rhythm method (calendar)	2	
Condom (sheath)	4	
Spermicide or douch (foam, cream)	8	
Diaphragm (cap)	16	
I.U.D. (Loop, copper 7, Dalkon Shield)	32	
Contraceptive pill or injection	64	
Don't know not sure	128	

c40-42

054 Could you tell me the reasons for not using contraceptive methods?

Wish to have another child	1
Religious objections to contraception	2
Asthetic or personal objections	4
Economical reasons	8
Fear of inhibiting lactation	16
Husband objects	32
Health reasons	64
Other reasons (please specify)	128

.....

c43-45

We now have some questions about outside interests.

055 Do you and your husband take part in outside interests, activities, clubs etc together?

	c46
Always, virtually always	1
Usually, most of them	2
Some together, some separate	3
Very few together, occasionally	4
Never, virtually never	5

056 In how many organisations or regular activities did you participate before the baby was born?

c47-48

Please list them:

- |      |     |       |        |                      |
|------|-----|-------|--------|----------------------|
| 057  | 1.  | ..... | c49-50 | <input type="text"/> |
| -066 | 2.  | ..... | c51-52 | <input type="text"/> |
|      | 3.  | ..... | c53-54 | <input type="text"/> |
|      | 4.  | ..... | c55-56 | <input type="text"/> |
|      | 5.  | ..... | c57-58 | <input type="text"/> |
|      | 6.  | ..... | c59-60 | <input type="text"/> |
|      | 7.  | ..... | c61-62 | <input type="text"/> |
|      | 8.  | ..... | c63-64 | <input type="text"/> |
|      | 9.  | ..... | c65-66 | <input type="text"/> |
|      | 10. | ..... | c67-68 | <input type="text"/> |

CODER

Write the general codes (nnn) to the right of each of the specific codes (nn); add up each different general code to yield a total and write it here.

c69-71

067 In how many organisations or regular activities do you participate now, since the baby has arrived?

c72-73

Please list them:

- |      |     |       |
|------|-----|-------|
| 068  | 1.  | ..... |
| -077 | 2.  | ..... |
|      | 3.  | ..... |
|      | 4.  | ..... |
|      | 5.  | ..... |
|      | 6.  | ..... |
|      | 7.  | ..... |
|      | 8.  | ..... |
|      | 9.  | ..... |
|      | 10. | ..... |

CODER

494

Repeat the above procedure here. The boxes for the nn line codes (specific codes) and for the nnn total of the general codes appear on the next page.

c74  
c75  
c76  
c77  
c78  
c79  
c80

FOR OFFICE USE ONLY  
Cols 1-4 Duplicate  
Col. 5   
Cols 6-20 Duplicate

Question	Col. No.	Specific Codes	Question	Col. No.	Specific Codes
068	c21-22	<input type="text"/>	073	c31-32	<input type="text"/>
069	c23-24	<input type="text"/>	074	c33-34	<input type="text"/>
070	c25-26	<input type="text"/>	075	c35-36	<input type="text"/>
071	c27-28	<input type="text"/>	076	c37-38	<input type="text"/>
072	c29-30	<input type="text"/>	077	c39-40	<input type="text"/>
General Codes total c41-43		<input type="text"/>			

Next we would like to ask you about feeding your baby.

078 How has your baby been fed up until now? Firstly, what has your baby received?

- Entirely breastfed c44  
1
- Breastfed with milk supplement 2
- Breastfed with juice supplement 3
- Breastfed with milk & juice supplement 4
- Entirely breastfed and solids 5
- Breastfed with milk supplement and solids 6
- Breastfed with juice supplement and solids 7
- Breastfed with milk & juice supplement and solids 8
- Other (please specify) 9
- .....

079 And secondly, what method of feeding has been used?

- Entirely breastfed (n/a) c45  
1
- Bottle only 2
- Cup only 3
- Spoon only 4
- Bottle & cup 5
- Bottle & spoon 6
- Cup & spoon 7
- Bottle cup & spoon 8
- Other (please specify) 9
- .....

080 How do you feel about feeding your baby (whether breastfed or bottlefed)?

- |  |     |             |
|--|-----|-------------|
|  | c46 |             |
| Thoroughly enjoy it, no problems                         | 1   | } Go to 082 |
| Enjoy it, accept the difficulties                        | 2   |             |
| Part of looking after the baby, not especially enjoyable | 3   | } Go to 081 |
| Dislike it, a necessity                                  | 4   |             |
| Thoroughly dislikes it, hates it                         | 5   |             |

081 What other arrangement would you prefer?

	c47-48
--	--------

082 What (if anything) do you like, and what (if anything) do you dislike about how you feed your baby?

Likes	c49-50
Dislikes	c51-52

083 How do you feel about the feeding of your baby? Has it been easy, or difficult?

- |   |     |           |
|---|-----|-----------|
|   | c53 |           |
| Very easy - no problems                 | 1   | Go to 087 |
| Quite easy - minor problems             | 2   | Go to 084 |
| OK - some problems                      | 3   | Go to 085 |
| Quite difficult - some major problem(s) | 4   | Go to 086 |
| Very difficult - many/major problems    | 5   | Go to 086 |

084 What were these minor problems?

	c54-55
	c56-57
Go to 087	

085 What were these problems?

	c58-59
	c60-61
Go to 087	

086 What were these major problems?

	c62-63
	c64-65
	c66-67

087 Artificially fed babies.  
 (Babies entirely breastfed, go to 088).

Was your baby ever put to the breast? If so when did he/she first start having milk from the bottle?

	c68		
Never put to the breast	1		
Put to the breast but started milk feeds at _____ weeks (at home)	2	c69-70	
Changed from breast to artificial feeding in hospital: _____ days after the baby was born	3	c71-72	

When you feed your baby could you tell me do you

	Yes	No
<u>Always feed baby yourself</u>	c73 1	2
<u>Cuddle baby close to you when feeding</u>	c74 1	2
<u>Alternate sides when feeding</u>	c75 1	2
<u>Does your husband feed the baby</u>	c76 1	2
<u>Do other members of your family feed the baby</u>	c77 1	2
<u>Do your friends feed the baby</u>	c78 1	2
<u>Do you ever prop your baby for feeding</u>	c79 1	2

FOR OFFICE USE ONLY

c80

Cols 1-4 Duplicate

Col. 5

Cols 6-20 Duplicate

088 Have you anything more to say about problems or advantages of feeding your baby the way you do?

Problems	c21-22
Advantages	c23-24

Can we now turn to the pleasures of parenthood?

I have here a list of some things which various women have said they have enjoyed since the birth of their first child. I'd like you to read each of them and then I'd like you to show whether you have enjoyed each thing "Very much", "Somewhat" or "Not at all". There are differences of opinion about these things; we would like to know what you think.

Please mark a tick opposite each statement in the appropriate column to show whether you enjoyed it "Very much", "Somewhat" or "Not at all".

		I have enjoyed this.....		
		Very much	Somewhat	Not at all
089	Being proud of my baby's growth and development, his/her "milestones"			
090	Being less bored, not bored			
091	Being closer to my relatives, to some (eg mother, mother-in-law)			
092	Appreciating family, family traditions etc more			
093	Having more contact with the neighbours etc			
094	Having more to talk to my husband about, more to share			
095	Feeling closer to my husband			
096	Feeling more "fulfilled"			
097	Appreciating my parents more			
098	The baby is fun to play with			
099	Life has more "purpose"			
100	The baby's company is enjoyable			
		Very much	Somewhat	Not at all

Is there anything not listed here that you have enjoyed?

		Very much	Somewhat
101			
102			
103			

I have here a list of some of the things which various women have said bothered them or caused them concern following the birth of their first child. I'd like you to read each of them and then I'd like you to show whether each thing has bothered you "Not at all", "Somewhat" or "Very much". There are differences of opinion about these things; we would like to know what you think.

Please mark a tick opposite each statement, in the appropriate column to show whether it bothered you "Not at all", "Somewhat" or "Very much".

		This has bothered me.....		
		Not at all	Somewhat	Very much
104	My husband showing too little attention to the baby			
105	Suggestions or advice from in-laws			
106	Worry about my personal appearance in general (not loss of figure)			
107	Less contact with friends			
108	Interruption of routine habits of sleeping, going places etc			
109	My husband showing too much attention to the baby			
110	Additional amount of work (housework included)			
111	Being disturbed about my feelings (eg resentment) toward the baby sometimes			
112	The house not being as neat as it should be			
113	Myself being sexually less responsive			
114	Feeling generally more "distant" from my husband			
115	Being unable to sleep after going to bed			
116	Having to change plans we had made before the baby's birth			
117	My husband being sexually less responsive			
118	Meals not being on time			
119	My husband showing too little attention to me and too much to the baby			
120	Money problems greater than before			
121	Less privacy			
122	Doubting that I'm an adequate parent, can look after the baby properly			
<b>500</b>		Not at all	Somewhat	Very much

		This has bothered me.....		
		Not at all	Somewhat	Very much
123	Worry about loss of my figure			
124	Less contact with people at work, church etc			
125	Physical tiredness, fatigue			
126	Feeling "edgy" or upset			
		Not at all	Somewhat	Very much

Is there anything not listed here that has bothered you?

		Somewhat	Very much
127			
128			
129			

Coding Q. 089-103 on page 15

Qtn	col.	VM	S	NAA	Qtn.	Col.	VM	S	NAA	Qtn.	Col.	VM	s	NAA
089	c68	3	2	1	093	c72	3	2	1	097	c76	3	2	1
090	c69	3	2	1	094	c73	3	2	1	098	c77	3	2	1
091	c70	3	2	1	095	c74	3	2	1	099	c78	3	2	1
092	c71	3	2	1	096	c75	3	2	1	100	c79	3	2	1

FOR OFFICE USE ONLY							
c80	<input type="checkbox"/>	Cols 1-4	Duplicate	Col. 5	<input checked="" type="checkbox"/>	Cols 6-20	Duplicate

Qtn	Cols.	Code	Col.	VM	S
101	21-22	<input type="checkbox"/>	27	3	2
102	23-24	<input type="checkbox"/>	28	3	2
103	25-26	<input type="checkbox"/>	29	3	2

Coding Q. 104-129 on pages 16-17:

Qtn	Col.	VM	S	NAA	Qtn.	Col.	VM	S	NAA	Qtn.	Col.	VM	S	NAA
104	c30	3	2	1	112	c38	3	2	1	120	c46	3	2	1
105	c31	3	2	1	113	c39	3	2	1	121	c47	3	2	1
106	c32	3	2	1	114	c40	3	2	1	122	c48	3	2	1
107	c33	3	2	1	115	c41	3	2	1	123	c49	3	2	1
108	c34	3	2	1	116	c42	3	2	1	124	c50	3	2	1
109	c35	3	2	1	117	c43	3	2	1	125	c51	3	2	1
110	c36	3	2	1	118	c44	3	2	1	126	c52	3	2	1
111	c37	3	2	1	119	c45	3	2	1					

Qtn	Col.	Code	Col.	VM	S
127	c53-54	<input type="checkbox"/>	c59	3	2
128	c55-56	<input type="checkbox"/>	c60	3	2
129	c57-58	<input type="checkbox"/>	c61	3	2

130 Overall, how would you describe your baby?

	c62
Gorgeous, wonderful etc (ecstatic)	1
Lovely, good etc (approving)	2
Dear - but sometimes naughty etc (mixed)	3
Difficult, a problem, a pest etc (disapproving)	4
Demanding, awful, terrible etc (negative)	5

131 When the baby cries during the night, who gets up to him/her?

	c63
Always my husband	1
My husband more than myself	2
Either of us equally often	3
Myself more than my husband	4
Always myself	5
N/A	9

132 At about what time is your baby generally put to bed for the night?

c64-67

133 Are any of the following true of your baby?

Very active, "on the go" a lot	01
Noisy (not specifically crying)	02
Cries a lot, or yells	04
Feeding can be/is a problem	08
Sleeps less than other babies	16
Has been ill	32

c68-69

Not especially active	01
Quiet	02
Placid, contented, doesn't often cry or yell	04
Feeds well	08
Sleeps through the night (usually)	16
Healthy	32

c70-71

134 About how many soiled nappies do you have in a 24-hour period?

c72-73

135 About how many wet (not soiled) nappies do you have in a 24-hour period?

502 c74-75

When both yourself and your husband are available, how do you share the following tasks to do with the baby?

	Always his task	Usually his task, sometimes my task	Equally my task & his task	Usually my task sometimes his task	Always my task
136 Take baby to the doctor					
137 Burp the baby					
138 Feed the baby					
139 Change wet nappies					
140 Groom the baby (hair etc)					
141 Put baby to bed					
142 Take baby outdoors (in pushchair etc)					
143 Bath the baby					
144 Change soiled nappy					
145 Washing baby's nappies etc					
146 Getting baby up					
147 Watch baby while other parent is busy					
148 Dress/undress baby					
149 Play with baby					
150 Oil/powder baby					
151 Give baby medicine					
152 Cuddle baby					
153 Cut baby's nails					
154 Wrap up baby in blanket, cuddly etc					
155 Hold the baby					
156 Take baby's temperature					
157 Try to soothe crying baby					

503

FOR OFFICE USE ONLY					
Cols. 76-80					
Cols 1-4	Duplicate	Col. 5	6	Cols 6-20	Duplicate

Coding for Q.136-157 on page 19

Qtn.	Col.						Qtn.	Col.					
136	c21	1	2	3	4	5	147	c32	1	2	3	4	5
137	c22	1	2	3	4	5	148	c33	1	2	3	4	5
138	c23	1	2	3	4	5	149	c34	1	2	3	4	5
139	c24	1	2	3	4	5	150	c35	1	2	3	4	5
140	c25	1	2	3	4	5	151	c36	1	2	3	4	5
141	c26	1	2	3	4	5	152	c37	1	2	3	4	5
142	c27	1	2	3	4	5	153	c38	1	2	3	4	5
143	c28	1	2	3	4	5	154	c39	1	2	3	4	5
144	c29	1	2	3	4	5	155	c40	1	2	3	4	5
145	c30	1	2	3	4	5	156	c41	1	2	3	4	5
146	c31	1	2	3	4	5	157	c42	1	2	3	4	5

159 Overall, how helpful has your husband been since the new baby came home?

	c43
Very helpful	1
Quite helpful, as helpful as possible	2
About typical, some help	3
Unhelpful	4
Very unhelpful	5

160 Have you had any extra help (apart from your husband) since you came home with the baby?

		c44-45 Major help	c46-47 Other help
None	No, none at all	01	01
Somebody stayed at the house	{ Yes, mother stayed some time	02	02
	{ Yes, mother-in-law stayed some time	03	03
	{ Yes, other relative(s) stayed some time	04	04
	{ Yes, friend(s) stayed some time	05	05
	{ Yes, had Karitane, etc to live-in	06	06
Had regular visiting help	{ Yes, mother visited regularly to help often	07	07
	{ Yes, mother-in-law visited regularly to help often	08	08
	{ Yes, other relative(s) visited regularly to help often	09	09
	{ Yes, friend(s) visited regularly to help often	10	10
	{ Yes, had home help etc to visit	11	11
Had some (occasional) visiting help	{ Yes, some help from mother	12	12
	{ Yes, some help from mother-in-law	13	13
	{ Yes, some help from other relative(s)	14	14
	{ Yes, some help from friend(s)	15	15
	{ Yes, some use of paid services	16	16
	Other answer	17	17

161 How do you feel about looking after the baby?

	c48
Thoroughly enjoy it	1
Get definite pleasure from it most of the time	2
Accept it has to be done, worth it	3
Rather wearisome, a burden, wonder whether it's worth it, feel trapped	4
It's a burden, wish that it wasn't necessary, dislike it	5
N/a (not caring for baby; has Karitane; uses day care centre etc)	9

162 When your baby cries, how does that make you feel?

	c49
Angry, irritated, exasperated	1
Very worried, worried, distraught	2
Mildly concerned, aware but not upset	3
Not really bothered or worried	4
Not at all bothered or worried	5

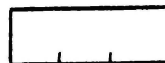
163 When your baby cries, how do you feel you cope (your general reaction or behaviour, not what you specifically do)?

	c50
Completely accept crying as normal	1
Cope quite routinely with it	2
Usually cope adequately with it	3
Quite often can't really cope with it	4
Cannot cope with it, don't know how	5

164 What do you do about the baby's crying?

Check for wet/soiled nappies	1
Check for other specific problems	2
Consider whether thirsty, hungry, offer breast, bottle etc	4
Pick up, cuddle, rock, walk about	8
Ignore it, let him/her cry	16
Scold, tell off, reprimand	32
Smack, shake, chastise physically	64
Other answer	128
.....;	
.....	

c51-53



165 How well do you feel you are coping with the baby on average?

	c54
Very well, on top of the situation	1
Fairly well, some feelings of inadequacy	2
Ups and downs, OK, not too badly	3
Just coping, so-so, not so good, a strain	4
Not coping, feels inadequate, a failure	5

To what extent do you and your husband agree, or disagree, on each of the following:

	Always agree	Usually agree	Sometimes agree Sometimes disagree	Usually disagree	Always disagree
166 Money matters, the family family finances					
167 Recreation, hobbies, outings etc					
168 Demonstrating affection, (hugging, kissing etc)					
169 Friends (who they are, seeing them etc)					
170 Sex (how often, when etc)					
171 What is right and proper (generally)					
172 General outlook on life					
173 Relations with in-laws					

Now we have some questions about married life.

506

sometimes

For each topic (if any) on which you and your husband/usually or always disagree, what is the usual result?  
And if there is disagreement, is this a problem?

	Not Applicable (Always/usually agree)	Wife's point of view "wins"	Husband's Point of view "wins"	Sometimes one sometimes other	Disagreement no problem	Disagreement a problem
174 Money matters, the family finances						
175 Recreation, hobbies, outings etc						
176 Demonstrating affection (hugging, kissing etc)						
177 Friends (who they are, seeing them etc)						
178 Sex (how often, when etc)						
179 What is right and proper (generally)						
180 General outlook on life						
181 Relations with in-laws						

Coding for Q.166-173 and Q.174-181 on page 21

Qtn.	Col.	Aa	Ua	Sasd	Ud	Ad	Qtn.	Col.	N/a	Ww	Hw	So so	Col.	Np	P	Na
166	55	1	2	3	4	5	174	63	9	1	2	3	71	1	2	9
167	56	1	2	3	4	5	175	64	9	1	2	3	72	1	2	9
168	57	1	2	3	4	5	176	65	9	1	2	3	73	1	2	9
169	58	1	2	3	4	5	177	66	9	1	2	3	74	1	2	9
170	59	1	2	3	4	5	178	67	9	1	2	3	75	1	2	9
171	60	1	2	3	4	5	179	68	9	1	2	3	76	1	2	9
172	61	1	2	3	4	5	180	69	9	1	2	3	77	1	2	9
173	62	1	2	3	4	5	181	70	9	1	2	3	78	1	2	9

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c79-80	<input type="checkbox"/>
Cols 1-4	Duplicate
Col. 5	<input checked="" type="checkbox"/>
Cols. 6-20	Duplicate

182 How do you think the baby has changed you as a person?

1.	c21-22
2.	c23-24
3.	c25-26

183 How do you think the baby has changed your husband as a person?

1.	c27-28
2.	c29-30
3.	c31-32

184 How would you describe your relationship with your husband?

	c33-34

185 Which of the following best describes how happy your marriage is at present?

- |   |     |
|---|-----|
|   | c35 |
| <u>It is very happy indeed</u>                    | 1   |
| <u>It is as happy as most</u>                     | 2   |
| <u>It is mostly quite happy</u>                   | 3   |
| <u>It is not very happy really</u>                | 4   |
| <u>It is unhappy at present</u>                   | 5   |
| Not applicable (not married, separated, divorced) | 9   |

186 Which of the following best describes any problems you have recently experienced in your marriage?

- |  |     |
|--|-----|
|  | c36 |
| <u>No problems at all</u>  | 1   |
| <u>Only minor problems</u>   | 2   |
| <u>Some major problems but we're coping with them</u>              | 3   |
| <u>Some major problems that are proving difficult to cope with</u> | 4   |
| <u>Major problems are causing the marriage to break down</u>       | 5   |
| Not applicable (not married, separated, divorced)                  | 9   |

187 Overall, how would you describe the effect your new baby has had on your marriage?

508	c37-38

Now we have some questions about your own childhood.

188 Up until the age of 16 years who had the major responsibility for bringing you up?

- |                                 |     |   |           |
|---------------------------------|-----|---|-----------|
|                                 | c39 |   |           |
| Both natural parents            | 1   | } | Go to 189 |
| One natural parent & stepparent | 2   |   |           |
| Natural mother only             | 3   |   |           |
| Natural father only             | 4   |   |           |
| Adoptive parents                | 5   |   |           |
| Foster parents (one pair)       | 6   |   |           |
| Relatives (one pair)            | 7   |   |           |
| Various situations              | 8   | } | Go to     |
| Institution                     | 9   |   |           |

189 Did you experience any major periods of separation from either parent (or substitute), or any major change of parent (or substitute) up to the age of 16 years?

- |                                      |     |   |           |
|--------------------------------------|-----|---|-----------|
|                                      | c40 |   |           |
| Yes - one or more separations        | 1   | } | Go to 190 |
| Yes - one or more changes            | 2   |   |           |
| Yes - both separation(s) & change(s) | 3   |   |           |
| No                                   | 4   |   | Go to     |
| Various situations (to Q. )          | 5   | } | Go to     |
| Institution (to Q. )                 | 6   |   |           |

190 How many separations or changes were there?

Separations	c41-42	<input type="text"/>
Changes	c43-44	<input type="text"/>

191 Thinking of the first major separation or change, what happened?

- |   |        |
|---|--------|
|   | c45-46 |
| Parents divorced/separated & stayed with mother                 | 01     |
| Parents divorced/separated & stayed with father                 | 02     |
| Parents divorced/separated & went to different family situation | 03     |
| Parents divorced/separated & went to non-family situation       | 04     |
| Father died & stayed with mother                                | 11     |
| Father died & went to other family situation                    | 12     |
| Father died & went to non-family situation                      | 13     |
| Mother died & stayed with father                                | 21     |
| Mother died & went to other family situation                    | 22     |
| Mother died & went to non-family situation                      | 23     |
| Both parents died & went to other family situation              | 31     |
| Both parents died & went to non-family situation                | 32     |
| Father absent (for a period)                                    | 41     |
| Mother absent (for a period)                                    | 42     |
| Sent to boarding school   | 43     |
| Solo mother remarried   | 51     |
| Solo father remarried   | 52     |
| Parents reconciled  | 53     |
| N/a (no separations/changes)                                    | 99     |
| Other separation or change                                      |        |

509

192 How old were you when this happened or began? c47-48

193 Thinking of the second major separation or change, what happened?

	c49-50
Parents divorced/separated & stayed with mother	01
Parents divorced/separated & stayed with father	02
Parents divorced/separated & went to different family situation	03
Parents divorced/separated & went to non-family situation	04
Father died & stayed with mother	11
Father died & went to other family situation	12
Father died & went to non-family situation	13
Mother died & stayed with father	21
Mother died & went to other family situation	22
Mother died & went to non-family situation	23
Both parents died & went to other family situation	31
Both parents died & went to non-family situation	32
Father absent (for a period)	41
Mother absent (for a period)	42
Sent to boarding school	43
Solo mother remarried	51
Solo father remarried	52
Parents reconciled	53
N/a (no/only one separation(s)/change(s) )	99
Other separation or change	
.....	

194 How old were you when this began?

c51-52

195 Thinking of the third major separation or change, what happened?

	c53-54
Parents divorced/separated & stayed with mother	01
Parents divorced/separated & stayed with father	02
Parents divorced/separated & went to different family situation	03
Parents divorced/separated & went to non-family situation	04
Father died & stayed with mother	11
Father died & went to other family situation	12
Father died & went to non-family situation	13
Mother died & stayed with father	21
Mother died & went to other family situation	22
Mother died & went to non-family situation	23
Both parents died & went to other family situation	31
Both parents died & went to non-family situation	32
Father absent (for a period)	41
Mother absent (for a period)	42
Sent to boarding school	43
Solo mother remarried	51
Solo father remarried	52
Parents reconciled	53
N/a (no/only one/only two separation(s)/change(s) )	99
Other separation or change	
.....	

510

196 How old were you when this began?

c55-56

197 How would you describe your relationship with your mother (or mother substitute) during adolescence (say 12-17 years)?

	c57
Very relaxed	1
Relaxed	2
Sometimes relaxed, sometimes tense	3
Tense	4
Very tense	5
N/a	9
	c58
Very close	1
Close	2
Sometimes close, sometimes distant	3
Distant	4
Very distant	5
N/a	9

198 How would you describe your relationship with your father (or father substitute) during adolescence (say 12-17 years)?

	c59
Very relaxed	1
Relaxed	2
Sometimes relaxed, sometimes tense	3
Tense	4
Very tense	5
N/a	9
Very close	
Close	
Sometimes close, sometimes distant	
Distant	
Very distant	
N/a	

1 INTERVIEWER  
 2 Please write  
 3 the code circled  
 4 opposite in c79  
 5 box on page 29  
 9

199 How would you describe your parents' expectations for their child(ren)?

	c60	c61
	Mother	Father
Very high or demanding	1	1
High or demanding	2	2
Realistic or average	3	3
Low or undemanding	4	4
Very low or undemanding	5	5
N/a	9	9

200 How would you describe your parents' methods or standards of discipline?

	c62	c63
	Mother	Father
Very strict	1	1
Strict	2	2
Average	3	3
Not very strict	4	4
Not at all strict	5	5
N/a	9	9

201 How would you describe your family's financial situation during your adolescence?

- Very much above average, affluent c64 1
- Above average, comfortable 2
- About average 3
- Below average, just managed 4
- Very much below average, poor 5

202 Overall how would you describe your childhood.

- Very happy c65 1
- Happy 2
- Average 3
- Unhappy 4
- Very unhappy 5

Can I now turn to some questions about the Hospital.

203 Have you heard about the Mothercraft Unit at the Waikato Hospital?

- Yes (have been there) c66 1 } Go to 204
- Yes (but has not been there) 2 } Go to 208
- Not sure (respondent affirmative) 3 } Go to 210
- Not sure (respondent's answer) 4 }
- No 5 }

204 Would you tell me about your use of the Mothercraft Unit please?  
When were you there?

- After being in C-J for (more or less) the usual period - not having been home c67 1
- After going home came back to the Mothercraft Unit 2
- Other answer (different) 3
- .....
- .....

205 On whose recommendation or advice did you use the Mothercraft Unit?

	c68-69
--	--------

206 Why did you use the Mothercraft Unit?

1.	c70-71
2.	c72-73

207 Do you feel that your stay in the Mothercraft Unit was worthwhile?

Yes, definitely	c74
Yes, on balance	1
Not sure, pros and cons	2
No, although some use	3
No, definitely not	4
	5

208 What are the advantages of using the Mothercraft Unit?

1.	c75-76
2.	c77-78

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Cols. 1-4 Duplicate  
 Col. 5  7  
 Cols 6-20 Duplicate

Still card 6

Col. 79  (Q. 198 second scale)  
 Col. 80

209 What are the disadvantages or inadequacies of the Mothercraft Unit?

1.	c21-22
2.	c23-24
3.	c25-26

Married or de facto married : Skip the text on the upper part of p. 30 and go straight to Q. 210, and ask Q. 210 - 229 as appropriate. Then go to Q. 253 and ask Q. 253-254.

Single girl keeping baby : Read out the text on p. 30 and proceed with Q. 210 - 254 as appropriate.

INTERVIEWER

The following text applies only to single girls who have kept their babies. It does NOT apply to those who are:

- (a) married
- (b) de facto married, or
- (c) single girls who have placed their babies for adoption.

Finally I would like to talk to you about your feelings and attitudes in your particular situation, and would value your comments on some topics especially relevant to mothers in similar situations to yourself.

We would be happy if you would answer all the relevant questions, but realise you may find some of them difficult to answer.

Firstly, we have some questions about some practical matters.

210 Could you tell me about your present accommodation? What is it?

- |  |        |
|--|--------|
|  | c27-28 |
| Rented flat (private)                        | 01     |
| Rented flat (Housing Corporation)            | 02     |
| Rented house (private)                       | 03     |
| Rented house (Housing Corporation)           | 04     |
| Owner-occupied flat                          | 05     |
| Owner-occupied house                         | 06     |
| Living with own parents                      | 07     |
| Living with parents of baby's father/husband | 08     |
| Living with friends                          | 09     |
| Living with other relatives                  | 10     |
| Hostel or similar accommodation              | 11     |
| Other answer (please specify)                | 12     |

.....

211 Does your present accommodation meet your needs?

- |     |     |           |
|-----|-----|-----------|
|     | c29 |           |
| Yes | 1   | Go to 214 |
| No  | 2   | Go to 212 |

212 In what ways is it unsatisfactory?

	c30-31



219 Do you find this job to your liking?

- |                      |     |
|----------------------|-----|
| Like it very much    | c41 |
| Quite like it        | 1   |
| It's ok              | 2   |
| Don't really like it | 3   |
| Dislike it           | 4   |
|                      | 5   |

220 Do you expect to change this job in the next year?

- |     |     |           |
|-----|-----|-----------|
| Yes | c42 |           |
| No  | 1   | Go to 221 |
|     | 2   | Go to 222 |

221 Why would this be?

	c43-44
Go to 222	

222 Do you hope in the future to receive additional training and/or education which will enable you to get a better job or promotion at your present job?

- |     |     |
|-----|-----|
| Yes | c45 |
| No  | 1   |
|     | 2   |

223 Are there any problems with your present job?

	c46-47
Go to 225	

224 Is there any particular reason why you are not in employment at present?

Go to 226	c48-49

Now we'd like to ask you a few questions about your baby.

225 What arrangements do you have for care of your baby while you are working?

Main arrangements	c50-51
Others	c52-53

226 Married: How do you feel about others (not your husband) looking after your child during the day/in the evening?  
Single : How do you feel about others looking after your child during the day/in the evening?

During the day	c54-55
In the evening	c56-57

- 227 Married: If you and your husband wanted/needed to spend a weekend or up to a week without your baby, who (if anybody) would be able to look after your baby?  
Single : If you wanted/needed to spend a weekend or up to a week without your baby, who (if anybody) would be able to look after your baby?

First choice	c58-59
Second choice	c60-61

- 228 Do you feel that there are adequate day care facilities (e.g. day care centres, or creches) suitable for your needs, available in Hamilton?

	c62	
Yes	1	Go to 230
No	2	Go to 229

- 229 Could you tell me more about this? What is needed?

	c63-64

**Married or de facto married: Go to Q. 253 (Single + keeping baby: continue).**  
Now we have a few questions on the topic of finance

230 Could you describe the sources of financial support you are now receiving?

Domestic Purposes Benefit	1
The baby's father supports both	2
The parents of the girl support both	4
The parents of the baby's father support the girl and the baby	8
The girl receives maintenance from the baby's father	16
The girl has a part-time job and also looks after the baby	32
The girl has a full-time job and has the baby minded	64
The girl is supported by friends etc.	128
The girl is helped financially in other ways	256
Other answer (please specify)	512

c65-67

231 Did you find the ante-natal classes of any practical help on the financial side?

	c68
Yes	1
No	2

232 Would you say that your present financial arrangements provide satisfactory/adequate support?

	c69
Yes	1
No	2

The next questions are on the topic of how you've been feeling and who has been helping you.

233 Could you tell me who gives you emotional support, who you can or could talk to when things get you down?

The baby's father	1
The girl's parents	2
Other relative(s) of the girl	4
The girl's friends	8
Social Worker/ health professional (please specify)	16
Voluntary agency/counselling etc. (please specify)	32
Other(s) (please specify)	64

.....

c70-72

Specify here codes 16/32:

234 How much help and support have you received from community agencies, that is other than your family and friends?

First mentioned	c73-74
Second	c75-76
Third	c77-78

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c79-80

Cols 1-4 Duplicate  
Col 5  8  
Cols 6-20 Duplicate

235 How did your parents react when they were told/learned about your pregnancy?

	c21-22
--	--------

And now looking back on your pregnancy:

236 Did you consider having, or trying to have, your pregnancy terminated?

	c23	
Yes	1	Go to 237
No	2	Go to 238

237 Why did you decide otherwise/did you find this was not possible?

	c24-25
--	--------

238 Before you became pregnant, do you feel you were adequately informed about contraception?

	c26
Yes	1
No	2

239 Would you say which of the following reasons explains your pregnancy?

Contraceptive failure (i.e. didn't work)	1
Didn't know then about conception etc.	2
Deliberate decision to become pregnant	4
Didn't think it would happen to me	8
Under the influence of alcohol etc	16
Unwilling partner (includes rape)	32
Any other reason (please specify)	64

.....

c27-29

240 Was the baby's father present during labour and delivery?

	c30
Yes - both	1
Yes - labour only	2
Yes - delivery only	3
No	4

241 Did he visit you at Campbell-Johnstone after the baby was born?

	c31
Yes	1
No	2

242 Were you living with him at the time you became pregnant?

Yes	c32
No	1
	2

243 Have you ever thought about placing your baby for adoption?

Yes	c33	
No	1	Go to 244
	2	Go to 245

244 Why did you decide to keep your baby rather than place him/her for adoption?

	c34-35

And finally your thoughts about the present and the future:

245 How do other people your age, especially males, react when they learn about your situation?

	c36-37

246 How about older people, such as your friends' parents - or your parents' friends?

	c38-39

247 Have you thought about whether your child will be at a disadvantage in the future only having one parent?

	c40-41

248 What do you think about marriage?

	c42-43

249 Would you like to be married?

- |                     |     |
|---------------------|-----|
|                     | c44 |
| Yes - definitely    | 1   |
| Yes - probably      | 2   |
| D.K.                | 3   |
| No - probably not   | 4   |
| No - definitely not | 5   |

250 What sort of problems do you envisage in the future?

	c45-46
	c47-48
	c49-50

251 If you "had your time over again", would you make the same decision to keep your baby and live in your present arrangements?

	c51	
Yes	1	Go to 253
No	2	Go to 252

252 What would you change?

1.	c52-53
2.	c54-55

253 Do you have any other comments to make on pregnancy and parenthood?

	c56-57

254 Do you have any comments to make on this interview or on the Project as a whole?

<u>Interview</u>	c58-59
<u>Project</u>	c60-61

Many thanks indeed for participating in the Project.

## ERRATA

### Introduction

A number of items were omitted from the References; these have been added on the appropriate pages in the References. The following corrections apply to errors in the text.

### Page Line Correction

47	27	"(Zelditch, 1955)" should read "(Zelditch, 1956)".
49	8	"three" should read "four".
54	35	"1966a" should read "1966".
55	23	"Society for Research on Women in New Zealand (Inc.) and Swain, 1979" should read "Society for Research on Women in New Zealand (Inc.) and Swain, 1978".
55	30	"Society for Research on Women in New Zealand (Inc.), 1976a; 1976b" should read "Society for Research on Women in New Zealand (Inc.), 1976".
56	3	"Society for Research on Women in New Zealand (Inc.), 1972a; 1972b" should read "Society for Research on Women in New Zealand (Inc.), 1972".
87		Figure 3.2: the two connectors marked (A) indicate a connection on this diagram; they do not connect to any other diagram.
87		Figure 3.2: "See Figure 3.2" between connectors (C) and (D) should read "See Figure 3.3".
110		Figure 3.9: There should be an arrow-head on the horizontal line linking "Goal attainment" to the vertical (E) line.
143	41	"revision" should be "reversion".
147	9	Delete [5].
169	47	"in" should be "is".
190	40	The formula in footnote [2] should read $R=(P -P)/2$ .
207		Table 6.4 line 6 "nappIES" should be "nappies".
218	6	"nineth" should be "ninth".
220	8	"Swain and Swain, 1983" should be "Swain and Swain, 1982".
223	17	"Crawford and Pool, 1979" should be "Pool and Crawford, 1979".
245	34	"there" should be "their".
251	19	"one-quarter" should be "one-sixth".
263	20	"is" should be "in".
272	44	"Abbott and Koopman-Boyden, 1983" should be "Koopman-Boyden and Abbott, 1983".
293	27	"Wainwright (1964: 96-7)" should be "Wainwright (1966: 96-7)".
308	25	"Deutscher (1962; 1964)" should be "Deutscher (1959; 1962)".
320	1	"Harvey, 1978" should be "Harvey, 1980".
324	8	"Society for Research on Women in New Zealand (Inc.) and Swain, 1979" should be "Society for Research on Women in New Zealand (Inc.) and Swain, 1978".

THE TRANSITION TO PARENTHOOD IN NEW ZEALAND  
AND A DEVELOPMENTAL CONCEPTUAL FRAMEWORK  
FOR THE ANALYSIS OF FAMILY CHANGE

POSTSCRIPT: SOME QUESTIONS & ISSUES

Introduction

In the Preface of this thesis (Swain, 1985: iii) I quoted a passage from the work of Roy H Rodgers (1973: 55n) which is especially relevant to this Postscript:

'I fully recognise my limitations in this ... and take full responsibility for the inadequacies in the treatment of this area which others with greater expertise are sure to find. In my opinion, however, one way to stimulate work in a field is to present it in its incomplete state so that others may see what needs to be done'

The examination process is certainly one opportunity to examine some of the issues raised in this thesis and to generate further stimulating questions. The following nine questions were specifically raised by examiners, so it is appropriate that they are appended to the thesis as a postscript. Unattributed quotations under each question are from the same examiner's report. A somewhat longer document (Postscript: Further Questions and Responses), with a broader range of matters arising from the examiners' reports - some of them suggesting directions or foci for further research, and especially for further use of the developmental model or conceptual framework for the analysis of family change - is available from the author.

References cited in this Postscript which have already been cited in the thesis may be found in the References section of the thesis. References to the thesis itself are in the form (Swain, 1985: page number/s). Any new references will be given at the end of this Postscript.

1. "Aside from the finding of 'no crisis', what substantive theoretical or empirical contribution does this thesis make to the family sociology literature?"

In this thesis I show quite unequivocally that:

there was no crisis as previously defined in the 'parenthood as crisis' or 'transition to parenthood' literature in my 'sample' (more properly, serial coverage of a cohort or population;

much of the previous work (up to about the time of my fieldwork) proclaimed that there was 'crisis' on the basis of research with avoidable and relatively serious methodological deficiencies in such matters as sampling frame, sample size and/or response rates; and

much of the previous work (excepting Oakley, 1980, and perhaps LeMasters, 1957) was largely atheoretical, in the sense that the shaping assumptions, definitions of concepts etc. were unstated and seemingly unconsidered, especially prior to conducting fieldwork.

More generally, it is not accurate to state that this thesis 'focusses on the question as to whether or not first-time parenthood constitutes a crisis'. This was the initial research question, but the finding of no crisis necessarily led to a major re-focussing of the research on the development of a conceptual framework and/or model of developmental change in families which should be neutral in terms of a bias towards either finding or not finding changes to be 'crisis'. Oakley (1980) makes it quite clear that in her study crisis is a basic assumption or a priori description of becoming a mother and hence becoming a housewife. None of the other studies of 'the transition to parenthood' or 'parenthood as crisis' state their premises so clearly. It is of course quite legitimate (indeed, usual) to have such basic premises in social research; it is unfortunately less common to have them presented clearly to the reader. With the conceptual framework and/or model of developmental change in families developed in the latter portion of this thesis, the choice of basic assumptions is set out, and the user is required to spell out the assumptions etc. made.

My data are compared not with 'some of the existing literature' but with all of 'the existing literature on the transition to parenthood' defined as such by those reporting the research (see Swain, 1985: 39-40, Table 2.2) plus a wide though incomplete coverage of cognate studies (Swain, 1985: Appendix A) plus all of the relevant New Zealand studies.

With regard to what has been identified by the present examiner as the 'crucial passage' in the thesis (Swain, 1985: 330), this does not simply state that the thesis "'perhaps" achieves a review of some important conceptual propositions in the field of family sociology'. It comprises the following points:

in terms of the measures used in the literature, the transition to parenthood in this New Zealand study cannot be characterised as a 'crisis';

it is more aptly characterised as a demanding but rewarding transition for virtually all of those studied;

previous findings regarding factors which reduce crisis have not been replicated - even when 'crisis' is redefined as relatively higher scores on the Hobbs Checklist rather than absolute crisis groups as such;

a variety of propositions suggested by Burr (1973: Chapter 6) have been shown to be useful in making sense of the data;

specific concepts and propositions have been shown to be useful for further research;

some new concepts have been defined, shown to be useful, inte-

grated into Burr's framework, and explored using the present dataset; and above all

a conceptual framework and/or model of developmental change in families has been constructed, presented and - used as a model - has been investigated using the present dataset.

It should be noted that this 'crucial passage' only refers to the first theme of the thesis, i.e. crisis. It does not refer to the model or conceptual framework which has been presented and explored (see Chapter 9).

A major feature of the thesis is thus the developmental model or conceptual framework for the analysis of family change presented in Chapters 3, 4 and 9. This may be termed a model or a conceptual framework according to the use to which it is put. I would term the collection of interdefined and interrelated concepts a model if it is used to order and guide the presentation and analysis of data, and a conceptual framework if it is used to shape and focus research.

This model or conceptual framework draws upon a variety of theoretical perspectives in family sociology and in sociology more generally; it incorporates in a non-pathological definition elements often seen in terms of social pathology (e.g. conflict); and it explicitly provides for change, a key dynamic of families (and an important feature of many other social units). When the model or conceptual framework is used for the analysis of families, it centres on the key concepts of family career categories and transitions between categories. It could, however, be used as the starting point for developing a model or conceptual framework for the analysis of other non-family social units.

Considering the family focus first, there are a variety of role transitions throughout the family career to which the conceptual framework could be applied. Of particular interest would be: (a) the transition out of day-to-day parental roles (with its inherent contrasts with the transition into such roles); (b) the transition from not married ('engaged') to married roles (exploring for example the changes in domestic role allocations demonstrated by Koopman-Boyden and Abbott (1983)); and (c) the various role transitions associated with paid employment, including the adolescent or young adult child's transition to paid employment, the multiple re-entries into the paid workforce of married women, and/or retirement from the paid workforce.

There are a variety of other changes or transitions, in which the role element is less central, which could be used to elaborate and improve the conceptual framework, such as major normative changes e.g: (d) religious conversion of adolescent family members to a charismatic sect; or (e) ideological conversion of the wife-mother to feminism.

Substantive topics such as marital breakdown, juvenile delinquency and family conflict could be investigated from a more sociological perspective using this conceptual framework, especially if the 'circumplex model of marital and family systems' with its dimensions of cohesion and adaptability (Olson and Craddock, 1980) were to be incor-

porated. This represents a positive approach to the problem of a 'social work bias' in family sociology (Swain, 1985: 340). The model or conceptual framework is open-ended, and it is quite feasible to consider incorporating other useful models or frameworks such as 'the circumplex model'.

Two further areas highlighted in the model or conceptual framework which invite empirical exploration are 'thresholds' (Swain, 1985: 139-141) and 'morphogenesis' (Swain, 1985: 142-143). Carefully defined areas of behaviour could be explored in relation to thresholds, such as adolescent sexual behaviour, while morphogenesis or deliberate social change could be explored in relation to the growing range of courses, 'laboratories' and other experiential learning situations available in New Zealand in the 'personal growth' and 'relationships' areas.

These further uses and developments of the model or conceptual framework are discussed at greater length in Postscript: Further Questions and Responses, to which reference is made in the Introduction above.

2. Am I confident about deriving conclusions about norms from precoded questionnaires; and if so, what kinds of arguments would I use to support such confidence?

There are several questions here. We may begin by asking why the instruments used were chosen? Were they appropriate to the research objectives? Were largely precoded structured questionnaires appropriate to the study of norms?

Swain (1985: 165-167) shows how the question of the appropriateness of research instruments changed as the research strategy necessarily changed. The MAPI (Blau, Welkowitz and Cohen, 1964), Hobbs Checklist (Hobbs, 1965; 1968) and Russell Checklist (Russell, 1975) were relevant to the original strategy, a quantitative multivariate data-dredging exercise. Once the data had been collected, it was apparent that there was no 'crisis' as conceptualised and measured in earlier studies, and hence the strategy was changed. The dataset was used to explore the model of developmental change in families, and vice versa. The data were not ideally suited to this task. This was particularly the case with regard to the normative dimension - which has been a problem in family sociology (see especially Swain, 1985: 260-264).

These specific instruments were chosen for the original strategy after an extensive review of the literature available prior to fieldwork (i.e. up to 1975). The Russell Checklist (Russell, 1974) had only been published the previous year; the Hobbs Checklist (Hobbs, 1965; 1968) and the MAPI (Blau, Welkowitz and Cohen, 1964) had been available for rather longer. In addition to these formal instruments, an extensive range of pre-coded and open-ended questions was used. These were derived from the literature more generally, and especially from the exploratory research (Swain, 1985: 175-177). Had construction, exploration and improvement of the developmental conceptual framework for the study of family change been the initial objective, then rather a different methodology and hence instruments would have been used.

More particularly, what are the problems of using structured and pre-coded questionnaires to yield information about 'diffuse' areas such as norms? The problems are considerable (Swain, 1985: 167-168). A qualitative approach is very likely to be preferable (see Hubert, 1974; LaRossa, 1977; Graham, 1977; Oakley, 1980). There are evidently considerable problems in the handling of the normative dimension in family sociology (Swain, 1985: 260-264) - perhaps because of the bias towards quantitative methods. The normative dimension was not a major focus of the initial research strategy. It became more salient with refocussed attention on the model or conceptual framework of developmental change in families.

Not all questions were precoded; a variety of open-ended questions gave respondents some opportunity to identify issues, specify areas of concern and so forth. It is recognised however (Swain, 1985: 167) that there are problems of reliability and validity with post hoc coding of open-ended questions, and it is not claimed that conclusive results with regard to norms can be obtained in this way.

3. How do my findings on postnatal depression relate to those of other research in this area? Why is this not discussed in the thesis, and how do I square my conclusion that first-time parenthood is not a crisis with the fact that two out of three mothers reported being depressed?

The earlier literature on post partum depression was mainly clinical, and undoubtedly chauvinistic (see Swain, 1985: 394-411 for a review). Oakley (1980) has dealt with this matter. Her research is focussed on post partum depression, and 'crisis' at first parenthood - as defined - is taken for granted in the terms in which it is defined. The starting point is the realisation that the role or status of 'housewife' (with all its often severe adverse consequences for many women) is typically precipitated by the transition to motherhood.

'Motherhood entails a great deal of domestic work - servicing the child, keeping its clothes and its body clean, preparing food. The demarcation lines between this and house- or husband-work blur. It is a crisis in the life of a woman, a point of no return' (Oakley, 1980: 1).

Neither post partum depression nor post partum maternal feelings more generally were a particular focus of this work as it turned out. Had a significant level of crisis been found, then it would have been appropriate to pursue these substantive topics, and to pay particular attention to the issues raised in Oakley (1980). As it turned out, these matters were judged to be rather less central to the emergent focus of the work, viz. the building of a developmental model or conceptual framework for the analysis of family change.

A comprehensive contemporary account of the transition to motherhood would need to take into account the nature and extent of post partum depression. Such an account would need to be 'contextualised' and interpreted in relation to the 'clinical and academic debate ... about

the cultural 'meaning' of these conditions'. The initial focus of this project was 'crisis' as defined in the extant literature; as a consequence of the data generated by the Hobbs Checklist, the project was reformulated as the construction and initial exploration of a model and/or conceptual framework for the analysis of family change. An extensive discussion of post partum depression was not seen as central to this exercise. It could not, in any case, have been pursued in terms of its 'cultural meaning' without further extensive and sensitive (probably qualitative) data collection.

4. There is a discussion of the 'meaning' of postpartum depression in relation to the potential crisis of first childbirth in Ann Oakley, Women Confined (1980). Very little use is made of this in the thesis. Is this a serious omission?

Oakley (1980) is referenced or quoted several times, in relation to: (a) the allocation of domestic roles (Swain, 1985: 208 in reference to Oakley, 1980: 77-81); (b) the common, shared experience of obstetric processing for women who otherwise have different life experiences and lifestyles (Swain, 1980: 232 in reference to Oakley, 1979; Oakley, 1980; and other studies); and (c) the relationship(s) between antenatal experience(s), labour and delivery, and post partum outcomes (Swain, 1985: 410-411 in reference to Oakley, 1979; Oakley, 1980; and other studies).

The study by Oakley (1980) could well have been discussed more extensively. Women Confined is subtitled 'Towards a sociology of childbirth' (see also Stewart and Erickson, 1977) and is concerned with the sexism and 'chauvinistic ... tendencies' of 'male sociology' in general and family sociology in particular; and the four main consequences of this for the sociology of reproduction (Oakley, 1980: 72-81). These are: (a) the empirical focus on married women in studies of reproductive intentions and motivations, and contraception - at the cost of overlooking the underlying assumptions about marriage; (b) conceptualisation of the same domain for single women as a social problem - thus magnifying the stigma and its social consequences; (c) focus on the impact of reproduction on marriage, not on its meaning sui generis for women - thus reinforcing the notion that reproduction signifies 'the maturation of a marriage' (see LeMasters, 1957; Meyerowitz and Feldman, 1968: 94); and (d) 'child-centred' and not 'woman-focused' research on motherhood.

"Transition to parenthood" as a sociological concept has ... had a limited meaning. Applied narrowly to marriage as the culturally approved context for reproduction, it has been interpreted in a divisively gender-differentiated way. The tasks men and women confront in 'adjusting' as husbands and wives to parenthood have been regarded as different, both explicitly in the framework and conclusions of particular studies, and implicitly in the instruments of inquiry (methodology, interviewing techniques, interview questions) selected for the generation of data ... It follows, therefore, that in sociological studies of the transition to parenthood, only those 'adaptational' tasks relevant to the traditional

gender-differentiated model constitute the research enterprise (are taken as the research problem)' (Oakley, 1980: 77).

Some of these points are raised in a general discussion of the inadequacies of family sociology to date (Swain, 1985: 16-18), with similar references to those made by Oakley (1980: 77), e.g. to Bernard (1973) on 'his and hers' marriage. More particularly, there is reference in the thesis to an earlier treatment of point (d) elsewhere, in which adult-focused research on parenthood, rather than child-focused research on child rearing, is espoused (see Swain, 1978b).

5. Of the initially eligible women, 34.2% were not included in the final sample. It is perfectly possible that the experience of parenthood was different for these women, thus invalidating the main 'finding' of the thesis. Why was an attempt not made to compare the non-respondents with the respondents on characteristics such as age and social class?

Are my non-contact (17.8%) and refusal (16.4%) rates high? Whether given response rates are 'high' or not is a question of judgement and a matter of degree. One standard of comparison is with the literature. The study most closely comparable with the present research is Oakley (1980), which was also a prospective longitudinal study. She restricted her sample to married or de facto married women aged 18-31 with no previous pregnancy (except early miscarriage), who booked-in to the study hospital by the 25th week of their pregnancy, who were born in Britain, Ireland or North America, and who were living within restricted radius of research hospital.

Oakley (1980) recorded first bookings at the research hospital antenatal clinic May-July 1975 (n=86) as the basis of her sample. By the end of her fieldwork (4th interview) loss due to non-contact, refusal and 'attrition' was 36.0%. The following details are from Oakley (1980: 100). It is difficult to reconcile Table 4.1 and the associated text, so the tabular material is used.

Table A: Non-Response in Oakley (1980)

Initially eligible n=86		100.0%
Non-contacts (various)	8.1%	
Medical exclusion	8.1%	
Refusals (various)	7.0%	
		76.8%
Attrition between i/vs 1 & 2	11.6%	65.2%
Attrition between i/vs 2 & 3	0.0%	65.2%
Attrition between i/vs 3 & 4	1.2%	64.0%
Final response rate:		64.0%

In Swain (1985: 171) a cohort or population was recruited serially from May to November 1976. The only criteria were routine booking-in to the study hospital (to exclude cases of obstetric difficulty from outside the unit's routine catchment area) and no previous live birth. A comparison with Oakley (1980: 98-100) follows. Categories used in Swain (1985: 180-181) have as far as possible been harmonised with Oakley (1980); percentages for Oakley (1980) follow in parentheses:

Table B: Non-Response in Swain (1985)

Initially eligible n=366		100.0%
Non-contacts/exclusions	17.8%	(16.2%)
Refusals/attrition n.e.c.	16.4%	(19.8%)
, Response rate		65.8% (64.0%)

It can be seen that Oakley (1980) finally achieved a response rate of 64.0% compared with my 65.8%. It could be argued that the eligibility criteria used in Oakley (1980), which were appropriate to her purposes, may have made her sample easier to recruit and retain, compared with the cohort or population coverage in Swain (1985). However, there is no indication in Oakley (1980) that the response rate is unduly low, or that it may have unduly influenced the findings. Both Oakley (1980) and I apparently came to similar conclusions: that our response rates were such that no warning as to possibly misleading effects of non-response was necessary. Indeed, Kirkpatrick (1978) found no such warning necessary with a response rate of 21.4%.

Turning to other studies, only four (Hobbs, 1965; Hobbs, 1968; Russell, 1974; Kirkpatrick, 1978) used random samples drawn from defined working universes. Hobbs (1965) reported a response rate of 'about 65%' but gave no further details. Russell (1974) with a random sample from birth records of n=511 couples achieved a response rate of 53.0% (for couples; for wives it was 57.9% and for husbands it was 53.4%). She gave no further details regarding non-contacts, refusals etc.

Kirkpatrick (1978) used a stratified proportionate simple random sample with n=2000. Non-contacts (wrong address) were 5.1%; incomplete returns were 1.6%; refusals/non-responses were a massive 71.9%. Thus the effective response rate was 21.4%, not 'about 25%' as stated by Kirkpatrick (1978: 61).

In considering whether the non-respondents in my research may have differed from respondents, my administrative records may be examined for details of the grounds for these forms of non-response. Of the non-contacts, 77.4% were (or appeared from medical records to be) married; other categories were thus 22.6%. This indicates that single women, and those in transition out of marriage, were somewhat over-represented among the non-contacts. This was consistent with suggestions made by expert and key informants prior to fieldwork, and parallels the experience of the C-J Antenatal Clinic who found single women as a group were more likely to book-in late, less likely to keep

appointments, and more difficult to contact. Specific reasons for or background to non-contact were difficult to determine, and were obtained for only 25.8%. These were all in the category of social circumstances.

Over three-quarters (78.9%) of excluded respondents were married (21.1% other categories). Of these exclusions, 42.1% were on medical grounds (e.g. maternal ill-health), 26.3% were on social grounds, and there were no recorded reasons (except the expert adviser's notice of exclusion) for the remainder (31.6%).

Of the refusals, 86.8% were married, and 13.2% were not married. The proportions in the total sample were: married, 83.9%; other categories 16.1%. Most of the refusals (83.0%) did not give a reason (nor were reasons sought); the remainder (17.0%) gave various social circumstances as reasons.

It can be seen that refusals corresponded more closely to the marital status pattern of the respondents, while exclusions diverged somewhat and non-contacts diverged rather more. However, the basic measure of crisis was based on married respondents only, in order to be consistent with the other reported research. Thus it is unlikely that the undue proportion of single women among the non-contacts will have affected the basic conclusions.

It is of course possible that a disproportionate number of married refusals, exclusions and/or non-contacts are women who would have reported higher crisis scores. To this extent, any response rate less than 100.0% raises some doubts as to the findings, and especially their statistically normative value. In the present research, however, these doubts are of acceptable magnitude.

6. How representative was the final sample of the population [sic] in terms of obstetric intervention rates? Did my 'sample' receive 'atypical' obstetric care? What 'antenatal medical interventions' did they receive?

I state in several places that this was a 'normal' group or population of prospective parents (e.g. Swain, 1985: 2, 4-6, 171-172). In one place (Swain, 1985: 186) I refer to respects in which Hamilton and Campbell-Johnstone Obstetric Unit may have been atypical.

In sociodemographic terms Hamilton comes as close as any city in New Zealand, and closer than some, to being 'typical' or 'average' (i.e. similar to national sociodemographic characteristics). The two major child development studies in New Zealand are being conducted in Christchurch and Dunedin, which are clearly less representative than Hamilton in some ways (ranging from ethnic composition to cot death rates).

Hamilton does have a high level of inward and outward geographical mobility, which may mean the young adult population have fewer kin and other social network resources than in more stable communities, and hence might be more likely to experience crisis at the transition to

parenthood. However, the city also has very extensive and energetic community organisations, especially in the parent education/support areas, and these might serve to reduce the experience of crisis.

Turning to Campbell-Johnstone Obstetric Unit, the respondents were clearly a normal cohort in the sense that they were drawn from those who were routinely 'booked-in' to C-J, excluding those from outside the C-J catchment area (but within the Waikato Hospital region) who might be referred for obstetric problems. As C-J was the only obstetric and/or maternity facility in Hamilton, and there were at the time no home births, the coverage of the urban and associated rural population was complete.

It is possible that the general policy and atmosphere of C-J at the time of the fieldwork were more 'positive', 'progressive' or 'relaxed' than was the New Zealand norm at that time. Thus, there were efforts to accommodate women's wishes as to who was with them at labour and delivery, position for childbirth, medication, and so forth. Specifically, the woman's partner and/or the baby's father was encouraged to be present and supportive. Some emphasis was also placed on staff skills in human relations. These features might be thought to reduce the chance of later experiencing crisis, although the converse could also perhaps be argued.

With specific regard to obstetric care, expert and key informants in the exploratory research indicated that this was uniform across the sample, and was the standard approach at the time for women delivering at a larger unit (it may have been less formal at a smaller suburban or rural maternity hospital). This is outlined in the thesis (Swain, 1985: 238-240). The general practitioner had an important role for these women (Swain, 1985: 241), although this may have diminished somewhat since then. The respondents saw C-J Ante Natal Clinic doctors and nurses regularly throughout their pregnancy from the time of booking-in, and reported at the second interview (36 weeks of pregnancy) that they were 'well' (70.5%) or 'well with minor problems' (25.7%).

I am not entirely clear as to what 'antenatal medical interventions' refer, but I presume this includes medication during pregnancy, antenatal hospitalisation (e.g. for HOP syndrome - 'toxaemia'), and induction of labour. No information was obtained on antenatal medication. Antenatal admission to C-J was experienced by 17.8% of the respondents - for HOP in half of these cases (9.1% of the sample) - and the induction rate was 6.1% (Swain, 1985: 247).

The experience of labour and delivery was relatively highly 'medicalised', with only 34.5% experiencing a vaginal delivery without obstetric intervention, 29.4% experiencing forceps assistance (mostly low forceps), 22.2% experiencing manual manipulation, and 10.3% experiencing a caesarian section (Swain, 1985: 247-248). It is difficult to obtain comparative national data for these interventions, and indeed the whole question of 'typicality' requires specification of the grounds of comparison.

My best judgement in this regard is that at the time C-J was not significantly different from other obstetric units attached to base hospitals, all of which may have somewhat higher levels of intervention than outlying maternity hospitals (which cover only a minority of the population). Insofar as the question as formulated can be answered, the obstetric care of these respondents was 'typical'.

7. On what basis did I decide to include and discuss in the text some statistical associations between variables, and not include others?

Statistical associations were included on one or more of several grounds: (a) they had been reported in the literature, (b) they were prima facie relevant, and/or (c) they reached or approached statistical significance as between the high and low Hobbs Checklist scores.

The data are original in the sense that they refer to a previously unresearched community in a largely unresearched society; they are unoriginal in that findings from previous research are being tested. They are unsurprising in that there is no 'concealed' crisis, and no differences were found (despite deliberately exhaustive testing) between those respondents with the highest 'crisis' scores (albeit scores which cannot usefully be characterised as 'crisis' per se) and the remainder of the respondents.

If I had not checked out these possibilities, I would be vulnerable to the charge that there might be meaningful differences between the two constructed groups - 'crisis' and 'non-crisis'. A parallel might be drawn with the classic strategy used by Emile Durkheim in a similar exercise in respect of possible non-social causes of suicide.

8. To what extent is there a 'social work bias' in the transition to parenthood literature, and more generally in family sociology? Do I give sufficient attention to this epistemological issue?

The general epistemological issue is raised at the beginning of the thesis (Swain, 1985: 3-4), mainly in regard to the perhaps subtle and probably insidious influence of unexamined conceptual frameworks and theoretical orientations on the interpretation of empirical findings which are not entirely unambiguous. The question of a 'social work bias' is a cognate issue.

I would define this as several related features of the family sociology literature, in no particular order of importance: (a) the use of 'at risk', 'client' and/or other non-normative populations or sampling frames in research which is then used as the basis of what are treated as (statistically) normative statements; (b) an interest in the application of social research findings to social policy and social action (including social work practice) which shapes the definition of research problems, interpretation of data, etc.; (c) conceptualisation, research design, instrumentation and/or analysis based upon assumptions etc. derived from social intervention practice (e.g. parent education, social casework, etc.).

There are examples in the literature on the transition to parenthood of research based on 'at risk', 'client' and/or other non-normative populations or sampling frames (e.g. LeMasters, 1957) which is then used as the basis of (statistically) normative statements, especially in secondary sources (e.g. Winch, 1971: 353-354). Where the non-normative aspect is clearly stated in the primary material, and analysis explicitly takes this into account (especially in generalisations from the special or working universe to a more general universe), there is no problem with that primary material. The problem, then, lies with its secondary use (e.g. in textbooks) as descriptive of normative patterns. Where the focus is on analysis of relationships or processes rather than description of normative characteristics of a society or group, it is quite possible that valuable findings can be derived from non-normative data.

The second issue, where an interest in the application of social research findings to social policy and social action (including social work practice) shapes the definition of research problems, interpretation of data, and so forth, is a more subtle problem. It is perhaps embedded in a more substantial problem for family sociology: the appropriate means by which to effect the selection, identification and delineation of research problems or topics.

This is often (perhaps most characteristically) begun by selecting a substantive topic, perhaps on the basis of convenience or some other pragmatic consideration (Sjoberg and Nett, 1968), and then - or perhaps later, after data collection - seeking some applicable concepts and theoretical propositions. From one point of view, this makes the social research vulnerable to the sort of bias indicated in the above criticism. It has however been argued (Mazur, 1968) that sociology is 'the littlest science' because it lacks the massive amounts of data which have transformed, for example, astronomy or physics. A consideration of social problems is thus seen to be as useful a way as any of identifying the research topics which are to yield these massive infusions of data - because (following Popper, 1960) we cannot know in advance what new knowledge will be most fruitful in advancing our understanding! On this view, the influence of an interest in social action or the application of social research findings is not ipso facto a problem. It may be a problem if the grounds upon which research topics are selected etc. are not made clear.

The third issue, of conceptualisation, research design, instrumentation and/or analysis being based upon assumptions etc. derived from social intervention practice (e.g. parent education, social casework, etc.), seems rather to depend upon the extent to which the basis of assumptions etc. is made explicit. This criticism could be reformulated in terms of hidden assumptions etc. rather than the assumptions etc. per se.

A reading of the specific 'transition to parenthood' literature (and more helpfully, the original questionnaires, researchers' affiliations and the like) suggests that the problem with this body of literature lies more in the implicit character of the social action/work interests, assumptions etc. than in 'bias' per se.

9. To what extent may changes in contraceptive practice (and hence degree of choice in becoming parents) between the earlier studies showing crisis [9] and the later studies showing little or no crisis [10] have influenced the degree of crisis experienced?

The general argument would be that the greater availability, convenience, reliability and use of contraception in more recent years may have improved the degree of choice in becoming a parent for the first time, and that this greater degree of choice is likely to have reduced the degree of crisis experienced at the transition to parenthood. Two situations are contrasted:

(a) the typical couples of the 1950s and early 1960s were likely to have conceived without the pregnancy being planned, intended or desired; in the absence of abortion they are likely to have experienced a 'shotgun' or precipitated marriage, or less dramatically an earlier and less desired transition to parenthood; and such couples are likely to report stress, distress and/or crisis; and

(b) the typical couples of the later 1960s and 1970s had improved contraception available, were more likely to have planned their first pregnancy, and hence were less likely to report stress etc.

This general issue was addressed in the thesis (Swain, 1985: 45) in the context of a similar point made by Rossi (1968: 30-31) about the involuntary assumption of parental roles. There are several points to discuss here.

When were the major improvements in contraception? The 'early 1960s' saw 'the development of the pill, the improvement of intrauterine devices, and the simplification of sterilisation techniques' in the United States (Levine, 1982). Westoff and Ryder (1977) refer to this period as the 'contraceptive revolution'. 'In the 1960s and 1970s ... use of oral contraceptives ... increased, and surgical sterilisation for the control of fertility rose markedly' (Ford, 1982).

The earlier studies are LeMasters (1957) to Dyer (1963); possibly Feldman (1971 - his data may be from Meyerowitz and Feldman, 1966); and Tooke, 1974. The findings from LeMasters (1957) and Dyer (1963) may well represent the period when the contraceptive revolution was occurring. Feldman (1971) and Tooke (1974) seem to refer to a later period, although the former's data may have been from earlier, and the latter's fieldwork was among disadvantaged Appalachian families who may not have experienced the contraceptive revolution.

The later studies are Hobbs (1965) to Kirkpatrick (1978); and of course Swain, 1985 (fieldwork 1976). They fall fairly readily into the later period of the contraceptive revolution. These respondents may have had more effective contraception more readily available.

In New Zealand the Hutt Valley (Reinken and Blakey, 1976) and Manawatu (Trlin and Perry, 1981) studies indicate that contraceptive use in New Zealand and similar societies is such that married women are more likely to practice contraception than single women, and those who have reached or exceeded their desired family size and/or sex composition are more likely to practice contraception (especially sterilisation) than those who have not done so.

This suggests that effective contraception is less likely to be practiced prior to the conception which results in the transition to parenthood than thereafter and prior to subsequent conceptions. Thus, changes in contraceptive practice are unlikely to have reduced the chances of experiencing 'crisis'.

With regard to my findings (Swain, 1985: 195, Table 6.2), there are some relevant data. To what extent did the married respondents plan the pregnancy which resulted in their transition to parenthood? One-third (37.6%) planned to conceive and planned the timing thereof; a further one-third (35.8%) intended in general to start a family at some stage, but did not plan to conceive when they did so; around one-sixth (18.8%) had no definite intentions one way or the other in regard to having a family, and certainly did not plan to conceive when they did, but found their conception acceptable; and a few (7.8%) had no definite plans to have a family, certainly did not plan to conceive when they did, and found their conception less than acceptable.

The contraceptive pill was the dominant contraceptive method used by the married respondents (70.6%), with very few using other methods (7.8% in total), and the remainder (21.6%) using no contraception prior to this conception. The phrase 'prior to this conception' was interpreted as meaning either prior to ceasing contraceptive use or prior to becoming pregnant. Cross-tabulation of pregnancy planning by contraceptive practice (Swain, 1985: 197) shows two relatively large groups: a quarter (25.3%) had completely planned this conception and had previously been on the contraceptive pill; and a quarter (24.9%) had intended to conceive at some time and had previously been on the pill. The remainder fell in small proportions into a large number of permutations.

What is clear is that only a quarter of the married respondents (25.3%) fell into a category consistent with the idea that the greater availability of contraception led to more planned parenthood and hence less or no crisis.

While neither the general arguments nor the findings are unequivocal, it seems reasonable to conclude that while major macrosocial changes may have shaped the general pattern (of earlier studies showing crisis while later studies do not), on balance this has not been demonstrated. From a demographic point of view it might well be argued that more attention should have been paid to these issues of contraception and family planning. From a feminist point of view it might well be argued that more attention should have been paid to post partum depression and its cultural context. This research was not on either demographic aspects of fertility decision-making per se or childbearing per se. It was initially centred on the sociological literature on the transition to parenthood, and thereafter on formulating and improving a model or developmental conceptual framework for the analysis of family change.

## Conclusions

The specific question and issues raised during the examination process have been discussed. Some of the criticisms are valid; some are debateable. Adoption of the 'stance of improvement' (Rodgers, 1973: 55) by a researcher requires that questions and comments be actively welcomed and - where appropriate - integrated into his/her work. A longer document (Postscript: Further Questions and Responses) is available which continues this open-ended process. Further contributions are welcome.!

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## Footnotes

- [1] The major earlier studies are LeMasters (1975) to Dyer (1963); possible Feldman, 1971; Tooke, 1974.
- [2] The major later studies are Hobbs (1965) to Kirkpatrick (1978); and of course Swain, 1985 (fieldwork 1976)

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